

# Psychology and Substance Use

An Interest Group of the Australian Psychological Society

## Convener's report

As you have recently had my letter detailing the activities we have been undertaking this year, I will just highlight a few issues. This will be our last newsletter before the APS conference and our AGM in New Zealand – if you are attending the conference, please join us for the AGM in the Epsom Room 1 of the conference venue on Friday 29 September 8am-8.30am. We will provide coffee and croissants while we discuss the role and activities of PSU for the coming year.

As I highlighted in my letter, we are still looking for someone to take on the role of Website Editor. This position does not require a high degree of technical expertise – there are staff members at the APS office with the technical know-how to upload and organise the material. We simply need someone to keep an eye on the website and help us to ensure it remains up to date, as the website receives many hits per day and is an important vehicle for communicating about AOD issues. If you are interested, please let me know by emailing: [clinical.dir@adfact.org](mailto:clinical.dir@adfact.org)

### APS Conference, Auckland, NZ

The upcoming conference is occupying our thoughts and time at the moment as we prepare for the Substance Use Forum: *Working with the complex substance using client – is one approach better than another?* The forum takes place on Friday 29 September at 2-3.30pm and will introduce a case study and four different treatment approaches: Family Therapy (Malise Arnstein), Motivational Interviewing (Joel Porter) Dramatic Psychological

Storytelling (Rob Allen) and Interactive Drawing Therapy (Russell Withers). It promises to be an interesting and informative session.

### Training for Psychologists in AOD Work

I am interested to hear from psychologists working in the field in relation to AOD training requirements proposed by a growing number of jurisdictions. How does this impact on you professionally – and what will you need to do in order to address this requirement? We are working on this issue with providers in each of the States and Territories, and there are now a number who are able to provide the specific training in the core competencies needed. At the same time, it is also an issue we are addressing at university level, and asking psychology departments to consider the need to include these core subjects at undergraduate level.

As you would be aware, there are few undergraduate courses for psychologists that provide specific training in AOD work. There are some that are available at graduate and post-graduate level, however the majority of training programs in all States and Territories are offered through the TAFE system.

The Core competencies required are:

- CHCAOD2C: Orientation to the AOD Sector
- CHCAOD6B: Work with clients who are intoxicated
- CHCAOD8C: Assess the needs of clients who have AOD issues
- CHCAOD10A: Work with clients who have AOD issues

In addition, other Work Specific competencies will be required where people are working in particular work places (eg. Needle and Syringe Programs, Withdrawal Units). While this is potentially a huge shake-up for everyone working in the AOD field, it is an important strategy designed to ensure the development and maintenance of a consistently competent and professional AOD workforce. It is therefore an important development which needs to be supported.

### Drug Issues Policy Statement

The Interest Group is once again working with the APS to develop a Policy Statement on Alcohol and other Drugs. Professor Debra Rickwood, who is coordinating this process, would like to hear from all members in relation to:

- Strategy for consultation with psychologists – how do we achieve wide input from Interest Group members?

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- What are the key issues – including AOD relationship with mental health?

We have a tight timeline – the APS would like to consider this Policy Statement at their meeting in December. We would therefore like to have a draft for discussion at the AGM in September. Please contact Debra with ideas and suggestions – particularly if you can be of assistance in your own area in bringing others together to discuss

these issues and provide feedback. Debra can be contacted by email: [Debra.Rickwood@canberra.edu.au](mailto:Debra.Rickwood@canberra.edu.au)

I look forward to hearing from you and meeting up with PSU members who will be in New Zealand in September.

*Lynne Magor-Blatch*  
National Convener

## 2006 Joint APS & NZPsS Conference in Auckland, NZ

We are pleased to announce that AOD issues are firmly on the agenda again this year at the Joint APS & NZPsS Conference in Auckland. In addition to our AGM (8.00-8.30 Friday 29 September), PSU has sponsored two events:

- Friday 29 September 2.00-3.30 PM - Practice forum: Working with the complex substance using client – is one approach better than another?
- Saturday 30th September - Full day workshop: Motivational Interviewing (Joel Porter)

Other AOD related presentations at this year's conference include:

- Girls, substance abuse and juvenile justice: A 10 year review (Christopher Lenning)
- An evaluation of the effectiveness of custodial alcohol and drug treatment units in reducing alcohol related recidivism (Kirsty Williams)
- Dramatic Psychological storytelling: applications in therapeutic, organisational and educational settings (Rob Allen)

## Collaboration with DANA: Advanced Motivational Interviewing

Following the successful collaborations with APSAD at the 2005 APSAD conference, we have the pleasure of working with yet another AOD professional agency, the Drug and Alcohol Nurses Association (DANA). With nurses and psychologists often working alongside each other in the AOD field, the two agencies sought to support each other in hosting a unique opportunity to develop advanced skills in Motivational Interviewing.

Motivational Interviewing is a valuable tool in assisting people to change behaviours, yet there are few avenues for clinicians to gain advanced training beyond the usual introductory workshops. The program of workshops offers a rare opportunity to take our Motivational Interviewing knowledge and skills to the next level.

The project was initiated by Jodie Shoobridge, the then President of DANA and member of the PSU executive, and supported by both organisations. The program will be run across two states, S.A. and Victoria.

We have previously assisted DANA to gain specialist PD points for Motivational Interviewing workshops run by Joel Porter, Director of Pacific Centre for Motivation and Change (NZ).

The presenters bring a wealth of combined experience in the research and application of Motivational Interviewing to a broad range of behaviours, including substance use, sexual practices, dietary and exercise behaviours, management of chronic illness and co-occurring mental health issues, and treatment adherence.

The program includes three workshops:

- Learn advanced skills in the application of MI (Workshop 1: Denise Ernst and Joel Porter)
- Apply MI to those experiencing mental health and co-occurring disorders (Workshop 2: Alan Zuckoff)
- Apply MI to negotiate health behaviour change (Workshop 3: Suzanne Habib)

The Melbourne workshop (two days) offers a slightly abridged version of the Adelaide program (two and a half days).

**Melbourne workshop:** November 9-10 2006

**Adelaide workshop:** 13-15 November 2006

An outline of the program details, presenters and registration details will be emailed to members shortly.

## Editorial policy

**Content:** The views expressed by contributors to the PSU Newsletter are not necessarily those of the Australian Psychological Society Ltd or PSU. Please note: final content is at the discretion of the Editor.

**Solicited articles:** The Editor may approach suitable authors to write on relevant issues.

**Unsolicited articles:** The Editor encourages PSU members to contribute unsolicited articles to the newsletter. Publication of unsolicited articles cannot be guaranteed. The Editor, in consultation with PSU representatives, has the final decision for inclusion of material

and the form it takes. Unsolicited articles should not exceed 800 words, except by prior arrangement.

**Advertising:** Placement of an advertisement in the newsletter is not necessarily an endorsement of the advertiser by PSU. Approval of advertisements rests with the Editor, who may consult with the National Executive. Fees for advertising available on enquiry.

**Submission of material:** Material should be submitted to the Editor by the relevant deadline. Submissions are to be in electronic format only, in Microsoft Word or text only format, and sent via email to the Editor, Helen Mentha, at [helenmentha@yahoo.com.au](mailto:helenmentha@yahoo.com.au).

## When you can't see the wood for the trees: What does drug treatment consumer satisfaction really tell us?

### Background

At the 2003 APSAD conference in Brisbane, Dr. Adam Winstock, Louise Rushworth and Telea Slavin from Reckitts Benckiser, and I discussed the issues of satisfaction for people engaged in drug treatment. This conversation sowed the seed for us to seek funding for a study to explore consumer's treatment satisfaction, comparing methadone and buprenorphine within public, pharmacy and private settings.

This is an exciting project that AIVL is thrilled to be part of. Not only was the study worthwhile, AIVL was again being recognised as experts and treated as an equal partner. Our involvement in the study has included the development of the questionnaires, collecting the data (Annie Madden and I interviewed all of the participants) and data analysis. Annie and I visited each site and administered the questionnaires using a lap top. The survey took approximately 10 – 15 mins to complete. Each participant was paid for their time and was offered related information as well as a copy of "Users News", the magazine of the NSW Users and AIDS Association (NUAA), to take away with them.

The data gathering commenced in January 2005 and was completed in July 2005. For the purpose of this paper, I am only going to present some of the initial quantitative findings concerning treatment satisfaction.

### The study

The study consisted of three components:

1. Consumer interviews: The questionnaire was split into several sections, including demographics, buprenorphine, methadone and treatment satisfaction.
2. Nurse Unit Manager interviews and
3. Clinic observation sheet at each site.

In total, we interviewed 448 consumers who were engaged in either methadone or buprenorphine treatment programs across nine public clinics in both metro and non metro areas of NSW. Of this, 62% were male and 38% were female. The majority of people (86%) were born in Australia and 96% spoke English at home. It will be of no surprise that 69% of participants indicated heroin as their drug of choice. In relation to how long people had been engaged in their current episode of treatment, 17% reported less than three months, 26% reported 2-5 years and 17% to more than 10 years. The mean age of participants was 36 years.

### Treatment satisfaction

Undertaking this survey in the various clinics that we accessed was an enlightening experience for us both – particularly for me. My only treatment experience is that of a provider of treatment in the UK. Many of you will know that Annie Madden has been engaged on the methadone program for over 10 years. So between the

two of us we had great expertise and insight. This was for me a really important experience. Far removed from the daily grind of being engaged on a public treatment program, I found myself at the clinics each day when they opened for dosing and I became acquainted with the consumers who arrive early – some up to an hour or so before the clinic opens to be first in. Annie and I found the process exhausting and I was enabled to witness first hand, although as an outsider, what it meant to have a life that is dictated by inflexible policy.

Our experience of conducting the questionnaires, did not match our findings. Dr. Adam Winstock would often call us at the end of an interview session to ask how it went. More often than not we would inform him that things were not looking that good, that people were by and large unhappy and that it appeared that there was a great deal of work needing to be done to improve consumer satisfaction. So then our quantitative findings were on one hand surprising and on the other hand confusing:

1. 82% of people on methadone and 90% of people on buprenorphine reported that they were happy with their dose.
2. People on buprenorphine only wait an average of 5 mins to be dosed and those on methadone, 10 mins.
3. The average rating for (1 being useless, and 10 being excellent) how helpful their case manager had been on the following issues:
  - Their opiate use – 6.5
  - Other drug use issues – 6
  - Mental health issues – 6
  - Accommodation – 5
  - Employment – 4
  - Parenting – 5
  - Legal issues – 4.5
  - Physical health – 5
  - Financial – 3.

This showed that the clinics perform best in supporting people with their drug use and mental health – holistic care is not really what is on offer. Annie and I anticipated that the scores were going to be much lower across all of these questions.

We also asked people to score the following in the same way:

1. A fair and consistent service – 7
2. Personal safety at the clinics – 7
3. The clinic being respectful of drug users – 7
4. The quality of the staff – 7.5
5. Clinic confidentiality – 7.5
6. The opening times – 5.5
7. How much better they felt since commencing treatment – 7.5.

When we look at these results it appears that, by and large, the clinics are doing a fair job. Anecdotally,

participants told us that, while access to other services was poor, they were not really that bothered because they do not want their case managers knowing what is going on in their lives. It is very much a case of “enter, dose and leave” with as little interaction as possible. Nevertheless, 20% of people were very satisfied with their treatment, 48% were satisfied and 22% of participants thought that their treatment was OK. Only 10% reported any level of dissatisfaction. And it is here that it gets confusing and has made us think about what it is that consumer satisfaction questionnaires actually tell us.

When we investigated a bit further we found that 65% stated that they do not like some of the rules and regulations at the clinics and, importantly, 80% of the participants reported that they would prefer to be dosed at a pharmacy. This is of course related to takeaway availability and a whole range of other issues, but if things were so good at the clinics then why do people want to leave?

### **So what do consumer satisfaction surveys tell us?**

I have tied myself up in knots thinking about this. We do not want to discredit the findings of this study and neither do we want to beat the clinics with a stick – the clinics that we went to, on a continuum of best practice, were clearly at the higher end. We met many dedicated staff whose professional abilities are hindered due to overcrowding, lack of resources and inflexible policy. Great efforts have been made in the clinics to make them welcoming and engaging but ultimately, from our perspective, they just aren't good enough. I am also aware of the limitations of quantitative data, however; there are other issues at play. So what is it then that makes us on the outside, so to speak, think that services are poor and the actual people who engage with these clinics think differently.

To put it bluntly, I can explain it like this – if all you have ever done is eat out of dustbins and you then eat at McDonalds then of course you would score McDonalds high. The converse of this is someone who has regularly eaten at reasonable restaurants and cafes, and would quite happily see an end to McDonalds and its super sizing, would of course score it low.

Satisfaction is based on experience and expectation, and if poor service provision is all that a person has experienced then expectation will be low. So when a person then accesses a service that is deemed “better” than past experience it will score higher.

In the paper Patient Satisfaction: A review of issues and concepts, Sitzia and Wood (1997) state that:

*“Expectations emerge repeatedly as having a fundamental role in expressions of satisfaction... Expectations make more complex the concept of satisfaction as an evaluation tool. As patient satisfaction is a recognised component of Quality Assurance, it is therefore tempting to equate “high” levels of reported satisfaction with high levels of quality of care. However, in considering patient satisfaction study results, it is necessary that “expressions of satisfaction should always be interpreted in the context of some understanding of the rationale that underlies those expressions rather than being taken at face value”.*

### **The way forward**

For us to really get to the crux of consumer satisfaction – so that it has meaning and can facilitate processes of change within clinics to optimise treatment provision and consumer experiences – we need to act. And we need to do so quickly.

Here in Australia, the Quality Improvement Council (the non-profit independent Australasian body) has developed a set of standards for health and community services. Within these standards is a module for the alcohol and drug sector. There are also, at the State and Territory levels, accreditation procedures and standards that have been or are being implemented. For example, in NSW there is the NSW Methadone Accreditation Standards. AIVL welcomes these developments, which are a good start; in real terms, however, they are just the tip of the iceberg.

AIVL recognises that for some organisations, quality standards may pose some challenges to current practice. However, services can and should meet comprehensive standards even though organisational change and development takes time and has resource implications. Services need to plan effectively and timetable their agenda for quality improvements. Studying, assessing and evaluating organisational practice provides the greatest opportunity for developing high quality and effective organisations and services.

While many of the current accreditation standards are relatively comprehensive, one of the key gaps that we have identified is that of consumer involvement. Despite talk of rights and responsibilities for consumers and some involvement with consumers in consultation processes, real consumer input is thin on the ground.

The UK Alcohol Concern and the then SCODA (now DrugScope) developed QuADS: Organisational Standards Manual in 1999, which provided alcohol and drug treatment services with an assessment tool to help with the development of quality in services. QuADS was developed in response to the 1996 Task Force to Review Services for Drug Misusers (known as the “Effectiveness Review”), which highlighted the variable quality of drug treatment services, especially in the areas of: management systems, monitoring systems and forward planning. QuADS has included a clear and detailed section for services to aspire to on involving and empowering service users (see Table 1).

For us to increase treatment experience, the desired outcome from undertaking satisfaction surveys, all stakeholders – including consumers – need to work together. Together we can develop standards that all services can work towards and that can be monitored to ensure quality assurance. These standards must include consumer involvement.

In the UK, it is now a requirement by the National Treatment Agency (NTA) that Drug Action Teams (DAT) and those responsible for the commissioning of drug and alcohol services ensure that the views and experiences of service users are incorporated into the development, delivery and commissioning of those services. The NTA has placed high priority on the involvement of users and carers in the design, planning and monitoring of local

treatment systems. This is not only to address the historic marginalisation of these groups, but reflects growing evidence that user and carer involvement results in improved access, retention and client outcomes.

Organisations such as the Alliance (a National user-led organisation that provides advocacy, training and helpline services to those currently in drug treatment, those who have accessed drug treatment in the past and those who may access drug treatment in the future) offers training to services to enable them to build better relationships with their clients. This level of partnership needs to be achieved here if we truly are going to improve consumer satisfaction.

**Final comments**

In conclusion, while not discrediting satisfaction surveys in their entirety, such surveys will only have very limited value until we have absolute commitment to agreed levels of quality and educate consumers about their rights and the standards of care that they are entitled to. And until there is policy change and a revisiting of the treatment models (or lack of them) here in Australia, improving

quality for consumers and workers will be a test for us all. A test that is worth giving a fair go!

**Nicky Bath – Treatment Program and Policy Manager, AIVL**

**(co-author Annie Madden – Executive Officer, AIVL)**

**Acknowledgements**

I would like to thank: the 2005 APSAD conference organisers for allowing AIVL to present this paper – the inclusion of drug user organisations assists us in initiating and building upon our partnerships across the sector; Telea Slavin, the Product Manager for Buprenorphine from Reckitt Benckiser, who funded the study; Dr. Adam Winstock and Toby Lea from Drug Health Services Sydney South West Area Health Service with whom we partnered to undertake this study; all of the services that took part and the wonderful participants who took the time to answer our questions; and last, but by no means least, the amazing Annie Madden, my co author.

**Table I: QuADS Standards for involving and empowering service users**

<i>Standard Statement</i>				
<i>The service seeks to maximise involvement of service users with regard to the type, delivery and development of services.</i>				
Criteria	Evidence	M/GP	Criteria met	Comment
16.1	There are procedures for consulting with service users to inform service planning and delivery <sup>1</sup> .	Written procedure(s).	M	
16.2	Service users are provided with information on types of services provided and the standards they can expect.	Information available to service users.	M	
16.3	Service users are represented in management structures.	Mechanism for involvement/feedback established and publicised.	GP	
16.4	The service has a charter of service users' rights and responsibilities, provided to service users on request. <sup>2</sup>	Statement of rights and responsibilities available.	M	
<b>Guidance notes</b> 1. Consultation may take the form of consultation groups, satisfaction surveys (see Standard 18: Complaints procedures), or service user representatives on the management body. 2. This could involve the service developing its own charter or subscribing to a published charter (eg SCODA <i>Charter of Service User Rights</i> , see Appendix 2).				

**Websites of interest**

Australian user groups offer clients and clinicians alike with a wealth of information, support and insights. The AIVL website provides information on affiliated state-based user groups without a website. Contact your local NSP for more information on local peer support services.

- **Australian Injecting and Illicit Drug Users League (AIVL):** [www.aivl.org.au](http://www.aivl.org.au)
- **Network Against Prohibition NT (NAPNT):** [www.napnt.org](http://www.napnt.org)

- **New South Wales Users & AIDS Association (NUAA):** [www.nuaa.org.au](http://www.nuaa.org.au)
- **SA Voice for IV Education (SAVIVE):** [www.acsa.org.au/savive.html](http://www.acsa.org.au/savive.html)
- **Victoria Drug Users Group (VIVAIDS):** [home.vicnet.net.au/~vivaid/](http://home.vicnet.net.au/~vivaid/)
- **WA Substance Users Association (WASUA):** [www.wasua.com.au/](http://www.wasua.com.au/)

## **Review: Miller, G. (2005) Learning the language of addiction counseling (2<sup>nd</sup> Ed.) Hoboken: John Wiley**

The book aims to offer “A comprehensive, up-to-date, and user-friendly resource” and, to a fair extent, achieves its goal. Geri Miller provides an overview of theoretical framework, assessment, individual and group treatment, self-help groups, relapse prevention, specific client issues, emerging approaches and professional development issues for counsellors. The writing is clear, the content by and large useful and evidence-based. It was also interesting to note that Seligman’s Positive Psychology made it into the “current and evolving therapy approaches and techniques”; this is not an approach often seen cited in reference to substance use treatment.

Ironically, one aspect of this text that concerned me was the author’s own “language of addiction”. Miller’s approach appears to be heavily influenced by the 12 step model, with a strong focus on abstinence, and is scattered with references to “enabling”. References to “the addict” and “the alcoholic”, while they have their role in 12 step programs, risk reinforcing stereotypes and assumptions about the kind of person who misuses substances.

Having worked in the alcohol and other drug field for over eight years now, the only thing I can say for sure that people who use drugs have in common is that they use drugs; the use of psychoactive substances is a behaviour, not a personality trait. Of course, there are recurring themes, familiar stories and common biological responses in working with alcohol and other drug use; but no one pattern fits all people. With a behaviour as stigmatizing as substance misuse, it is our responsibility as professionals not to reinforce assumptions and expectations that further disempower and strip individuals of their right to common dignity and respect.

Any author in Miller’s position faces the dilemma of what to include and what to leave out. While the attempt to raise more “related issues” and “special populations” than may typically feature in an introductory text is admirable in intention, the scope of the book seems ambitious and as a result, much of this additional information suffers from paucity of detail and remains largely superficial. Miller repeatedly states the need to collaborate with clients, question one’s own assumptions and approach the work with an open mind; yet the brevity of the many specialist concern areas leaves potential for new assumptions to replace the old.

### **PSU National Executive**

Please contact us with any queries, concerns and ideas!

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For example, a reasonable statement such as “Lesbians often have some different issues that need to be addressed in treatment” soon slips into a far more emphatic statement that “Therefore, treatment with lesbians needs to focus on relationship-oriented issues such as parenting and domestic violence.” Maybe. Maybe not. You would need to ask the client what she wants to focus on before making such a decision, especially if she was single, childless or in a positive relationship that did not bear on the substance use.

In short, Miller’s text has a lot to offer and aims to contribute a thorough addition to the range of introductory texts available. However, I would encourage readers to go beyond this text to ensure their introduction to the field of AOD use and treatment included Australian material with a philosophy and language more closely aligned with current practice in AOD treatment services across the country.

**Helen Mentha**

*Reprinted from APS Victorian Branch Newsletter*

## **HELP!**

**PSU is run by a small group of volunteers. Help us make the most of the group by getting involved - just contact Lynne. Here’s a few easy ways:**

- **Share information on your work, research, websites, events and resources with other members**
- **Provide a speaker or venue for a seminar**
- **Become our web-editor**
- **If you think we should be doing something, tell us!**