PSYCHOLOGY AND SUBSTANCE USE
AN INTEREST GROUP OF THE AUSTRALIAN PSYCHOLOGICAL SOCIETY

PSU Newsletter

August 2002

Volume 2 Issue 2

Inside this issue:

Convener's Report	1
NSW Update	2
PD Calender VIC	2
Email Updates	2
Journals for Review	2
A drug called…? David Ryder	3
Working with parents of adolescents who use substances. Sally Walker	4
Notice of 2002 AGM	4

By the way...

Stanton Peele is something of a maverick in the American alcohol and other drug scene. If you can get past his quirks, such as rating websites with 0-5 pictures of his own head, he is a committed voice for a more moderate approach to clients with alcohol and other drug solutions. Whether you agree with everything he says, he is a worthy source of food for thought and, in person, a warm and compassionate man who has the courage to go against the conservative tide to advocate for a more respectful and less prescriptive response to AOD clients.

http://www.peele.net

Convener's Report

A big hello to our new members and a warm welcome back to our existing members. We're looking forward to the coming subscription year of PSU and hope you find it a significant contribution to your professional work.

I have just been to a day long session for interest group conveners at the APS head office (yes, I survived, thank you for your concern). I was impressed with the general level of enthusiasm amongst the APS staff and volunteer conveners for the profession and what it has to contribute. One of the more immediate changes is the opportunity to create a website for the interest group on the new APS website. But the day also provided information on the resources available to us and some good food for thought that I hope will translate into practical benefits for you and your work over the coming months.

Between his many other duties, our wonderful secretary Graeme has been working hard (as always) to hunt down more books and journals for members to review (and keep). One day he might just run away and join the circus, so let's appreciate him while he's willing to sacrifice so much of his personal time for us.

And speaking of websites, the ADIN website is going from strength to strength. One function that may be of interest is that you can not only save a search, but also have updates of new items relating to your search emailed to you, which is useful if you have a particular topic you are interested in (http://www.adin.com.au).

In July I attended Babette Rothschild's workshop on working with trauma, and the symptoms of hyperarousal and dissociation in particular. Apart from finding myself next to a PSU member (hi Kathy!), it was an interesting experience. Rothschild pulls together the work of people like Bessel van der Kolk on the physiology of trauma and the longer term changes that can occur in response to traumatic experiences, immediacy skills of approaches such as Gestalt therapy, and her own background in body psychotherapy. And as such, Rothschild does not present new information so much as translate a range of body-based approaches into an easy to understand format for the counsellor who works within the traditional "talking cure".

Throughout the workshop, I kept thinking on how relevant Rothschild's presentation was to our work in the drug and alcohol field. So many people who have experienced some kind of trauma - whether it was individual events or chronic exposure throughout their childhood - learn that alcohol or other drugs can provide relief, at least in the short term. In addition, substance use is itself a physical solution that directly manipulates body functions. Yet chronic substance use can also interfere with the ability to identify and accurately interpret physical sensations. I remember one young woman who had just stopped using heroin. She described an incident from the previous week where she had strange stomach pains and was trying to work out what was wrong. Not sure what else to do, she ate something and the pain went away. "I must have been hungry!" she said with genuine surprise.

In the break before the workshop came to a close, I asked Rothschild to comment on how she worked with clients who used substances to cope with their trauma. After such a positive, warm workshop where respect and compassion for clients was continually emphasised, I was saddened by her response that she generally required substance-using clients to attend AA or NA. While these groups can provide life-saving support to some clients, others find the twelve step approach is not helpful and, at times, invalidating or even a source of further trauma.

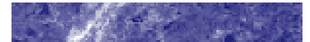
Yet the positive side of the disappointment I felt was the opportunity to reflect on the culture of the Australian approach to alcohol and other drug use issues and, to be honest, I think we're doing pretty well. Substance use issues can easily become a blind spot in the awareness of otherwise highly skilled clinicians. Let's face it, chronic substance use can be hard to work with. Yet while we continue to develop greater understanding and strive to improve our treatment systems, there is an awareness that different people need different solutions. In embracing the pragmatism of harm minimisation, we are less likely to adhere to a "one size fits all" approach that may present some clients with more difficulties, not less.

We also hope the PSU forum "From Pavlov's Dog to Hair of the Dog" at the coming APS conference will provide an opportunity to reflect on the overlap between traditional psychological theories and the work being done within the alcohol and drug field, as well as provide practical strategies born of deeply held belief that we can offer our clients a greater range of options than simply recommending AA and NA.

Helen Mentha
Convener

Articles by van der Kolk, go to http://www.trauma-pages.com/

Rothschild's website go to:



NSW Update

Jenny Melrose was involved in a survey of NSW members to ascertain level of interest in establishing a State Branch there, as well as wanting to gauge members' interests and needs.

Regrettably only 6 members responded. If a state branch is to be established, APS by-laws require the signature of 10 members prepared to be involved. Three positions essential are the Chair, Secretary and Treasurer. We'll keep encouraging NSW members to consider establishing at least NSW activities if not a state branch as it would be a pity to only offer PD opportunities in Victoria as members have voiced a strong desire to attend PD activities. This has been shown in the numbers to PD seminars we run in Victoria.

The new funding arrangements mean that state branches are allocated funding to assist in running activities for members. This would assist in the hiring of venue and speaker costs. Those interested, contact me.

Graeme Kane

PD Calender Victorian - 2002

Date	Topic	Speaker
18th September	Drugs: How do they act? What if we mix them? And what if we use them for a long time?	Dr Jenny Redman
20th November	Motivational Interviewing (2 Generalist PD Points for this workshop only)	Helen Mentha

The venue for the two remaining seminars is the Boroondara Community Health Centre—378 Burwood Road, Hawthorn. They run from 7.00 to 8.30 pm. Entry is via the rear gate and those intending to attend do need to contact me so that I can ensure that adequate seating is provided. RSVP - graemeedas@iechs.org.au or on 03-9810 3087. If you have any ideas for next year's calendar, let me know at the above postal or email address or call my direct number.

Graeme Kane

Email Updates

Members who have supplied the APS with their current email addresses will be familiar with my occasional contact with updates on books for review.

I use emails to ensure that members across all states and territories are provided with up-to-date opportunities and information that may be of use to them. This applies to those in other states and in non-urban areas. I will be emailing members about web sites, journals and books available for review, professional development, and other bits and pieces of interest. The subject heading will have PSU and other relevant information to assist you judging its relevance to you. For example, the next newsletter will not clog up your account as I will be alerting members that they can download it from the APS web site.

Please note however that when an email bounces back to me, I do make a note to post the newsletter. I would ask members to advise APS when you change your email address as we intend to reduce paper use, postage and provide a faster, more flexible information service.

Graeme Kane

Haworth Press Inc

I am pleased to announce a new opportunity for members!

I have fostered a close link with an editor and staff from Haworth Press Inc in New York. This will translate into opportunities for members to obtain sample journals and books for review for the newsletter, as well as publication opportunities.

I have a small collection of sample journals available to members willing to review them. Please contact me, nominating the journal that you would like to receive and a brief outline as to how it relates to your work, study, area of interest or research.

Graeme Kane

Journals Available for Review

- Journal of Child and Adolescent Substance Abuse
- Journal of Ethnicity in Substance Abuse
- Journal of Teaching in the Addictions
- Journal of Addictive Diseases
- Alcoholism Treatment Quarterly
- Journal of Social Work Practice in the Addictions

Contact Graeme Kane by my email or postal address if you would like to receive a sample copy for free. In return, we ask that members provide a brief review (500-800 words) for this

National Executive Contact Details

Feel free to contact us at the following email and postal addresses:

National Convener Helen Mentha helenedas@iechs.org.au

National Secretary Graeme Kane graemeedas@iechs.org.au - 378 Burwood Road, Hawthorn, VIC, 3122

National Treasurer Yvonne Tunny yvonne@bchs.org.au

A drug called ...? Can psychologists have a major impact for minimal effort on public health? David Ryder

Let us play an old television quiz show and ask a series of questions about a certain behaviour?

1. Which drug has been used in the last twelve months by 23% of Australians aged 14 and over? (Australian Institute of Health and Welfare, 2002).
2. Which drug is used every day and usually several times each day by 19.5% of Australians aged 14 and over, an estimated 3 million people? (Australian Institute of Health and Welfare, 2002).
3. Which drug is used by 56% of indigenous Australian males and 48% of Australian females aged 15 and over? (Cunningham, 1997).
4. Which drug will lead to dependence in 32% of those people who have ever used it? (Anthony, Warner and Kessler, 1994).
5. Which drug kills 50% of those who use it regularly in the manner that it is intended to be used by it's supplier? (Peto, Lopez, Boreham, Thun and Heath, 1994).
6. Which drug kills 15% of all Australians who die each year from all causes, producing a loss of 88, 266 person years of life, an average of 4.7 years loss of life for every person who is killed by this drug? (English et al, 1995).
7. Which drug contributes substantially to: cancer of the lung, larynx, oral cavity, oesophagus, bladder, kidney, pancreas, stomach and cervix; coronary heart disease; cerebrovascular disease; chronic obstructive airways disease; pneumonia; lowered fertility; low infant birth weight; sudden infant death syndrome; and peptic ulcer; to name just a few? (Australian Institute of Health and Welfare, 1996).
8. Which drug, conservatively, cost the Australian economy $12,000 million in 1992? (Collins and Lapsley, 1996).
9. Which drug contains, in addition to it's major psycho-active constituent, carbon monoxide, polynuclear aromatic hydrocarbons, vinyl chloride, nitrosamines, hydrogen cyanide, ammonia, acrolein and formaldehyde (International Agency for Research on Cancer, 1986, United States Department of Health Human Services, 1989).
10. Which drug has been offered to 57.2% of the Australian population aged 14 and over? (Australian Institute of Health and Welfare, 2002).
11. Which drug is seen as being the drug most associated with a drug problem by just 2.7% of Australians aged 14 and over? (Australian Institute of Health and Welfare, 2002).
12. Which drug is seen by 40% of the Australian population as acceptable when used regularly by adults? (Australian Institute of Health and Welfare, 2002).
13. Which drug is more likely to be used by female teenagers (16%) than male teenagers (14%) every day and several times during the day? (Australian Institute of Health and Welfare, 2002).

The answer, as you have probably worked out, is smoking cigarettes. While the above questions highlight the bad news – cigarette smoking is a major cause of morbidity, mortality and economic costs to the community and is a most difficult behaviour to cease once one has become dependent upon regular nicotine doses – there is some good news.

There are clear benefits from stopping smoking. Immediate gains result in improved lung function and general cardiovascular fitness. All-cause mortality falls to that of those who had never smoked within 10 to 15 years of smoking ceasing. The risk of coronary heart disease falls by 50% within a year of stopping. The risk of Myocardial Infarction is twice that of those who have never smoked within two years of stopping and is the same as those who have never smoked four years after stopping (United States Department of Health and Human Services, 1990). Changes in cancer risk vary depending upon the type of cancer. Lung cancer risk always remain higher than for those who never smoked, but reduces significantly the longer one remains an ex-smoker (Okuyeme et al, 2000).

So what has this got to do with psychologists? Evidence shows that relatively brief intervention with smokers leads to small but, from a public health point of view, highly significant reductions in smoking. Law and Tang (1995) reviewed 20 studies of brief advice (5 minutes or less) and showed a 2% reduction in smoking compared to 0.1% reduction in those who had no intervention. They also showed that additional interventions in the form of follow up letters, telephone calls, demonstrating improvements in lung function using a spirometer and extra visits improved quitting rates to 5%. While at first glance these rates may prompt pessimism, in a public health sense they are very significant. In the USA primary care physicians have access to 70% of all people who smoke, which is 35 million people. It is calculated that a quit rate of 5% with these smokers would result in 1.73 million smokers given up smoking each year (Okuyeme et al, 2000). Russell, Wilson, Taylor and Baker, (1979) note that a 4% quit rate by general practitioners in the United Kingdom would yield half a million ex smokers each year, which is more than could be achieved by setting up 10,000 specialist smoking cessation clinics with claimed quit rates of 20% to 25%.

Much emphasis regarding brief intervention and smoking has focussed on doctors, but there is no reason why psychologists should not also make a contribution to reducing a significant public health burden. A 2% to 5% reduction in smoking amongst those clients who are smokers is a significant gain for minimal input. Procedures are available which can be readily used for this purpose. The American Agency for Health Care Policy and Research (1996) recommends a 5 step approach: ask all clients whether they smoke; advise those who do smoke to give up; assess the smokers willingness to quit; assist those who are willing to quit by setting a quit date, providing brief guidance as to how to successfully quit; and arrange a follow up. Quit rates can be further improved by the use of nicotine replacement therapy in the form of chewing gum, patches, nasal sprays and inhalers, and non-nicotine drugs, including the anti-depressant zyban. While low dose nicotine gum is available over the counter from pharmacists, higher dose gum and other drug treatments require a prescription. Developing good working relationships with a doctor would certainly be useful.

There is much, appropriate attention paid to harm that arises from the use of illegal drugs. But in a non-dramatic, low key and resource limited way psychologists are well placed to contribute to the health of Australians by assisting smokers to quit.

References

Agency for Health Care and Policy Research (1996). Cessation: Clinical Practice Guidelines. Journal of the American Medical Association, 275, 1270-1280.

Anthony, J.C., Warner, L.A. & Kessler, R.C. (1994) Comparative epidemiology of dependence on tobacco, alcohol, controlled sustances and inhalants: basic findings from the comorbidity survey. Experimental and Clinical Psychopharmacology, 2, 244-268.

Australian Institute of Health and Welfare. (1996). Australia's health 1996. Canberra: Australian Government Publishing Service.

Australian Institute of Health and Welfare (2002). National Drug Strategy Household, First Report. Canberra: Australian Government Publishing Service.

Collins, D. and Lapsley, H. The social costs of drug use in Australia in 1988 and 1999. NDS Monograph Series No 30. Canberra: Commonwealth Department of Health and Human Services.

Cunningham, J. (1997). Cigarette smoking among Indigenous Australians. Occasional paper, ABS Cat. No 4702.0. Canberra: Australian Bureau of Statistics.

English, D.R. et al. (1995). The quantification of drug caused morbidity and mortality in Australia 1992. Canberra: Commonwealth Department of Health and Human Services.

International Agency for Research on Cancer (1986). Monographs on the evaluation of the carcinogenic risk of chemicals to humans: Tobacco smoking, volume 38. Lyon, France. World Health Organisation.

Law, M. & Tang, J.L. (1995). An analysis of the effectiveness of interventions intended to help people stop smoking. Archives of Internal Medicine, 155, 1933-1941.

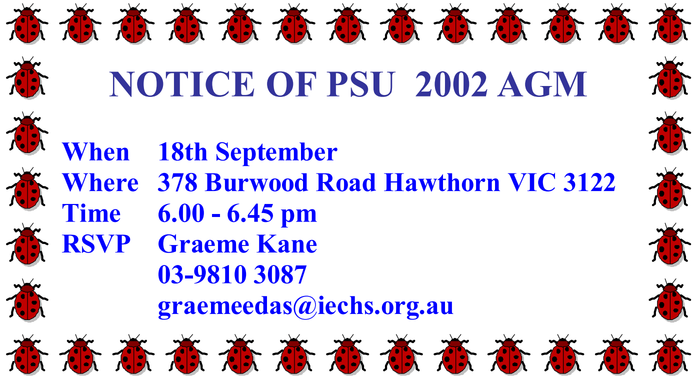
Okuyeme, K.S., Ahluwalia, J.S. & Harris, K.J. (2000). Pharmacotherapy of smoking cessation. Archives of Family Medicine, 9, 1-29.

Peto, R., Lopez, A.D., Boreham, J., Thun, M. & Heath, C. (1994). Mortality from smoking in developed countries. 1950-2000. Oxford: Oxford University Press.

Russell, M.A.H., Wilson, C., Taylor, C. & Baker, C.D. (1979). Effect of general practitioners advice against smoking. British Medical Journal, 279, 231-235.

United States Department of Health and Human Services (1989). Reducing the health consequences of smoking: 25 years of progress. A report of the Surgeon General. Washington DC: Public Health Service.

United States Department of Health and Human Services (1990). The health benefits of smoking cessation. Washington DC: Public Health



Working with Parents of Adolescents who use Substances: Summary article of PSU workshop May 22nd 2002, Sally Walker

Recent literature has indicated that family functioning contributes to potential adolescent drug use (Jenkins, 1998; Nurco, 1998 and Gabel, 1998). Nurco (1998) notes that parental history of substance use, sole and step parent families and the gender of the main parental figure are factors that may increase the likelihood that an adolescent will engage in drug use. Particular parenting styles, such as lack of supervision, lack of closeness and inconsistent discipline are possible risk factors to the involvement in drug use (Nurco, 1998 and Califano, 2000). Other factors to be considered include an adolescent's peers, socio-economic status, community and cultural background. Adolescent drug use usually occurs within a context of multiple factors (Hawkins & Catalano, 1992).

In addressing these health behaviours an understanding of adolescent developmental pathways is critical in order to intervene in a manner that will be relevant to the adolescent. When working with families one approach that has been effective is the ultisation of brief solution focused therapy (Coatsworth, 2001). The essence of this approach is to work from a solution focus rather than remaining problem saturated. The client is the expert in the process and that the use of particular therapeutic tools by the therapist facilitates the intervention (Walter & Peller, 1992).

When working with parents of adolescents who use substances common themes that parents present with include emotional states of blame, anger and fear. Provision of education about adolescent drug use is often a helpful starting point when working with these families (Toumbourou, 2001). Exploring with parents the family's values and beliefs system regarding substance use, that is, zero tolerance vs harm minimisation, will assist to determine the nature of information that will be most effective in supporting the family initially. Previous notions of a "tough love" approach have been challenged with the alternative to be the encouragement of healthy limit setting in order to appropriately support the adolescent.

References

Califano, J. (2000) It's all in the family. America, 182, 6-8

Coatsworth, J.D. (2001) Brief strategic family therapy versus Community control: Engagement, retention and an exploration of the moderating role of adolescent symptom severity. Family Process, 38 5-26.

Gabel, S. (1998) Family variables in substance-misusing male adolescents: the importance of maternal disorder. American Journal of Drug and Alcohol Abuse, 24, 61-84.

Hawkins, J. & Catalano, R. (1992) Risk and protective factors. Alcohol and other drug problems in adolescents and early adulthood. Psychology Bulletin, 112, 64-105.

Jenkins, J. E. (1998) The relationship of family structure to adolescent drug use, peer affiliation and perception of peer acceptance of drug use. Adolescence, 33, 811-822.

Nurco, D. N. (1998) The family experiences of narcotic addicts and their subsequent parenting practices. American Journal of Drug and Alcohol Abuse, 27, 651-687.

Toumbourou, J. W. (2001) Working with families to promote healthy adolescent development. Family Matters,59, 54-60.

Walter, J. L. & Peller, J. E. (1992) Becoming Solution-Focused in Brief therapy. Brunner/Mazel. Levittown, PA.

Presented by:
Sally Walker – Clinical Counsellor in Private Practice. Service provision in the areas of drug and alcohol, mental health, eating disorders, and grief and loss. Counselling and Supervision available. Contact details include: 0404 012 679 or sallywalker@optusnet.com.au.