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

PSU Newsletter

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By the way...

TRANX is the Tranquilliser Recovery and New Existence Program in Melbourne—a service specialising in benzodiazepine (eg Valium, Xanax, and Serepax) and anxiety difficulties.

Check out their website for information on benzodiazepines and a good list of useful links.

www.tranx.org.au

Convener's Report

So we come to the last newsletter for the year… it's been a busy year, but a rewarding one.

The achievement we're most proud of is the collaboration between PSU and the APS head office to produce the "Alcohol and other Drugs Tip Sheet" – a practical, down to earth resource for both professionals and the general public. So far, the feedback we've received has all been good, and we're planning a more extensive evaluation in the new year to ensure it is as useful as it can be.

We have also been negotiating with the APS head office to extend the APS website to include resources for APS members on working with particular presenting difficulties, starting with alcohol and other drugs.

Imagine being able to just head to the website to access up-to-date resources and links on a whole range of issues, such as trauma, eating disorders, anxiety, attention deficit disorder, gambling, or relationship problems to name but a few possibilities. This addition to the current website would provide another opportunity for members of the APS to share the wealth of knowledge and experience within our profession.

I would like to express my gratitude to Jenny Melrose and Anna Powell for their time in supporting PSU. Both worked to develop professional development seminars in Sydney on PSU's behalf, and Anna generously volunteered to become our National Treasurer, despite an already challenging workload. Jenny made a significant contribution to the Tip Sheet and continues to explore ways to get local activities happening now that she has moved to Queensland. I would also like to express my appreciation of the hard work and dedication that Graeme Kane, our National Secretary, has contributed with his ongoing ideas, time and ability to get things happening. And thank you to everyone who has contributed suggestions, articles and reviews!

We held our AGM on September the 10th – we reviewed the year's achievements and started making plans for 2004. No surprises that Graeme and I retained our offices, since no one else nominated. Anna Powell officially became our new National Treasurer. All positions will be up for nomination in 2005 – if you are interested in standing for any of the positions, contact us and we can let you know what's involved.

After consulting with the PSU Committee, I joined the Australian Professional Society on Alcohol and Other Drugs (APSAD) on behalf of PSU; I intend to use the membership to collaborate with APSAD psychologists in ensuring our profession is well represented in the AOD field, and increase learning opportunities for PSU members.

We've been a little quiet the last couple of months as our work commitments have taken our attention, and the arrival of spring rains and sunshine have enticed us away from our computers and into the garden.

But there is always something going on behind the scenes, as we continue to review and reflect on how we can best make use of the opportunity an interest group provides. The result of some of this back-stage work will be coming your way early in the new year.

In the meantime, we hope you enjoy the coming festive season and have the chance to recharge your batteries in time for the new year. If you're writing your list of New Year's Resolutions, why not include "Offer some suggestions to PSU on what we can achieve in the coming years." Hey, why not go that extra step and add "Get involved in PSU somehow." We'd love to hear from you!

And remember the wisdom of experience… *What's the best thing for a hangover? Drinking heavily the night before!*

Have a safe and happy holiday season.

Helen Mentha
National Convener

Proposed changes to the Disability Discrimination Act

The government has proposed changes to the Disability Discrimination Act that would remove the prohibition on disability discrimination on the ground of a person's addiction to a prohibited drug. The provisions would not apply to people who are receiving treatment for their addiction.

Democrats Senator Nettle moved and it was agreed to, that the Bill be referred to the Legal and Constitutional Legislation Committee for inquiry and report by 25 March 2004. For more information on the proposed changes, go to: http://www.aph.gov.au.

This amendment is likely to contribute to further stigmatisation of an already marginalised group in our community, and perpetuate ill-informed, negative stereotyping that suggests illicit drug users pose an automatic threat to the safety and security of others, willfully choose addiction and are of significantly greater risk to the community than are people dependent on legal substances. Substance dependence alone is in no way a reliable predictor of a person's behaviour, risks or resources, and to pretend otherwise leads into potentially unhelpful territory, where people are judged according to stereotype rather than their actual behaviour.

Although possibly well-intentioned in its way, this amendment demonstrates a profound lack of understanding of the complexities of dependence, self-control and the difficulties of seeking treatment for some members of our community. It is not consistent with the bioopsychosocial model of dependence that also acknowledges the role of factors such as poverty, inequality, mental health issues, violence and physiology.

The APS is considering its response to these changes. If you would like to contribute your thoughts or concerns, please contact me at helenmentha@yahoo.com.au.

We also encourage you to express your independent views on this issue to your local Members of Parliament.

Helen Mentha

GP Project

The Australian Government funded NCETA to develop a package of materials relevant for GPs to assist their responses to illicit drug issues.

The first of these is soon to be released, *Alcohol and Other Drugs: A handbook for health professional*, produced by the NCETA consortium. This handbook provides a comprehensive overview of most issues dealt with by health professional dealing with the range of AOD issues in everyday practice. It has an easy read format, and includes tools and tips to assist everyday practice.

The Resource Kit for GP Trainers on Illicit Drug Issues is also soon to be completed, and likely to be produced early next year.

While oriented to GPs, it is anticipated that trainers of health professionals such as psychologists and social workers, will find it of significant value. It differs from many existing AOD training resources in that it is designed to be a 'mix and match ' of resources, building on the skills of trainers to offer a needs-based approach to training.

To complement the Resource Kit is a website, intended for novice GPs, who have a general interest in AOD, and need rapid to access information, but are not interested in developing specialist skills.

Jodie Shoobridge
NCETA

The AOD Nurse Practitioner Project

The AOD Nurse Practitioner Project is an initiative of a consortium comprising Drug and Alcohol Nurses Australasia (DANA), Drug and Alcohol Services Council (DASC), Flinders University School of Nursing and Midwifery (FUSNM), and the National Centre for Education and Training on Addiction (NCETA).

The broad aim of the project is to develop a national approach to the development and implementation of Alcohol and Other Drug Nurse Practitioners across Australia.

A survey is currently being distributed aiming to identify the perceptions of nurses, medical officers, psychologists, social workers and pharmacist views about the AOD Nurse Practitioner role, to identify whether services have identified a need for the role, to identify critical tasks between different levels of nurse, and their current training needs. As the role is subject to some controversy in the AOD field, we are seeking the responses from both those who support or do not support the role, in order to identify the issues pertaining to the role, and how we may be able to respond to those concerns.

In order to acknowledge contributions to the project, everyone who completes the questionnaire is entitled to enter a prize draw for a free registration to APSAD November 2004, to be held in Fremantle, WA, or the DANA Conference in Canberra, late 2004. APS members are invited to participate (of course, participation is voluntary) by contacting the Project Officer Jodie Shoobridge on (08) 8201 7540 or you can email her at jodie.shoobridge@flinders.edu.au for a copy of the questionnaire, or for a chat about how you feel about the role. The questionnaire is also available online at www.danaonline.org

Closing date for submitting a completed questionnaire was December 19, but Jodie would is still the best person to contact regarding the project.

Opening of the World Health Organisation Collaborating Centre

In April this year, the South Australian Department of Human Services, Drug and Alcohol Services Council was designated as an official World Health Organisation Collaborating Centre for Research into the Treatment of Drug and Alcohol Problems, under the auspices of the University of Adelaide's Faculty of Health Sciences. The centre, located at the University of Adelaide, was officially opened by the Minister of Health, the Hon. Lea Stevens on the 18th November 2003, and will undertake and coordinate major research activities throughout the world and particularly in the Asia-Pacific region. The centre already has several projects underway including:

- The WHO-ASSIST Study – Phases I, II & III. Coordination of and participation in the development of the WHO ASSIST (Alcohol, Smoking and Substance Involvement Screening Test) questionnaire for the detection of risky drug use amongst primary health care clients. Phase I and II of this study have shown that the ASSIST is a reliable and valid screening instrument across different countries. Phase III will be a Randomised Controlled Trial of linking the ASSIST to a Brief Intervention for drug use in primary health care patients and will be conducted in Australia, Brazil, India, Spain, Thailand, the United Arab Emirates and the USA.

- The WHO multi-site international evaluation of efficacy of maintenance treatment programs for opioid dependence and HIV/Hep C prevention. The coordination of an assessment of the effectiveness and feasibility of substitution treatment for opioid dependence as an essential part of HIV prevention and reduction of drug use and associated effects. This project will be undertaken in participating developing and transitional countries where such treatment has either not been available or only available on a limited scale. The project is being undertaken in several countries including China, Czechoslovakia, Iran, Indonesia, Lithuania, Thailand, Poland, and the Ukraine.

- Methamphetamine Psychosis Project. Involvement in a World Health Organisation multi-site study on methamphetamine-induced psychosis, being undertaken in four high prevalence countries in the Asian region. The study aims to explore the nature of psychotic symptoms associated with methamphetamine use, map current clinical approaches to psychosis, and identify primary prevention opportunities

- Evidence Based Practice. The Centre supports the International Cochrane Collaborative Review Group on Drugs and Alcohol, which has been established to provide evidence-based guidelines into the best treatment for drug and alcohol dependence and address health care relevant to the problematic use of drugs and alcohol.

- Functional Amphetamine Use in South East Asia. The Centre, in collaboration with The Integrated Substance Abuse Program, University of California Los Angeles (UCLA) is also currently seeking funding and support from the National Institute of Drug Abuse (NIDA) in the United States, for a proposed study investigating the efficacy of a brief intervention treatment for instrumental amphetamine users in South East Asia.

The WHO collaborating Centre will play a vital role in the development of quality evidence-based treatment options and enhance demand reduction strategies both within Australia and beyond. The aim of the centre is to increase the capacity of both Australia and other nations to treat drug problems effectively.

Dr Rachel Humeniuk
Senior Project Manager
World Health Organisation Collaborating Centre for Research in the Treatment of Drug and Alcohol Problems

Multicultural resources

There is a growing range of multicultural resources on alcohol and other drug issues, and one of the best places to find them is the Internet.

We've included a couple of sites with a good range of resources in different languages.

NSW Government sites: http://www.druginfo.nsw.gov.au/druginfo/info/nesb.html and http://www.mhcs.health.nsw.gov.au/health-public-affairs/mhcs/publications/langindex.html

Drug and Alcohol Multicultural Education Centre (DAMEC), funded by the South East Sydney Area Health Service: http://www.damec.org.au/

But we can also forget that English is often a second language for people from the deaf community who speak Auslan. Resources that rely heavily on text for communication are not always as accessible as might first be thought, given that Auslan is a visual language that uses 3-D space, while written English consists of letters that represent sounds.

The Victorian Deaf Society has developed a drug and alcohol project, which is featured on their website. The site includes information on the project and resources that may be more accessible to deaf people.

http://www.vicdeaf.com.au/ (follow the links under the information resources section)

Article review: Moos, R. H. (2003). Addictive disorders in context: Principles and puzzles of effective treatment and recovery. *Psychology of addictive behaviors, 17*, 3–12

Moos outlines seven principles of effective treatment and seven unresolved puzzles that future research could explore. My first reaction on reading the review was: "At last, a short and informative summary!"

The principles of effective treatment included the following:

- Principle 1: Treated or untreated, an addiction is not an island unto itself;
- Principle 2: Common dynamics underlie the process of problem resolution that occurs in formal treatment, informal care, and "natural" recovery;
- Principle 3: The duration and continuity of care are more closely related to treatment outcome than is the amount or intensity of care;
- Principle 4: Patients treated by substance abused or mental health specialists experience better outcomes than do patients treated by primary care or nonspeciality providers;
- Principle 5: Treatment settings and counsellors who establish a therapeutic alliance, are more oriented toward personal growth goals, and are moderately structured tend to promote positive outcomes;
- Principle 6: The common component of effective psychosocial interventions is the focus on helping clients shape and adapt to their life circumstances; and
- Principle 7: Among individuals who recognize a problem and are willing or motivated to receive help, formal intervention or treatment leads to better outcomes than does remaining untreated.

As a clinician and a clinical manager of a drug and alcohol counselling service, Principle 3 was particularly useful in providing an opportunity to reflect on, adapt and encourage staff to review the amount and intensity of psychological and counselling assistance we provide to our clients. This resulted in a subtle increase in case load, and an interesting decrease in pressure from immediate results, to a more realistic expectation of gradual change.

One of the strengths of Moos' review is the inclusion of broader psychosocial issues, as well as an acknowledgment of the unhelpfulness of confrontational interventions. However there are still echoes of 12-step narratives of recovery and abstinence. This doesn't detract from the valuable and excellent summary, but it is useful to remember that from an Australian context, abstinence is at one of end of the harm minimisation spectrum, albeit the most effective means of reducing harm.

Moos also outlined some of the dilemmas facing those who work with substance use:

- Puzzle 1: How can we best conceptualize and examine service episodes and treatment careers?
- Puzzle 2: What is the role of the health care work environment in treatment process and outcome and in enhancing clinicians' morale and openness to innovations in treatment delivery?
- Puzzle 3: How can we better understand the connections among the theory, process, and outcome of treatment?
- Puzzle 4: How can we identify effective patient-treatment matching strategies?
- Puzzle 5: How should we organize and sequence treatment for patients with dual disorders, such as patients with substance use disorders and major depression or post-traumatic stress disorder?
- Puzzle 6: How can we integrate formal substance abuse treatment and patients' involvement and participation in self-help groups?
- Puzzle 7: How can we develop more unified models of the role of life context factors, and formal and informal care, in the recovery process?

Puzzles 1 and 4 have implications for how the drug and alcohol service system delivers treatment. An interesting and possibly fruitful topic to explore is whether the biopsychosocial model offers the potential for a more systematic classification system, whereby clients are assessed according to biological, psychological and sociological risk and protective factors - and recommended various treatment modalities accordingly. This is an issue that is being explored in problem gambling. Blaszczynski (2000) categorised problem gamblers into three sub-groups that match the above classification system, but with similar common needs to be addressed (e.g., how to change a repetitive and at times, harmful behaviour). We might see a client who presents with a 10 year history of moderate alcohol consumption, has completed several residential withdrawal treatments, attended AA and numerous counselling attempts with psychologists, psychiatrists and drug and alcohol specialists, could be referred to a General Practitioner to assess for the appropriateness of a pharmacological treatment (e.g., naltrexone or acamprosate). A psychologist or drug and alcohol counsellor may assist with the emotional distress and other psychological factors with which the individual may struggle. A referral for assistance in housing, employment and training may also complement such a holistic approach.

Puzzle 5 considers how to treat clients presenting with dual diagnosis - that is, clients that have substance use issues as well as another mental health issue. Moos asks, "[c]an a single clinician effectively manage both disorders?" Clients experiencing greater distress in the form of psychosis, other mental disorders and substance use difficulties, may need the care of more than one mental health expert. However, I would suggest that psychologists, in most cases, are in an excellent position to answer ‘yes’ to the question of whether a single clinician can assist such individuals. Some of the techniques (e.g., motivational interviewing) may be more common in the drug and alcohol field, however the principles of assessment, engagement, rapport development, intervention and review are the same. And clients with dual diagnosis often have difficulties with communication, interpersonal skills, and family issues. A single clinician not only makes economical sense, but also clinical and ethical sense. This however does not ne-

Review: Moos (Continued)

gate the need sometimes for additional supports for both the client and clinician, and that some clients do better when seeing more than one clinician.

I found the review on treatment by Moos to be helpful reflecting on, and making subtle shifts in, how I go about delivering drug and alcohol treatment, as well as providing a list of relevant references that look forward to following up at a later time, in order to ponder the puzzles a bit more.

Moos' review article was published in the journal *Psychology of Addictive Behavoirs*, which comes as part of my membership to the American Psychological Association's Division 50. I would encourage members that are interested in the broader research and practice issues of "addictive" behaviours to consider joining the division. You don't need to be an international affiliate of the APA to join Division 50.

References

Blaszczynski,A. (2000, March 13) Pathways to pathological gambling: Identifying typologies. Electronic Journal of Gambling Issues. http://www.camh.net/egambling/issue1/feature/

Graeme Kane (MAPS)
Counselling Psychologist
Eastern Drug and Alcohol Service

Low Alco-ho-ho-ho-l drinks for Christmas

Traditionally, Christmas 'tis the season to be jolly intoxicated. But there is growing awareness that the festive season 'tis also the season to lose your licence, pash the married guy from accounts at the office party or punch on with Uncle Brian at the family lunch. You don't have to be a two glass screamer to know that too much of the Christmas spirits can end up in a whole lot of drama we just don't need.

So how can we and our clients enjoy the celebrations without going overboard? The first, and simplest, strategy is never to drink on an empty stomach – it's better for your stomach and liver, helps you to pace your drinking and the alcohol won't just go straight to your head. Drink plenty of rehydrating fluids like water, soft drink and juice. Have fruit, a milk shake or chewing gum just before the function, as they tend to highlight how sour or bitter the alcohol tastes and help you to pace yourself at first. Exercising before a function can also slow down your drinking as it highlights how alcohol takes the edge of a natural high, slowing you down and making you feel sluggish.

But it's also becoming easier to choose low alcohol drinks as well, without feeling like you're settling for the "lolly water".

Beer: There are plenty of light and mid-strength beers on the market that are getting better at rivaling full-strength beer in taste and enjoyment. For the hardcore beer lovers who think they'd miss the full beer experience, make the first one a full strength, savour it and move to lower strength beer after that – it's harder to tell the difference after the first beer.

Wine: Remember a standard drink of wine is only 100-120 ml – so become familiar with what 100ml looks like in different sized wine glasses so you can keep track and don't let people top up your glass before you've finished. It's now far more common for people to have a half glass of wine topped up with soda water, mineral water or fruit juice to keep the alcohol intake lower.

Spirits: Where possible, pour your own spirits to avoid someone else's "extra generous" helping that will knock your socks off. If you're mixing with other drinks, put in a smaller amount of spirits or top up with more mixer in a bigger glass. Alternate with alcohol-free drinks of just the mixer or other non-alcoholic drinks. A bourbon and coke looks exactly the same as coke and coke if you're worried about fitting in.

Mocktails: There are fruit juice outlets all over this country proving that people are willing to pay bar-prices for fresh, tasty juices. For sheer luxury, it's hard to beat cocktails without the alcohol – the full, indulgent flavours of many cocktails come from the other ingredients anyway. Fresh, pulped strawberries of a daiquiri, the full-flavour hit of Tabasco and Worstershire in a Virgin Mary (Bloody Mary without the vodka), the crisp tang of lemon, lime and bitters. Take your own ingredients but make sure you take more than you need, because others are bound to want some too!

And finally, if you end up with a drink you don't want – *you don't have to drink it!* Put it aside, offer it to someone else or don't be afraid to just tip it out – it's not a waste if it saves you from getting wasted.

Helen Mentha

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