March 2014

CONNECTIONS

The Newsletter for Addiction Professionals

President's Message

By Albert Alvarez

Happy New Year and Happy Valentine's Day! Yes, I'm an old romantic who enjoys the holidays; however, I'm progressively aware to recognize our addiction recovery profession has moved forward with a paradigm shift. Simply put, we have become a professional membership which promotes APIT to LAC to LCAC and shows our students and clients we have ethical and professional integrity. Also, it is Indiana Law (please read code 25) which states only those who have the LCAC can call themselves "Addiction Counselors" and do clinical practice, such as, full biopsychosocial assessments, give suggested diagnosis, and do any kind of clinical therapy (including group therapy). This law is to protect our recovering clients with appropriate best practice treatment by educated clinicians who know how to clinically practice. This law not only protects our recovering clients; it supports our addiction recovery profession as ethical, professional and a full discipline. It is a good law for Indiana. However, IAAP, because of this good law, experienced a major paradigm shift, that is to say, from mainly a certification association to a full professional membership association. What does that mean for you and me in IAAP? We are now a full professional membership association which focuses on professional rapport, education, mentoring and training, and workforce development, all emphasizing the very best addiction recovery. (please read our IAAP Mission and Purpose).

Continued on page 2 see PRESIDENT

ARE YOU UPDATED?

Please contact us to update your address & email to avoid missing important information!

WE MOVED!

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INSIDE THIS ISSUE

IAAP NEEDS YOU!

Look Inside this issue for Exciting Leadership and Advocacy Opportunities to Gain Skills and Support Addiction Professionals

A MESSAGE FROM YOUR EDITOR IN CHIEF

Have we had enough winter yet? I can barely stand my car; it is so dirty from road splashes. Surely Spring will come quickly?

There is a new feature I'd like to draw your attention to this edition: It is written by Steve Stone, IAAP's Ethics Committee Chair, and will feature discussions around IAAP's Code of Ethics. It will be informative and you will not want to miss it. We also have been asked to announce Ft. Wayne's Park Center 's coming workshops that might be of interest for your continuing educational needs. And Im still waiting for your laughable notations! Come on, Addiction Counselors need some fun! Share your mirth!
Live well. Laugh often. Love much.
Kay

PRESIDENT Continued

If you have been reading our IAAP Newsletter (if not lately, please go to our website: www.iaapin.org), you know how I've been promoting ways to actually put into practice professional rapport, education and training and much needed support and mentoring of our students. (Now, before I get many emails and phone calls, our IAAP certification committee will still be able to grant, according to State law, gambling addiction certification, clinical supervisor certification, and renewals for those who want to keep their ICAC-I and ICAC-II. The Certification Committee's main focus will be to get all our students an APIT as each moves on to obtain the LAC and LCAC).

So, let me again say it loud and clear: "We are a membership association made up of students and addiction recovery professionals" Together, supporting one another and being good advocates, we are the major force of change for the better in addiction recovery in Indiana.

So, if you (or you know someone) dropped out of IAAP because you no longer need certification, then you are in danger of being so far behind the times seeing IAAP as a certification association with no mission and purpose. Please take another look and see we have moved forward as a very vibrant professional membership association with much needed mission and purpose who wants you back. Let's join together to pay it forward and get involved in developing further professional rapport, attend educational training, mentor students, become clinical supervisors- yes, get involved with IAAP and NAADAC to grow our profession: all because we believe in the wonderful miracle of addiction recovery!

Therefore, during March of 2014, IAAP will be reaching out and ask each of our lapsed IAAP members to renew their commitment to the best professional membership association, that is, IAAP, the State affiliate of the greatest professional addiction recovery association, that is, NAADAC.

When ALL the addiction recovery professionals work together in our professional membership association (IAAP), then we can truly say ---

Only Our Best,

C. Albert Alvarez, LMHC, LCAC, MAC, CGP.

Albert, your President
Albert Alvarez, LMHC, LCAC, MAC, CGP.

IAAP
The Indiana Association for Addiction Professionals
A NAADAC Affiliate

2014 IAAP Events Calendar

- IAAP Annual Spring Conference
  April 4-5, 2014 - *More Details Coming Soon!*
- IAAP Ethics Course
  July 11, 2014
- IAAP Annual Fall Conference
  October 10-11, 2014

Next Certification Committee Meeting:
March 22, 2014

Kudos To:

IAAP wants to recognize our members who achieve a professional goal, as in qualifying for a new level of certification or licensure, or an academic degree or a new place to put your skills to work.

At this time, IAAP would like to recognize our members, who have received their Certification this fall:

Lezly Scott – ICACI
Donna Slaboda – ICACI
Judy McKinney - ICACI
Megan Kostrubanic – ICACI
Lauren Workman – APIT
Robert Chrisman - ICACII

This is a great accomplishment, so be sure to congratulate these members when you come into contact with them!

Congratulations

A SOBER CHUCKLE … Rx: LAUGHTER

PUNS ABOUT TECHNOLOGY:

* The dead batteries were given out free of charge.
* I should have been sad when my flashlight batteries died, but I was delighted.
* Why did the capacitor kiss the diode? He just couldn't resistor.
* Talking to her about computer hardware I make my mother board.
* I crossed a cell phone with a skunk, and now the service stinks.
* He dropped his computer on his toes and had megahertz.
* If you take a laptop computer for a run you could jog your memory.

GROANNNNNNNN….

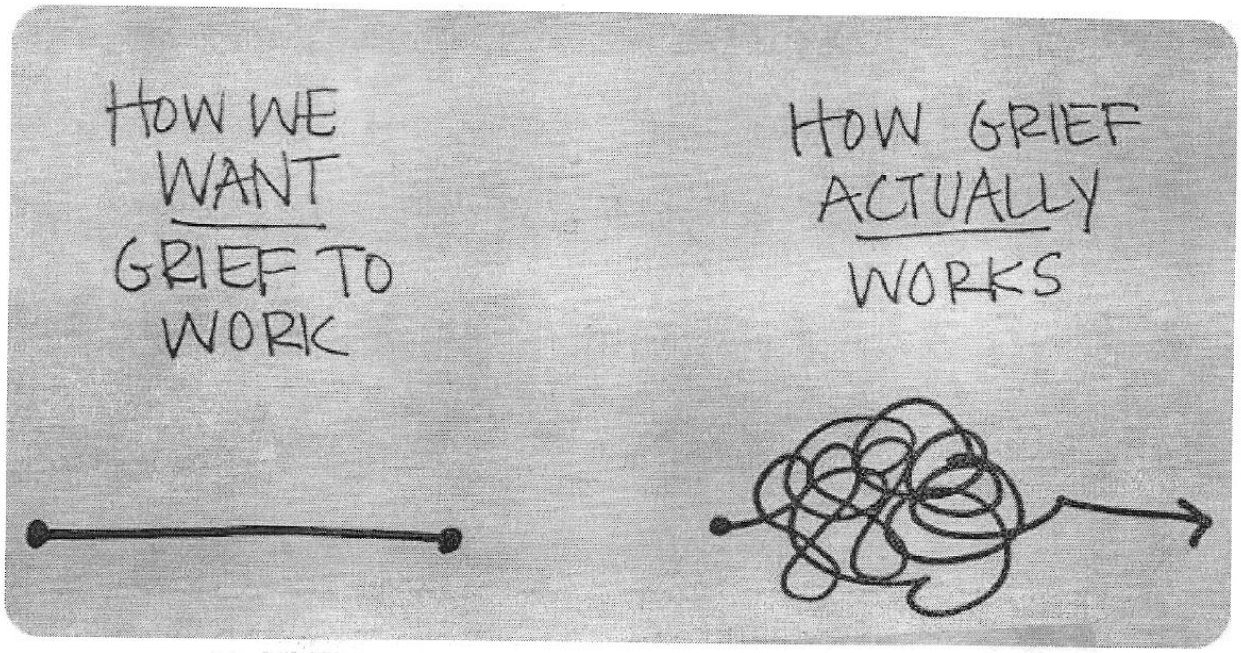
And finally….
There was a sign on the lawn at a drug rehab center that said, "Keep of the Grass."

Marketing & Membership

The Marketing/ Communication Committee announces we will soon give you the opportunity to advertise in our quarterly newsletter. We will welcome ads for your private practice, community mental health center, counseling center and/or any support services for the Addiction/Mental Health field of services. We will send out an email blast, when the details are available. Please watch for them.

Remember you have the opportunity to sponsor our conferences either as individuals, groups or businesses. We welcome the opportunity to give you the limelight of our gratitude during the conference. Please think about this for our Spring Conference on April 4 and 5, 2014. If you are hesitant to ask a potential sponsor, let us know we have board members who will take the information from you and make the call directly. For details please email our central office stephanie@centraloffice1.com.

Jeanne Hayes
IAAP Marketing Committee



"And the day came when the risk to remain tight in a bud was more painful than the risk it took to blossom." Anais Nin

Ethics Committee

Risk Factors for the Addiction Professional: Are you ethical or at risk?
By: Steve Stone MA, LCAC
IAAP Board Member
Ethics Committee

In a recent IAAP newsletter I suggested 15 tasks for Wellness that the Addiction Professional could address. By participating in these tasks, one can improve themselves and obtain greater degrees of health and wellness. A well Addiction Professional is less at risk for impairment and unethical behavior. In a similar manner, knowing some risk factors as an Addiction Professional can help you assess yourself or others. Such an endeavor requires you to be honest and willing. It requires you to self-reflect and engage in self-correction.

There are personal and professional risk factors that increase the Addiction Professional's risk for deviating from or violating ethical standards. Here are some briefly listed along with questions to ask yourself.

A. Lacking knowledge of or having a limited awareness of the actual Code of Ethics.
Have you read the Code of Ethics that you signed? Do you know why adhering to this Code helps guide you in best practice?

B. Personal crisis. Are you having significant life stressors? Are you making adjustments and reducing the stress?

C. Personal or Professional Isolation. How alone are you? Do you collaborate with others? Do you spend large amounts of time by yourself? Do you purposely avoid others?

D. Use of self-disclosure that is non-therapeutic. Who benefits from your self-disclosure? How does your disclosure enhance treatment and recovery in someone else?

E. Limited availability or use of supervision and case consultation.
Do you get supervision? Do you access it? When in doubt do you seek assistance or guidance? Do you often think you don't need supervision? When you need to consult do you avoid it and not seek it?

The literature consistently highlights that the majority of ethical violations in the human service professions were for dual relationships and exploitation of clients which includes sexual relationships with a current or former client. That being said, these categories are only the highest portion of founded violations. Be well, know your risks and take action.

Steve Stone can be reached by email at StoneBearHeals@tds.net or by telephone at 317-979-9017.

Conference & Continuing Education Committee

The Conference and Continuing Education Committee is responsible for planning in-service trainings, our two IAAP conferences, and programming for Annual Meetings. This committee collaborates with the marketing Committee to help procure sponsors for our trainings so as to keep the costs of training reasonable for those attending. If you are interested in being a part of the committee I would greatly appreciate your involvement.

I have several openings for new members. My cell phone is 219-781-8836, home phone is 219-844-4192, and I have a home and work email. You can reach me at:
peggypayonk@yahoo.com *or*
peggy.payonk@regionalmentalhealth.org

I look forward to working with you to develop topics for future conferences.

Peggy Payonk, MSW, LCSW, LCAC
IAAP Conference and Continuing Education Committee

Words of Wisdom

"One person with courage makes a majority." *Andrew Jackson*

"It is hard to fail, but it is worse never to have tried to succeed." *Teddy Roosevelt*

"Worry often gives a small thing a big shadow." *Unknown*

Bylaws Committee

As you all know, IAAP was at the forefront of securing licensure for our members in Indiana. We are all proud of that accomplishment and what that means for the profession and for our clients. Since you have already read Albert's President's message, you are aware of how that decision is affecting IAAP. We are moving away from being a state certifying body to becoming a professional membership organization, shepherding our members through the education and licensure process. This change in direction will require fundamental changes to the way IAAP does business. The Bylaws Committee is currently working to revise the Bylaws to reflect these needed changes. We will need to make corresponding changes to the Certification Policies & Procedures and create the Licensure Committee and all of the Policies & Procedures for the new committee. This sounds like a daunting task. However, the quality of our current Bylaws and Policies, which are serving as models for other states, and the clarity of our contract to provide licensure exams for the State of Indiana make this a fairly simple task (*thank you Valerie Jones*). That being said, three heads are better than one (*obscure Monty Python reference*) and six eyes are better than two. I know that many of you have keen legal minds and experience writing Policies & Procedures for you agencies. I need at least two additional IAAP members to help me with these changes. Collaborative work is the quickest, most efficient, and most thorough method to minimize errors and make positive change happen. Most of the work can be done by email, so there is no need to travel. Call me at 574-261-9051 or email me at ronald.chupp@bowencenter.org to take part in these historic changes. Don't be shy. This is your opportunity to make a lasting mark on our organization and our profession.

Please join me in welcoming Megan Kostrubanic as the newest member of the Bylaws Committee. Megan brings many years of experience working with IARCAA and DCS on policy development and revision. It is an honor to have her as a member of the IAAP Team!

Only Our Best,

Ron Chupp, Bylaws Committee Chair

Park Center
2014 Professional Training Series

Park Center, Inc. is a CARF-accredited, non-profit counseling and psychiatric center celebrating over 30 years of excellence in behavioral health education. Park Center's Professional Training Series (PTS) offers intermediate to advanced level workshops led by national and international experts in mental health and addictions. The goal of the PTS is to enhance professional competency and effectiveness by focusing on evidence-based or best practices in the field. Continuing education credit is available for social workers, addiction counselors, mental health counselors, marriage and family therapists, psychologists and Indiana law enforcement personnel. If you would like to join our mail list to receive our workshop e-flyers and our Continuing Education Highlights (CEH) newsletter, you can sign up below.

4/25/2014
Ethics in the Digital Age: Technology, Internet and Social Media
Presenter: Jeffrey E. Barnett, Psy.D, ABPP
Date/Time: April 25, 2014 8:30 a.m. to 4:00 p.m EDT
Location: Grand Wayne Center, Fort Wayne, IN

5/16/2014
PLAYFUL P.R.A.C.T.I.C.E: INTEGRATING CREATIVE TECHNIQUES INTO TRAUMA-FOCUSED CBT
PRESENTER: LIANA LOWENSTEIN, MSW, RSW, CPT-S
Date/Time: Friday, May 16, 2014 8:30 a.m. to 4:00 p.m. EDT
Location: Grand Wayne Center, Fort Wayne, IN

9/12/2014
UNDERSTANDING THE ICD-10 WITH DSM-5 CROSSWALK
PRESENTER: GREG J. NEIMEYER, PH.D.
Date/Time: Friday, September 12, 2014 8:30 a.m. to 4:00 p.m. EDT
Location: Grand Wayne Center, Fort Wayne, IN

10/24/2014
TREATING PTSD IN SUICIDAL & SELF-INJURING CLIENTS WITH BORDERLINE PERSONALITY DISORDER
Presenter: Melanie Harned, Ph.D.
Date/Time: Friday, October 24, 2014 8:30 a.m. to 4:00 p.m. EDT
Location: Grand Wayne Center, Fort Wayne, IN

Park Center, Inc., 909 East State Blvd., Fort Wayne, IN 46805 Phone 260-482-9125 X 2188

Anyone interested in attending any of these presentations may call Gin Moore at the above phone number or email her your interest in registering at VMOORE@parkcenter.org

Help Families

The core reason for including family in treatment of alcoholics/addicts is more for the benefit of the family member than for the alcoholic/addict. A family member's emotional and physical health improves as they come to understand their pursuit of enabling, co-dependency, and/or denial.

Without a doubt, an increased understanding of the disease of addiction as well as the family member's role is of utmost importance to family and loved ones. Perceiving addiction as a disease is often intellectually possible, though frequently an emotional challenge. Descriptors of this disease require that one be impacted physically, financially emotionally/mentally, and spiritually. This is a complex problem for both the client and the family member. Realizing the client may have used the symptoms of addiction as weapons or signs of disregard of self and others, the desperate search for understanding continues.

The family benefits as they begin to see how their lives have been impacted by the disease. They often admit to health problems that may include a lack of sleep, headaches, digestive problems as well as other physical symptoms. For many, the financial impact of this disease on their budgets is very high. The emotions, mental stress, and turmoil are impacted as the family searches for ways to help and fix the alcoholic/addict. As part of this they frequently diminish and not uncommonly ignore self care. Spirituality, it may seem, is not affected as the family reports never-ending prayers. As the disease progresses, it is not uncommon for some family members to question a higher power who would allow this devastation to take over the very being of their loved one and destroy their once functional family.

Once a client or family member is able to even take a few steps on the journey of acceptance of the disease concept, it becomes apparent that one must then develop respect for the disease. The required respect challenges families as the tornado-like behavior of this disease tears through their lives. Step one of the 12-step program states, "We have admitted we are powerless over alcohol (addiction)- -our lives have become unmanageable." It seems an appropriate step for the client to take considering all the facets of life that are severely impacted by this disease. With serious reflection it becomes obvious that any family member is equally powerless over the havoc created in their life by the disease of another.

The family may perceive the first step as saying, we are powerless over alcohol in another person. After some consideration, family members frequently acknowledge the life of powerlessness they are living, and begin to recognize the unmanageability that surrounds them.

The pain, frustration, and helplessness experienced by the client due to their addiction is equally, though differently experienced by family and loved ones. As clinicians it is imperative that we address the parallel process of the disease of the loved ones.

Submitted by Jeanne Hayes

The Marijuana Memory Connection

Researchers at the Northwestern University in Illinois did MRI brain scans of young adults who had smoked pot daily in their teens but then abstained for at least two years. The scans showed changes in the areas responsible for working memory, which appeared to shrink and collapse inward compared with the brains of subjects who hadn't used marijuana. The marijuana users also did worse on memory tests, and the abnormalities in their brain scans were similar to those of people with schizophrenia, the authors concluded.

Source: Schizophrenia Bulletin, Dec. 15, 2013
Submitted by Albert Alvarez

Survey Finds Ongoing Concerns with Alcohol use During Pregnancy - January 2014

Findings indicate many women still need to get the message about alcohol use

A recent survey by the Substance Abuse and Mental Health Services Administration (SAMHSA) found ongoing concerns about the number of women who drink alcohol during pregnancy. According to SAMHSA's National Survey on Drug Use and Health (NSDUH) for 2011-12, 18 percent of pregnant women age 15 to 44 reported at least some consumption of alcohol during their first trimester, a time when many women may not yet know they are pregnant. In addition, almost 7 percent reported an episode of binge drinking (five or more drinks within a couple of hours) during their first trimester, which may be especially harmful to the developing fetus.

However, the survey also found that alcohol use dropped to around 4 percent among women in their second and third trimesters. This result suggests that many women are heeding the message to avoid alcohol once they know they are pregnant.

Drinking at any time during a pregnancy is problematic. Exposure to alcohol places the developing fetus at risk for the wide range of physical, intellectual, developmental, or behavioral problems known as Fetal Alcohol Spectrum Disorders (FASD). The survey results indicate that almost one in five pregnant women drinks alcohol early in pregnancy and some continue to drink throughout their pregnancy, so there remains much work to do to reduce the risk of FASD.

Drs. Margaret Mattson and Rachel Lipari are researchers at SAMHSA's Center for Behavioral Health Statistics and Quality. We have asked them to give us some more insight into the survey results.

Questions
Q: What other information does the NSDUH tell us about women and alcohol use during pregnancy? According to the survey results, what age range of women who are pregnant had the highest rate of alcohol use?

Overall, about 8.5 percent of pregnant women reported having a drink of alcohol in the past 30 days, and 2.7 percent reported binge drinking.

By race and ethnicity, non-Hispanic whites and blacks are similar with 9-10 percent drinking any amount and roughly 3 percent binge drinking. Hispanic drinking rates are about half that of non-Hispanic, with 5.5 percent of pregnant Hispanic women drinking any alcohol and 1.5 percent binge drinking.

Young pregnant girls were at the greatest risk of an alcohol-affected pregnancy, with 13 percent of pregnant girls between 15 and 17 years of age reporting they drank in the past 30 days. Among pregnant women in the 18-25 and 26-44 age groups, between 7-9 percent reported some alcohol use, with 2-3 percent reporting binge drinking.

Q: What does the NSDUH show about women of childbearing age and drinking?

Among women between 18 and 44 years of age, the rate of drinking among non-pregnant women is much higher than among pregnant women, showing that many women have gotten the message to cease drinking while pregnant. Among pregnant women age 15 to 44, an annual average of 8.5 percent reported current alcohol use, 2.7 percent reported binge drinking, and 0.3 percent reported heavy drinking. These rates were lower than the rates for non-pregnant women in the same age group (55.5, 24.7, and 5.2 percent, respectively). As encouraging as this difference is, the 18 percent of women drinking during that important first trimester are a concern. Since FASD is 100 percent avoidable in the absence of alcohol exposure, we still need to continue reaching women in this age group.

Q: What is the public health significance of alcohol use during pregnancy?

The established public health message is that pregnant women should not drink any alcohol during their pregnancy, and that women of childbearing age who drink should take effective steps to avoid pregnancy. Because the exact amount and timing of alcohol's deleterious effect on the fetus are not yet understood, abstinence throughout pregnancy is by far the safest course.

Q: How can we reach more women of childbearing age to further decrease drinking during pregnancy?

SAMHSA's FASD Center for Excellence is a model for a two-step approach for reaching women. The first step is the identification of evidence based prevention interventions that have been shown effective in rigorously controlled studies. These tools include education and brief intervention by medical providers and by trained peers and paraprofessionals in a variety of settings such as medical offices, clinics, home visitation programs, etc. Many of these programs are especially targeted to high risk women, i.e., substance abusers.

The second step of the program is to multiply the effectiveness of these tools by disseminating them and offering technical assistance so that they can be incorporated into statewide systems of care throughout the country.

Continued on next page.

Continued from the previous page.

For more information on the interventions and dissemination go to:
http://fasdcenter.samhsa.gov/assessmentprevention/fasfasdprevent.aspx

Q: What do you feel is the impact of the survey results? What are some of the strengths and weaknesses of this survey?

The annual NSDUH provides unparalleled information on substance use and mental health among persons age 12 and older in households in the United States. This survey interviews over 67 thousand people each year and uses population-based weights to provide prevalence estimates representative of the United States as a whole as well as at the state level. Data from the survey is widely used to establish benchmarks for the prevalence of mental disorders as well as substance use and substance use disorders, including the use of illicit drugs, alcohol, and prescription drugs.

The NSDUH is not designed to collect information on some populations, such as homeless people, and those in long-stay hospitals, prisons or other institutions, or the military.

Also, the NSDUH defines binge drinking for both men and women as consuming five or more drinks within about a two hour period. However, alcohol affects women differently than men. For women, binge drinking is generally considered to mean four drinks within two hours.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

About the Experts
Margaret E. Mattson, Ph.D., is a research scientist in the Center for Behavioral Statistics and Quality at SAMHSA. Before coming to SAMHSA, she worked in program development and research for several Institutes at the National Institutes of Health. She received her doctorate in Neurobiology and Behavior from Cornell University. Her major interest is in developing interventions to address behavioral risk factors in chronic disease. She has published over 100 articles and book chapters, and has taught internationally on the effects of alcohol during pregnancy and early childhood, with an emphasis on fetal alcohol spectrum disorders (FASD).

Rachel Lipari, Ph.D., is a military sociologist currently serving as a statistician at the Center for Behavioral Health Statistics and Quality in SAMHSA. Before coming to SAMHSA, she was the lead overseeing gender, race/ethnicity, and military family research for the Office of the Secretary of Defense until 2011. Her research interests include mental health, family issues, substance abuse, diversity, and sexual assault. Dr. Lipari is an expert in military research and is applying her knowledge of survey design and analysis to the NSDUH.

Submitted by Angela Hayes, MS, LMHC, LCAC
President-Elect IAAP

IMPORTANT NEWSLETTER UPDATE:

In order to help the association **GO GREEN**, the IAAP newsletter is going to become electronic!

Beginning with our next issue of the IAAP newsletter, members will now see their newsletter in their email inbox! If you would prefer to receive a printed copy, please contact Stephanie by email at stephanie@centraloffice1.com.

Thank you for showing IAAP your **electronic support**!

Beating Pain and Painkillers: New Mental Intervention Treatment

With nearly one-third of Americans suffering from chronic pain, prescription opioid painkillers have become the leading form of treatment for this debilitating condition. Unfortunately, misuse of prescription opioids can lead to serious side effects -- including death by overdose. A new treatment developed by University of Utah researcher Eric Garland has shown to not only lower pain but also decrease prescription opioid misuse among chronic pain patients.

Results of a study by Garland published online Feb. 3 in the *Journal of Consulting and Clinical Psychology*, showed that the new treatment led to a 63 percent reduction in opioid misuse, compared to a 32 percent reduction among participants of a conventional support group. Additionally, participants in the new treatment group experienced a 22 percent reduction in pain-related impairment, which lasted for three months after the end of treatment.

The new intervention, called Mindfulness-Oriented Recovery Enhancement, or MORE, is designed to train people to respond differently to pain, stress and opioid-related cues.

MORE targets the underlying processes involved in chronic pain and opioid misuse by combining three therapeutic components: mindfulness training, reappraisal and savoring.

- Mindfulness involves training the mind to increase awareness, gain control over one's attention and regulate automatic habits.
- Reappraisal is the process of reframing the meaning of a stressful or adverse event in such a way as to see it as purposeful or growth promoting.
- Savoring is the process of learning to focus attention on positive events to increase one's sensitivity to naturally rewarding experiences, such as enjoying a beautiful nature scene or experiencing a sense of connection with a loved one.

"Mental interventions can address physical problems, like pain, on both psychological and biological levels because the mind and body are interconnected," Garland said. "Anything that happens in the brain happens in the body -- so by changing brain functioning, you alter the functioning of the body."

To test the treatment, 115 chronic pain patients were randomly assigned to eight weeks of either MORE or conventional support group therapy, and outcomes were measured through questionnaires at pre- and post-treatment, and again at a three-month follow-up. Nearly three-quarters of the group misused opioid painkillers before starting the program by taking higher doses than prescribed, using opioids to alleviate stress and anxiety or another method of unauthorized self-medication with opioids.

Among the skills taught by MORE were a daily 15-minute mindfulness practice session guided by a CD and three minutes of mindful breathing prior to taking opioid medication. This practice was intended to increase awareness of opioid craving -- helping participants clarify whether opioid use was driven by urges versus a legitimate need for pain relief.

"People who are in chronic pain need relief, and opioids are medically appropriate for many individuals," Garland said. "However, a new option is needed because existing treatments may not adequately alleviate pain while avoiding the problems that stem from chronic opioid use."

MORE is currently being tested in a pilot brain imaging trial as a smoking cessation treatment, and there are plans to test the intervention with people suffering from mental health problems who also have alcohol addiction. Further testing on active-duty soldiers with chronic pain and a larger trial among civilians is planned. If studies continue to demonstrate positive outcomes, MORE could be prescribed by doctors as an adjunct to traditional pain management services.

Source: Science Daily, February 2014
Submitted By B. Kay Bontrager

Higher Rates of Adolescent Substance Use in Child Welfare Vs Community Populations in the United States

Danielle L. Fettes, Gregory A. Aarons, Amy E. Green

Objective: Youth substance use exacts costly consequences for a variety of important health outcomes. We examined and compared prevalence rates and a common set of psychosocial factors of lifetime and current substance use among child welfare-involved youths and community youths from two nationally representative data sets.

Method: Using the National Survey of Child and Adolescent Well-Being and the National Longitudinal Study of Adolescent Health, we compared prevalence rates and conducted logistic regression models for eight binary outcome measures of substance use: lifetime and current use of alcohol, inhalant, marijuana, and other illicit drugs to examine predictors of substance involvement in the two samples.

Results: Substance use prevalence was higher among child welfare-involved youths than community youths for lifetime marijuana use, lifetime and current inhalant use, and lifetime and current other illicit drug use. Among both child welfare-involved and community youths, delinquency was the factor most strongly associated with all lifetime substance use outcomes. Notably, family structure and parental closeness were important protective factors against current substance use among child welfare-involved youths. For community youths, poorer emotional health was the strongest indicator of current substance use. **Conclusions:** Substance use among all adolescents is a critical public health concern. Given the heightened vulnerability of child welfare-involved youths, it is particularly important to focus prevention and early intervention efforts on this population. Further research should explore additional factors associated with substance use among these youths so that child welfare and behavioral health systems may jointly target prevention and intervention efforts. (J. Stud. Alcohol Drugs, 74, 825–834, 2013)

Source: Journal of Studies on Alcohol & Drugs
Submitted by: Albert Alvarez

Who Suggests Drinking Less? Demographic and National Differences in Informal Social Controls on Drinking

Paul Dietze, Jason Ferris, Robin Room

Objective: The purpose of this study was to examine variation in reports of pressuring others to drink less, as a form of informal social control of drinking, across countries and different types of relationship to the respondent.

Method: A cross-sectional survey was administered to 19,945 respondents ages 18-69 years in 14 countries included in the data set of the Gender, Alcohol and Culture: An International Study (GENACIS). Outcome variables were respondents' reports of pressuring others to drink less (yes/no) across a variety of relationships (their partners, other family members, workmates, or friends). Multilevel, multivariable logistic regression analysis was carried out on each outcome variable. The fixed-effects components included the Level 1 (individual) covariates of respondent age, gender, drinking status, and education level as well as the Level 2 (country level) covariates of percentage female drinkers and purchasing power parity. The random-effects components included country and current drinking status.

Results: Respondents most frequently reported pressuring male friends to drink less (18%), followed by male family members (other than partners, 15%), partners (15%), work colleagues (12%), female friends (9%), female family members (other than partners, 6%), and children (5%). There was marked variation across countries, with pressuring frequently reported in Uganda, Costa Rica, and Nicaragua across most relationship types. Multivariable logistic regression revealed consistent effects of gender, with women more likely than men to report pressuring others to drink less across most relationship types. The patterns in relation to education status and age were less consistent and varied across relationship type.
Conclusions: Informal social control of drinking varies dramatically according to whom is most likely to pressure whom to drink less as well as the country in which people live. (J. Stud. Alcohol Drugs, 74, 859–866, 2013)

Source: Journal of Studies on Alcohol & Drugs
Submitted by: Albert Alvarez

Assessing the Stimulant and Sedative Effects of Alcohol with Explicit and Implicit Measures in a Balanced Placebo Design

Fanny Kreusch, Aurélie Vilenne, Etienne Quertemont

Objective: Alcohol consumption is characterized by bi-phasic stimulant and sedative effects. In previous studies, various tools were used to assess these effects, including expectancy questionnaires, implicit association tests, and self-report scales. The present study was aimed at clarifying the relationships between these measures.

Method: Three different measures were used to directly or indirectly assess the stimulant and sedative effects of alcohol in 61 undergraduate students. The participants completed the Alcohol Expectancy Questionnaire (AEQ) and performed two unipolar Implicit Association Tasks to assess implicit associations between alcohol and the concepts of "stimulation" and "sedation." The levels of alcohol consumption also were recorded by means of the Alcohol Use Disorders Identification Test. An alcohol (0.4 g/kg) or placebo challenge was then administered using a balanced placebo design. After alcohol/placebo administration, the participants completed the Biphasic Alcohol Effects Scale (BAES).

Results: Alcohol consumption significantly correlated with AEQ alcohol explicit expectancies of arousal and relaxation, whereas no significant correlations were obtained with the implicit associations. There were positive correlations between AEQ and BAES subscales, especially for the arousal subscale of the AEQ. Self-reported sedation recorded with the BAES was significantly affected by what the participants believed that they had drunk but not by the actual consumption of alcohol.

Conclusions: These findings indicate that alcohol explicit expectancies of arousal measured with the AEQ best predict current alcohol consumption. Regarding explicit measures of alcohol-induced stimulation and sedation, BAES sub-scales seem to be more affected by alcohol drinking expectations than by actual alcohol consumption. (J. Stud. Alcohol Drugs, 74, 923–930, 2013)

Source: Journal of Studies on Alcohol & Drugs
Submitted by: Albert Alvarez

Cigarette Smoking Initiation During College Predicts Future Alcohol Involvement: A Matched-Samples Study

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Objective: Little is known about the relationship between cigarette smoking initiation and subsequent alcohol involvement. To address this question, the present study compared alcohol use between students who initiated smoking during college and a matched sample of never-smoking students. We hypothesized greater increases in alcohol involvement among smoking initiators, mediated by exposure to cigarette use situations.

Method: Included in the present study were 104 Chinese American and Korean American undergraduates who at baseline (freshman year) reported never having smoked a cigarette. Subjects were drawn from 433 participants in a naturalistic longitudinal study of tobacco use who were assessed annually each year in college. Cigarette smoking status was assessed annually as part of a structured interview. Initiators and never-smokers were matched on gender, ethnicity, baseline alcohol use, parental smoking status, and behavioral undercontrol.

Results: As predicted, participants who initiated smoking during college reported significantly greater increases in the number of past-30-day total drinks consumed ($p < .001$) and reported greater prevalence of heavy drinking episodes ($p < .05$). The effect of smoking initiation on the change in the number of past-30-day drinks at the final assessment was partially mediated by exposure to smoking ($p < .05$). Exploratory analyses indicated that greater recent smoking significantly predicted increased alcohol consumption over and above the effect of exposure.

Conclusions: Students who initiate smoking during college appear at risk for increased alcohol involvement. Part of this risk is explained by environmental contextual factors, specifically exposure to situations involving other smokers that also may result in greater exposure to alcohol use. (J. Stud. Alcohol Drugs, 74, 909–916, 2013)

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