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Substance use in the 21st Century: Different or more of the same?

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The April 1999 edition of *InPsych* asked the question 'Drug dependency: social crisis or media hype?'. The cover photograph by Stuart Owen Fox was an adaptation of The Scream by Edvard Munch, illustrated by an array of drugs – licit and illicit – demonstrating our society's dependence and preoccupation with substances.

At the time, the media carried news of worrying overdose rates, discussion of medically supervised injecting places (unfortunately and erroneously referred to as 'shooting galleries'), zero tolerance (despite the fact that we had in place a Government policy of harm minimisation[1]), decriminalisation of cannabis in some jurisdictions and the proposal for a heroin trial in the Australian Capital Territory.

As a policy worker in the ACT at the time, and working to Michael Moore, the Minister who had proposed the trial, I was involved in what was then exciting and ground breaking policy development. In the final analysis the heroin trial did not proceed, nor did all of the proposed supervised injecting places. However, the Sydney Medically Supervised Injecting Centre (MSIC) was established, and some eight years later continues to reduce the harms associated with illicit drug use by supervising injecting episodes that might otherwise occur in less safe circumstances. It is attempting to do what we all strive for in the alcohol and other drug (AOD) field – save lives and provide substance users with information and the opportunity to enter a treatment program when they are ready, recognising that both readiness for change and resistance to treatment are constructs which we need to address.

So nine years on, what are the topical issues in the Australian AOD field? There is currently a great deal of discussion – and often consternation – about young people and drinking, and this is the focus of significant government attention. The Federal Government has also responded to the increased prevalence of comorbidity, or co-occurrence of mental disorders and substance use disorders, with the establishment of the National Comorbidity Initiative. Funding has been provided under the Initiative for a range of projects, particularly within the non-government, community-based AOD sector and principally focusing on amphetamine-type stimulant use. There also remains ongoing discussion about how best to engage people who are using substances with appropriate treatment and assistance. This article will focus on these three topical issues and highlight the role that psychologists can play within the AOD field.

Alcohol use in young people

Professor Ann Roche, reporting in *Of Substance* in June this year, provides findings from the *2004 National Drug Strategy Household Survey*, indicating an increase in risky behaviours for young people 14–24 years of age (Roche, 2008). The Survey found that age of initiation of alcohol consumption has been decreasing. For each successive 10-year generation over the past 50 years, initiation into drinking has occurred at earlier and

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[1] Australia's harm minimisation strategy focuses on both licit and illicit drugs and preventing anticipated harm and reducing actual harm.

earlier ages. Therefore, over twice as many young people in the 20–29 year old age group had consumed alcohol by the age of 14 years compared to the 40–49 and 50–59 years old age group. By 18 years of age, approximately 50 per cent of both males and females are risky drinkers. However, the majority (67%) of young risky drinkers classify themselves as 'social drinkers'. Is this apparent denial of reality a consequence of the 'bullet proof' attitudes typical of young people, a lack of reliable education and information, or both?

The proportion of 12–15 year olds consuming alcohol at risky levels for short-term harm (at least weekly) increased from 13.2 per cent in 2001 to 17.5 per cent in 2004, and the average number of standard drinks consumed in a session for this group rose from 4.7 to 5.2. In some drinking circles this would seem somewhat trivial, where consumption is reportedly as high as 38 standard drinks (a cask of wine) in a single session. The most popular beverage types for 14–24 year olds are bottled spirits, liqueurs and pre-mixed drinks in cans and bottles, along with regular strength beer for males. Females aged 21–24 also prefer bottled wine. For 12–17 year olds, the most popular types of drinks for both sexes are pre-mixed drinks in a can and bottled spirits and liqueurs. Between 2000 and 2004, there was a three and a half-fold increase in the preference of young female risky drinkers aged 15–17 for spirits. This has led to the 'alcopops' debate, and specifically the issue of taxation and excise on alcoholic products.

> ## '*Of particular concern is the association between amphetamine-type stimulants (ATS), cannabis and mental health problems, particularly in young people.*'

The APS, in a submission to the Commonwealth Government in 2007 prepared by the Psychology and Substance Use Interest Group and the Psychology in the Public Interest team at National Office, provided a number of recommendations, including a volumetric tax (taxation on the alcohol content of drinks) and a low alcohol exemption to all alcohol products under 3.5 per cent. It was further recommended that availability of alcohol should be regulated and funding be increased to targeted education, prevention and treatment strategies, particularly through the direction of funds from excise and taxation. The submission also called for funding for the provision of effective interventions to assist parents and carers to better understand their role in the development and resolution of risk behaviour among young people.

As Professor Roche notes, today's 14–24 year olds were raised by 'baby boomers' (or their children) who hold substantially less rigid and authoritarian views than previous generations. Modern day parenting is far more relaxed than when the baby boomers were themselves adolescents, often resulting in well-resourced, affluent young people who are used to having their expectations met and for whom instant gratification is commonplace (Roche, 2008). Family structures have also changed significantly. People marry later in life and have fewer children at a substantially older age. The proportion of single-parent families has increased considerably, and many children are today being raised in households where a father has disengaged.

Even for parents who accept that experimentation and risk-taking is the norm and the 'rite of passage' in moving between adolescence and adulthood, the worrying issue remains: when does experimentation give way to dependence, and what are the consequences? When and how should a parent and others who are significant in the young person's life, intervene? While experimentation with both licit and illicit substances is common among youth populations, early onset or frequent use has been found to be associated with 'developmental harm', characterised by increased risks for the development of mental health problems, as well as a range of other adverse outcomes, in late adolescence and early adulthood (Lubman, Hides, Yücel & Toumbourou, 2007).

Amphetamine-type stimulants, cannabis and mental health disorders

It is generally accepted that rates of substance use are higher among those with mental illness compared to those without, and that people who use illicit drugs are more likely to experience mental illness than non-users. Results from the *National Drug Strategy Household Survey 2004* report that almost two in five persons who used an illicit drug in the past month reported high or very high levels of psychological distress. The most common mental health problems experienced by people who use illicit drugs are anxiety and mood disorders. Of particular concern is the association between amphetamine-type stimulants (ATS), cannabis and mental health problems, particularly in young people.

ATS are part of the psychostimulant group of drugs and include meth/amphetamine, ecstasy, cocaine and some pharmaceuticals (such as dexamphetamine and Ritalin). Methamphetamine comes in three common forms: powder (or 'speed'), methamphetamine base (or 'base') and crystal methamphetamine (or 'ice'). The *Victorian amphetamine-type stimulants (ATS) and related drugs strategy 2007–2010 Discussion Paper* notes that while the use of ATS in the general community remains low, these drugs are now the second most commonly used drugs after cannabis, with 3.2 per cent of the Australian population and 2.8 per cent of the Victorian population aged 14 years and over having used meth/amphetamine for non-medical purposes in the 12 months prior to the survey.

ATS stimulate central nervous system activity, producing a euphoric sense of wellbeing, wakefulness and alertness. Use of ATS is also associated with a range of potentially negative health consequences, including increased heart rate, blood pressure, sleeplessness and reduced appetite. There is also greater risk of mental health issues, aggression, violence and accidents resulting from unsafe behaviours, such as unsafe driving.

While it cannot be implied that cannabis use causes schizophrenia in people who would otherwise not have developed it, there is good epidemiological evidence of a significant association between cannabis use and the risk of meeting ▶

criteria for schizophrenia (Degenhardt & Hall, 2002). There is also good evidence to suggest that cannabis use is a more important risk factor for psychotic symptoms among those with a family history of, or pre-existing, schizophrenia (Degenhardt, Roxburgh & McKetin, 2007). Additionally, there is concern regarding the association between cannabis and ATS, especially methamphetamine, with increased admissions of young people to acute psychiatric facilities with apparent psychosis (Degenhardt, Roxburgh & McKetin, 2007).

The number of recorded hospital separations[2] for people with drug-induced psychosis as the primary problem among those aged 10–49 years increased from 55.5 per million population in 1993–1994 to 253.1 per million population in 2003–2004. Amphetamines accounted for the largest proportion of all drug-induced psychosis separations from 1999–2000 to 2003–2004, ranging from 41 per cent in 1999–2000 to 55 per cent in 2003–2004, while cannabis accounted for 39–45 per cent of separations over this period (Degenhardt, Roxburgh & McKetin, 2007).

The number of both cannabis- and amphetamine-induced psychosis hospital separations per million population was highest among the 20–29 year old age group, while age-specific rates among the 10–19 year old age group were lower for amphetamine-induced psychosis than for cannabis-induced psychosis (41.6–61.9 and 80.5–111.1 separations per million population, respectively). Data collected over this period, also showed that age-specific rates for cannabis-induced psychosis remained relatively stable across all age groups, compared with steady increases for amphetamine-induced psychosis (Degenhardt, Roxburgh & McKetin, 2007). While some of these presentations will remit, others will clarify into diagnoses of schizophrenia (Howard, Stubbs & Arcuri, 2007).

The National Comorbidity Initiative
The Australian Government National Comorbidity Initiative aims to improve service co-ordination and treatment outcomes for people with coexisting mental health and substance use disorders and focuses on the priorities of: a) raising awareness of comorbidity among clinicians/health workers and promoting examples of good practice resources/models; b) providing support to general practitioners and other health workers to improve treatment outcomes; c) facilitating and improving access to resources and information for consumers; and d) improving data systems and collection methods within the mental health and AOD sectors to manage comorbidity more effectively. As part of the Initiative, the Commonwealth has provided improved funding to AOD non-government organisation treatment services to develop appropriate systems for working with people with comorbid mental health and substance abuse issues, and to encourage the development of partnerships with wider health networks and workers with specialist training and resources to better identify and treat people.

Self-initiated change and treatment approaches
It is important to note that most people experiencing harmful substance use do not initially attend specialist AOD agencies, but instead may seek no help at all or be engaged with other services within the health, welfare and criminal justice systems. For most, the GP will in fact be the first point of contact. Furthermore, evidence indicates that up to 80 per cent of people who experience drug-related problems resolve these without any treatment (Sobell, Ellingstad, & Sobell, 2000). Consequently, it is essential to recognise the potential for self-initiated change and self-help (Granfield & Cloud, 1999), and the treatment role of a wide range of sectors and professional groups (including psychologists who do *not* specialise in AOD treatment). People are active shapers of their own change processes, and empowering clients is fundamental to sustainable and ongoing change. A positive therapeutic relationship is a major component of effective psychological treatment.

A wide range of treatment approaches to substance use reflects the diverse and varied factors that are believed to affect its development and maintenance. Recently, the most widely-accepted treatment options have expanded to incorporate approaches based on psychological principles of behaviour change, such as cognitive behavioural therapy and motivational interviewing. There is a large and growing body of research into what constitutes effective treatment.

The diversity of evidence-based treatment options is essential for effective intervention, and is consistent with the principles of harm minimisation. Miller and Hester (1995) advocate an 'informed eclecticism', defined as openness to a variety of approaches that is guided by scientific evidence. This approach is based upon four central assumptions:
1. There is no single superior approach to treatment for all individuals;
2. Treatment programs and systems should be constructed with a variety of approaches that have been shown to be effective;
3. Different individuals respond best to different treatment approaches; and
4. It is possible to match clients to optimal treatments, so increasing treatment effectiveness and efficiency.

People with co-occurring disorders present most frequently in community settings – especially when families, the judicial system, schools and work places are involved. Therefore at this point of contact it is important that eligibility criteria do not focus on one disorder exclusively (mental health or AOD) and exclude persons with the other disorder (Webster, 2008). This means that wherever the person comes to access treatment, either within an AOD, mental health or primary care setting, that there is an attitude of assistance and respectful welcoming, a policy of 'no wrong door'. Assessment is a process of engagement, information exchange and feedback, and discussion of treatment options (Magor-Blatch & Rickwood, 2008).

Roles for psychologists within the AOD field
Psychologists are practising and researching in the AOD field in many different capacities and bring skills from a wide variety of specialisations including clinical, counselling, forensic, health and community psychology. Psychologists work within the

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[2]Hospital separations refer to the reason for a patient's stay in hospital based on their medical records after treatment has been completed, rather than the reason for admission.

AOD field in a variety of roles, including:

• Managing clinical services, providing group and individual counselling, administration of psychometric testing, case management, and clinical supervision and training of other staff.

• Offering training in research and evaluation, and an understanding of human behaviour and emotional processes to encourage evidence-based, impartial debate on potential strategies and solutions.

• Playing a role in assessment and treatment of problematic substance abuse behaviours, as well as applying skills to better understand and prevent substance misuse.

• Developing education and prevention programs that focus on the underlying issues associated with both AOD use and comorbidity, including risk and protective factors.

• Providing a broader view of prevention, where drug use is one of a range of problem behaviours and is not seen in isolation.

• Working collaboratively with others concerned with problem behaviours, including crime, suicide and educational problems, to address the shared pathways to these outcomes.

• Providing an important resource in terms of program design and evaluation.

Psychologists bring to the AOD field a unique contribution in terms of assessment and treatment planning. This may be further enhanced through the use of psychometric testing. As part of a multidisciplinary team, psychologists are able to demonstrate efficacy and effectiveness of interventions. They bring to their roles a non-judgmental approach which is respectful and compassionate, treating the client as an individual, being welcoming, empathic, understanding, and demonstrating respect and active, persistent caring. These are among the trademarks of services that 'hang on to clients'.

Conclusion

So, have things changed in the AOD field – or do we have more of the same? In 2000, Shane Darke and Wayne Hall reported there was an estimated 74,000 dependent heroin users in Australia, a rate of 6.9 per 1000 adults aged 15–54 years. Three quarters of dependent heroin users were living in NSW (48%) and Victoria (27%) (Darke & Hall, 2000). In 2005, there was an estimated 72,700 dependent methamphetamine users. This represented 7.3 per 1000 population aged 15–49 years, 28,000 of whom lived in NSW – with 14,700 of these people in Sydney (McKetin, McLaren, Kelly, Hall & Hickman, 2005).

Are these essentially the same people, or do we now have more than 140,000 people dependent on opiates and methamphetamines? The likely explanation is that essentially this is the same group (assuming we are seeing attrition, as some people give up dependent use for various reasons, including entering treatment or prison, or in some cases, dying; while at the other end we will see some recruitment of new dependent users). What we understand is that people who are dependent on substances will alter their drug use depending on what is available. Therefore, the methamphetamine user is likely to also be the heroin user.

The prevalence and patterns of substance use are strongly related to a range of factors, and the use of licit substances is by far the most prevalent. However, a worrying trend in substance use is that age of initiation into most types of substance use has decreased (AIHW, 2007). The most recent data from 2004, reveal that the average age of initiation to tobacco and alcohol use among 12–24 year olds is 14.5 years and 14.7 years, respectively. For the most commonly used illicit drugs, the mean age of initiation to cannabis is 15.7 years, and 18 years for amphetamine-type substances.

The other major difference between now and a decade ago is the increased recognition and concerns relating to co-existing mental health and substance use disorders. This has led to a growing body of discussion and research into the efficacy of interventions, treatment, and service delivery. Ironically, for an AOD sector that has spent decades prising itself away from mental health in an attempt to gain recognition and adequate funding to provide evidence-based treatments and a skilled workforce, the current trends in drug use and the resulting increased incidence of mental disorders will force the sectors to once again reassess their relationship, where partnerships, collaboration and integration have become the necessary strategy. ■

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Adolescent drinking: The influence of parental attitudes, modeling and alcohol supply

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Adolescent drinking, particularly harmful binge drinking, has received considerable attention in the media in recent months – for good reason. Statistics show that 86 per cent of Australian students have tried alcohol by age 14, with this figure increasing to 96 per cent by age 17 years (White & Hayman, 2006). Moreover, 22 per cent of 14 year olds who are current drinkers consume alcohol at levels exceeding the Australian Alcohol Guidelines, with this figure increasing through adolescence, and peaking at 44 per cent among 17 year olds (White & Hayman, 2006). Adolescents are typically first introduced to alcohol in the family home, and those who drink regularly (weekly drinkers) report parents as their most common source for obtaining alcohol. In addition to providing alcohol to their teenagers, parents appear to influence children via their attitudes to drinking and, more directly, through the modeling of alcohol use. This article will examine the impacts of these three main areas of influence on adolescent drinking outcomes: (1) parental supply of alcohol use; (2) parental attitudes to drinking; and (3) parental modeling of alcohol use. The implications for working with parents and families to prevent adolescent alcohol misuse will also be discussed.

Parental supply of alcohol use

Parents are a major source of alcohol supply for many young Australians, and children are often first introduced to alcohol in the family home (King et al, 2005). The wisdom of introducing a young person to alcohol is contentious as research provides conflicting advice, making this a difficult decision for parents. A large body of research suggests that the younger the age at which a child or adolescent commences drinking, the greater the risk of problem drinking in the future, in addition to other negative outcomes including violence, motor vehicle accidents, memory loss, high risk sexual behaviour and physical injury (Clark et al, 2004). However, recent research shows that this relationship disappears once other factors are taken into account such as whether the adolescent becomes intoxicated at first use, family history of alcohol abuse, and delinquency (Warner & White, 2003). There is also evidence from Mediterranean countries, where alcohol is integrated into everyday life and served at the dinner table, that young people become intoxicated less frequently than in countries where alcohol is consumed less frequently but at higher levels (e.g., Nordic countries).

The jury is still out on whether parents should supply their children with alcohol. However, what does seem clear is that if adolescents consume the alcohol in the presence of their parents they are more likely to drink at lower risk levels, whereas if consumed in the absence of their parents and at parties, they are more likely to consume alcohol at higher risk levels.

Parental attitudes to drinking

Parental attitudes toward drinking represent an indirect means of social modeling and may be communicated either overtly or tacitly through the setting of limits or communication of values regarding alcohol use by parents. Research has found that parents who drink alcohol are more likely to exhibit permissiveness toward alcohol use in their adolescent children (Hayes et al, 2004). Parents' permissiveness regarding alcohol use appears to be influential in determining adolescent alcohol initiation and the later transition to heavier drinking.

Parental modeling of alcohol use

One of the key risk factors for adolescent alcohol use problems is the presence of alcohol use problems among parents. Studies have consistently found that parents' own use of alcohol increases both the likelihood that their adolescent children will engage in alcohol use and the risk for more significant alcohol-related problems (Hayes et al, 2004). It is likely that many inappropriate and harmful patterns of drinking are learned in the family. Children exposed to alcohol at home also tend to initiate alcohol use earlier and engage in problem drinking at a younger age than non-exposed children (Bonomo et al, 2001).

Research has also demonstrated that less problematic, but frequent parental drinking is associated with negative adolescent outcomes. For example, data from the Australian Mater University birth cohort study show that maternal drinking (more than one glass of alcohol a day), assessed when the adolescent offspring were age 14, was a strong predictor of alcohol use disorder in children at age 21, even after controlling for a range of biological, familial and interpersonal factors (Alati et al, 2005). While genetic and environmental components may contribute to such problems, social learning is also likely to be an important determining factor.

Intervention research

The research described above suggests that interventions which delay adolescent initiation or experimentation with alcohol and limit the progression to regular use, misuse and disorder, may be particularly salient in the prevention of alcohol problems. In

2003, the Cochrane consortium conducted a review of primary prevention programs for alcohol misuse among adolescents (Foxcraft et al, 2003). This review found that only three out of 56 studies examined demonstrated effective long-term benefits in alcohol reduction. One of the programs that showed the strongest effects was the *Strengthening Families Program (SFP)*. The SFP is a well-researched family program developed in the United States that aims to prevent the initiation of alcohol use in adolescents. It is a universal program for widespread application with parents and children in the general community. The program comprises seven once-a-week sessions for 10 to 14 year olds, which aims to enhance parental skills in nurturing, communication, and limit-setting, in addition to youth pro-social and peer resistance skills. The effectiveness of the SFP was tested among 446 families who were randomly allocated to treatment and control groups (Spoth et al, 1999). At the time of the intervention the children were in sixth grade. At the 1-year follow-up, significantly fewer children in the intervention group had initiated alcohol use compared with children in the control group. This treatment effect remained evident at the 2-year follow-up.

Clinical and practical implications of the research

Parents often express anxiety and confusion about how to address and manage drug and alcohol issues with their adolescent children. There are a number of important recommendations that can be made based on the research literature to help guide parents and families. Children are usually first introduced to alcohol in the family home, so it is important that parents are aware of the opportunity for prevention and management. Educating parents on the harms associated with early initiation to alcohol use is important considering there is no minimal legal age of consumption in Australia which prohibits the supply of alcohol to minors by parents in their own home. In working with parents and families concerned about how to introduce their children to alcohol, the research suggests that delaying initiation is advisable. Of course, there will always be children that are likely to consume alcohol irrespective of their parent's wishes. If this is the case, it is important for parents to realise that their child is far more likely to drink at low-risk levels if under their supervision than elsewhere. Likewise, parents should be advised of the important influence that both their own attitudes toward alcohol and their drinking patterns can have on children's drinking via modelling, socialisation and limit-setting. Providing clear direction to parents about how they can modify their own behaviour to prevent the development of alcohol problems in children is therefore important. Such interventions could include encouraging parents not to drink large amounts of alcohol in front of their children, confining alcohol use to times when children are not present to reduce exposure, and, if drinking in front of children, to drink moderately with food and water to model more responsible drinking patterns. In addition to these influences, guiding parents toward setting appropriate boundaries and limits on adolescent drinking is advised (e.g., supervising adolescent social activities, particularly events such as parties where alcohol is often introduced by peers).

Research clearly tells us that intervening early with families is better than waiting until problems have developed. This may mean raising concerns with families presenting for assistance with other issues, particularly those that may be indicative of the developmental trajectory often associated with later alcohol misuse. Successful intervention programs such as the SFP also highlight the need to assess and address not only parenting influences, but other factors that tend to co-occur, especially in families with adolescents at higher risk for alcohol problems. Such issues might include parent-child relational problems, child and adolescent externalising behaviour, and involvement in deviant peer friendship cliques. Connecting parents who are themselves experiencing significant alcohol or drug problems with treatment services is also a critical step to reduce the risk of children later developing drug and alcohol or other psychological problems. ■

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Recommendations for parents

- Research suggests more favourable outcomes when adolescent initiation to alcohol use is delayed.
- Children model themselves on their parents, therefore:
  – Do not drink large amounts of alcohol in front of children.
  – Confine alcohol use to times when children are not present where possible.
- If drinking in front of children, drink moderately with food.
- If an adolescent is going to drink, alcohol use should be supervised by parents.
- To minimise the impact of indirect or external influences, try to develop open and honest communication with adolescents and be involved in broader monitoring of activities.
- Early intervention is paramount, so help should be sought when guidance is needed or when warning signs appear.

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Working with substance misuse problems in private practice

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Individuals experiencing alcohol and other drug (AOD) problems have typically been under represented within private practice. For example, in the general population the prevalence of substance use disorders (7.7%) is comparable to that of anxiety (9.7%) and affective disorders (5.8%; Andrews, Hall, Teesson & Henderson, 1999). However, a recent APS survey showed that while 48 per cent of people treated by psychologists under the Better Access initiative presented with anxiety or depression, only 6 per cent presented for assistance with substance misuse problems (Giese, Littlefield & Mathews, 2008). Recent changes to the Medicare system have largely reduced financial barriers, presenting an opportunity for private practitioners to play a more active role in AOD treatment. This has the advantage of expanding the range of substance misuse services and increasing client choice. With psychologists commonly reporting reluctance to work with substance misuse problems (Miller & Brown, 1997), this article provides a description of the role that private practitioners can play in addiction treatment.

The role of private practice

There is an opportunity for private practitioners to complement specialist substance misuse services or target those individuals who do not typically access these programs. For many people, the perceived stigma associated with attending a psychologist will be substantially less than that associated with attending traditional AOD services. Specialist substance misuse services often require the client to be sufficiently 'ready' for treatment, often resulting in the person not attending or dropping out in the early stages of these programs. Private practitioners have training in a range of motivational strategies that prepare them well to support clients to identify their own treatment goals, plan further activities and access other specialised substance misuse programs as required. Additionally, specialist AOD programs typically focus on individuals with more severe substance misuse problems, often at the exclusion of people with less severe problems. Private practitioners are well suited to work with people in the early stages of problematic use or with individuals who are still functioning relatively well (e.g., currently employed).

What do psychologists have to offer?

Private practitioners have not traditionally promoted themselves as being able to work with AOD problems. For example, 87 psychologists in the Illawarra and Sydney regions have a Yellow Pages advertisement that describes the range of clinical problems they treat. Only seven (8%) of these private practitioners specify that they work with substance misuse problems. With university training in the assessment and treatment of substance misuse being highly variable, it is likely that many psychologists feel poorly prepared to work with this population (Harwood, Kowalski & Ameen, 2004; Miller & Brown, 1997). However, most private practitioners are well equipped to work with AOD problems in their practice. Research examining client outcomes in addiction treatment has consistently demonstrated the primary importance of the therapeutic relationship. Engagement in the initial stages of counselling is essential to maintain the person in treatment. This is primarily facilitated through a warm, trusting and non-judgmental approach, where the person feels comfortable to discuss their problematic behaviour (Washton, 2001). These are the same skills that most private practitioners would use for all clients attending their practice. Similarly, private practitioners are extremely well placed to work with co-occurring mental health problems. Psychologists have the advantage of being able to provide an integrated approach, where both the person's mental health and substance misuse problems are addressed concurrently in treatment.

Screening for substance misuse

As part of all initial assessments, private practitioners should routinely screen for the presence of AOD problems. At a minimum, this should involve asking all clients if they have ever misused drugs or alcohol as a component of the initial assessment interview. Where a person indicates that they may have problems, follow-up should examine the degree of their substance use. This would include identifying the types of substances used, and exploring the amount (e.g., total standard drinks) and frequency (e.g., days per month) of use. This information can then be used to track progress. Substance misuse problems rarely occur in isolation. It is important to use a holistic approach to assessment that examines the person's individual needs and how the substance misuse impacts on the rest of the person's life. This should include examining mental health, family relationships, work functioning, physical health and possible legal problems.

Intervention strategies

The Stages of Change model (Prochaska & Norcross, 2001) provides an extremely useful way to conceptualise a client's desire to tackle problematic substance misuse. It proposes that people progress through a series of stages as their desire and motivation to change increases. A common mistake made by many health professionals is to assume that because the person has turned up for treatment, they are in the 'Action' stage. People often attend private practitioners for a range of 'other' problems and

although they may admit to misusing substances and may view this as problematic, this does not necessarily mean they are ready to make a change. Thus, it is extremely important that assessment and intervention strategies target the person's readiness to change (see Table 1). It is also important to consider that the individual may be at different stages for different problems. For example, they may be in the 'Action' stage regarding their amphetamine misuse, although still in the 'Pre-contemplative' stage regarding their drinking.

The types of intervention strategies used with substance misuse problems are very similar to approaches psychologists would use with other health-related problems. When the individual is in the early stages of change, Motivational Interviewing is used as the primary tool to increase the person's motivation. As people move into the 'Action' stage, problem-solving strategies are used to develop practical behavioural skills to manage cravings and associated high-risk situations. Cognitive approaches are used to highlight and challenge permissive substance misuse thoughts. Additionally, relapse prevention planning is used to assist the person to maintain the positive change. Family support is encouraged throughout the person's treatment. There are several evidence-based treatment manuals available online that elaborate on these interventions and may be useful for private practitioners (e.g., Carroll, 1998).

Collaboration and referral

There are a range of specialist AOD services available in the community. These include detoxification, rehabilitation and pharmacotherapy services, and self-help groups. Private practitioners should be aware of the services available in the local area and continue to provide clients with a choice regarding further treatments. For example, self-help groups are likely to provide valuable social support for many people (e.g., Alcoholics Anonymous, Self Management And Recovery Training [SMART] groups). In relation to the physical health of the person, it is important that the private practitioner works collaboratively with their client's general practitioner. In particular, when a client is referred under a GP Mental Health Care Plan there should be liaison with the general practitioner when planning detoxification.

Conclusion

Changes to the Medicare system have the potential to increase the range of treatment options available to people with AOD problems. While psychologists have reported a lack of confidence working in this area, it is likely that most private practitioners currently have the skills to work quite successfully with individuals who have substance misuse problems. There is certainly need for such services in the community and it is likely that the more psychologists provide services to people with substance misuse problems, the more their confidence will grow. ■

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Table 1. Stages of Change and suggested intervention strategies

Stage	Description	Examples of intervention strategies
Pre-contemplation	Unaware of the problem or not considering change	*Aim: Raise consciousness* • Motivational Interviewing • Harm minimisation
Contemplation	Becoming aware, but still undecided about change	*Aim: Consider costs and benefits* • Increased awareness through Motivational Interviewing • Decisional balance to explore costs/benefits
Preparation	Starting to take steps to change	*Aim: Increase commitment and develop plan* • Individualised change plan development • Self efficacy promotion • Social support assistance
Action	Engaging in change behaviours	*Aim: Commence change plan* • Behavioural strategies to manage cravings • Social skills training
Maintenance	Consolidating gains	*Aim: Maintain successful change* • Relapse prevention strategies • Problem solving regarding difficulties

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Dual diagnosis and dual roles
Alcohol and other drugs and mental health services working together for better outcomes for young people

By **Kathryn Grimes Assoc MAPS**
Alcohol and Other Drugs Youth Consultant, Uniting*Care* Moreland Hall

Young people with dual diagnosis have a bleak and sad prognosis with poor treatment outcomes, increases in suicidal ideation, intent, planning and successful completion, severe physical illness, increased relapse, high service utilisation, greater problems associated with family and social networks, and overall a significant decrease in quality of life (Baker et. al, 2007). Young people with dual diagnosis have been referred to as the 'fringe dwellers' of our service sectors.

Co-occurring mental health and substance use disorders place a considerable burden on Australian society (Teesson, Hall, Lynskey & Degenhardt, 2000). Within alcohol and other drugs (AOD) treatment services, it has been estimated that 55-75 per cent of clients may have a history of mental illness, and that young people (aged 15-24 years) appear to be particularly at risk (Teesson & Proudfoot, 2003). This is supported by recent work (Lubman, Hides & Elkins, 2008), as well as data from Moreland Hall's Youth Co-morbidity Project, where over 80 per cent of young people screened (n=142) reported a high (>17) K10 score. This result indicates a high prevalence of anxiety and/or depression amongst the client group.

Initiatives to address dual diagnosis
The National Comorbidity Initiative and the National Action Plan on Mental Health 2006-2011 aim to expand and empower both the AOD and mental health (MH) sectors to work more effectively and efficiently with dual diagnosis young people, resulting in better outcomes for young people. Victorian AOD agency, UnitingCare Moreland Hall (Moreland Hall), is leading current practice in the development of initiatives and service provision for young people with dual diagnosis of disorders in substance use and mental health. An effective practice model has been developed and is based on strong integrated partnerships between the MH and AOD treatment sectors and nationally recognised training organisations.

Moreland Hall recognises the need for a 'no wrong door' approach to treatment for young people with dual diagnosis and identifies and advocates a client's right to treatment irrespective of whether it is from the AOD or MH sector. Ongoing support from the MH sector from services such as ORYGEN Youth Health has enabled AOD workers at Moreland Hall to effectively screen and support young people with a dual diagnosis. Collaborative partnerships have also ensured timely AOD specific treatment for
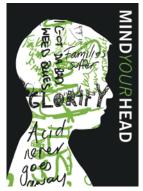
young people being referred from the MH sector.

The prevention and early intervention of coexisting mental health and substance use disorders relies on well-timed and effective treatment from both sectors. Psychologists and AOD clinicians have a role and a responsibility to improve outcomes for young people who have dual diagnosis by providing them with a timely response. Historically there has been a parallel or sequential attitude to treatment of dual diagnosis in young people. Young people were historically treated by two separate, unintegrated sectors or only one diagnosis being addressed at any one time. The challenge for the MH and AOD sectors is to develop an appropriate and sustainable model of co-ordinated care. It has been established that early intervention and management of dual diagnosis in young people needs to be embedded as core business by both sectors, providing young people with dual relationships – a MH and AOD worker – from either sector.

The outcomes of the recent initiatives have resulted in young people with dual diagnosis being serviced more effectively and no longer 'falling between the cracks' of the MH and AOD sectors, with both sectors now enmeshed. Further outcomes include capacity building of the AOD workers to effectively support clients who are presenting with MH related issues. Young people accessing AOD services such as Moreland Hall can now expect to receive mental health supports which are well-established in the service, such as co-located clinical psychologists, dual diagnosis clinicians, psychiatrists, clinical consultants and psychologists working as AOD specific counsellors, along with psychology students on placement.
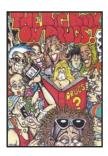
Dual diagnosis resources for young people
A number of affordable resources have been developed to enable young people to be more effectively serviced by both sectors. One example is the book *Mind Your Head – Some Things You Might Want to Know about Drugs and Mental Health* which has been developed through a partnership with Moreland Hall and specialist mental health organisations Nexus Dual Diagnosis Service, and the
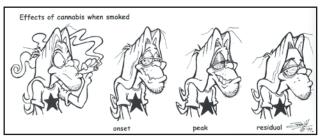

Design by Gozer Studio

Substance Use and Mental Illness Treatment Team (SUMITT). The 56-page book is designed for young people to use as a self-help resource, but is also available to be incorporated into educational curricula or psychological treatment. This is a unique resource that targets young people and provides detailed and accessible information regarding mental health concerns (such as anxiety issues, depression, psychotic episodes and suicide), and issues related to drugs and alcohol, and how the two areas can affect each other.

The *Big Book* series, developed by Moreland Hall, are youth focused resources with images and content appealing to young people. These resources provide information and assist the practitioner to engage the young person in conversations regarding their substance use and related issues. Images such as the cannabis cartoon (pictured) can initiate dialogue with young people on issues such as intoxication, patterns of use and long term effects of use, and the potential impact on mental health.

Effects of cannabis when smoked

onset   peak   residual

These resources can be purchased from the Australian Drug Foundation (www.adf.org.au). ■

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APS contribution to the substance use debate

By **Dr Stefan Gruenert MAPS**
Treasurer, APS Psychology and Substance Use Interest Group

As a profession and science, psychology has much to contribute to the understanding of substance use from theory, research and practice. Although debate continues regarding the most appropriate societal response to this issue, it is clear that the prevention of harmful substance use must focus on its underpinning social determinants and multiple risk and protective factors. Further, while many people recover from harmful substance use without any therapy, there is good evidence for a range of effective treatments to help those whose substance use has become more dependent.

Most people with substance use problems do not attend specialist alcohol and drug agencies, so competencies in assessing and treating these problems need to be widely available among psychologists and other health practitioners. It is essential that the APS contributes to the debate on alcohol and drug issues with carefully reasoned, evidence-based and realistic views, given its highly personal and political nature.

APS Position Statement

A Position Statement on Substance Use was prepared by a specially commissioned Task Group consisting of Debra Rickwood, Lynne Magor-Blatch, Richard Mattick, Stefan Gruenert, Neos Zavrou, and Amanda Akers, in collaboration with the APS Psychology and Substance Use Interest Group. A draft of the Position Statement was presented at the 2007 APS Annual Conference to gain feedback and was then further refined. The Statement was approved by the APS Board at its March 2008 meeting and is now available on the APS website along with previous APS publications on substance use issues (www.psychology.org.au/publications/statements/substance/).

The Statement confirms that alcohol is the most abused substance in Australian society, with cannabis being the most widely used illicit drug. The Statement emphasises that people using substances in a harmful way usually experience a range of social factors that impact on their substance use and wellbeing. Consequently, a holistic approach must be taken to prevention, harm reduction and treatment. The Statement supports Australia's harm minimisation strategy which includes minimising the supply of substances through law enforcement approaches, reducing the harm associated with substance use, and minimising the demand for substances through treatment and prevention.

To reduce harmful substance use in the longer term, the Statement argues that both cultural and legislative changes are required along with targeted education. Further, prohibition responses on their own are unlikely to lead to reduced substance use over time because of the adaptiveness of human behaviour in meeting needs and desires.

APS Psychology and Substance Use Interest Group

In addition to developing the APS Position Statement on Substance Use, the Interest Group has been involved in a number of other activities over the previous twelve months.

Media and parliamentary inquiries

In response to topical issues and specific media concerns, a number of media releases have been prepared over the past year on issues including youth binge drinking, ready-to-drink alcohol products, and alcohol, drugs and sport. Interest Group and APS staff members have undertaken radio and talk-back radio interviews in Sydney, Canberra and Melbourne.

The Interest Group has also prepared a number of submissions for the APS to parliamentary inquiries relating to the impact of drugs on families, amphetamine type substances and ready-to-drink alcohol products.

Professional development and training

In April 2008, 60 psychologists and probationary psychologists attended a seminar in Hobart on 'Improving family function in high risk families: The Parents Under Pressure Program' presented by Professor Sharon Dawe. The seminar was sponsored by the Interest Group and organised by Dr Raimondo Bruno from the School of Psychology at the University of Tasmania. The seminar focused on working with families in which parents have substance dependencies and a range of other complex problems.

In July 2008, the Interest Group co-sponsored an Addictions Summit in Melbourne attended by hundreds of drug and alcohol counsellors and psychologists. Keynote presentations and post summit workshops were given by an astounding line-up of renowned leaders in the addictions field including William Miller, Carlo DiClemente, Howard Shaffer, Alex Blaszczynski, Steve Allsop, Doug Sellman, Thomas McLellan, David Hodgins, Theresa Moyers and Allan Zuckoff.

Future activities

The Interest Group is keen to support a range of State and Territory forums such as seminars or film nights that raise awareness of alcohol and drug issues and their treatment. It will also continue to provide resources on its website and inform members of its activities through regular newsletters.

For further information on the APS Psychology and Substance Use Interest Group go to www.groups. psychology.org.au/psu/.