

PSYCHOLOGY & SUBSTANCE USE

Potential Contributions and Professional Training Needs

- Table of Contents
- Overview
- Involvement of psychologists in addressing AOD issues
- Competencies for psychologists and their application to AOD issues
- Competency 1: Discipline knowledge
- Competency 2: Research
- Competency 3: Framing, measuring and solving problems
- Competency 4: Service implementation
- Competency 5: Professional, legal and ethical approach
- Competency 6: Communication
- Competency 7: Professional and community relations
- Competency 8: Influence and change
- Education and training related to AOD for psychologists
- References

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TABLE OF CONTENTS

Overview	3
Involvement of psychologists in addressing AOD issues	4
Competencies for psychologists and their application to AOD issues	8
Competency 1 Discipline knowledge	8
Competency 2 Research	9
Competency 3 Framing, measuring and solving problems	10
Competency 4 Service implementation	11
Competency 5 Professional, legal and ethical approach	13
Competency 6 Communication	13
Competency 7 Professional and community relations	15
Competency 8 Influence and change	15
Education and training related to AOD for psychologists	17
References	19
Appendix 1: Resource material for psychologists working in the AOD field	20

OVERVIEW

The Australian Psychological Society (APS) Working Group on Substance Use prepared this document to encourage discussion of the role of psychologists, and further training needs for the profession, in relation to alcohol and other drug (AOD) related harm.

Psychologists have already made significant contributions to the AOD field, yet there is potential for greater involvement as a profession in addressing the challenges posed by AOD issues in our society. With the growing recognition that AOD use cannot realistically be understood in isolation from other areas of human behaviour, psychologists have more opportunities to demonstrate how they can contribute to the complex issue of reducing AOD related harm. This professional input is required at all levels, including education, prevention, treatment and policy.

The paper therefore aims to address four key themes:

- to show the importance and centrality of the role of psychologists in responding to AOD problems;
- to demonstrate the substantial overlap between psychologists' core competencies and those required for AOD work;
- to review these core competencies in light of their relevance to AOD work; and
- to encourage more psychologists to view AOD issues as being a part of their work, rather than as a separate area that automatically requires referral to an AOD specialist.

This document first presents some of the main issues that affect the level of involvement of psychologists in AOD issues, discussing the traditional view that AOD issues necessarily require specialist skills, and the advantages of psychologists recognising the relevance of core competencies as well as the commonalities between AOD use and other behaviours. The paper then outlines how the APS *Competencies for Psychologists* (1996) relate to working in the AOD field.

It is argued that training all psychologists in applications of the APS competencies to AOD issues would ensure an effective, skilled and professional response to AOD-related harm. It is acknowledged, however, that some specific skills and knowledge necessary to the AOD area may not be currently provided through psychological training. Possible training initiatives to redress this are suggested. The paper concludes with a discussion of the importance of education and training for all psychologists in AOD issues and considers the necessary components to facilitate such training.

The document is intended to be read in conjunction with another document developed by the APS Working Group on Substance Use entitled, *A Psychological Approach to Substance Use* (in preparation), which takes a broader perspective and presents a psychological approach to AOD issues in greater detail.

INVOLVEMENT OF PSYCHOLOGISTS IN ADDRESSING AOD ISSUES

AOD issues are widespread (Roche, 1998), with the majority of people in our society engaging in some form of substance use, whether licit or illicit (Australian Institute of Health and Welfare, 2000). Drug use is both a personal and public health issue, and needs to be considered in its wider socio-cultural context. It is well established that AOD-related problems are associated with significant costs to the individual and wider community, and present in a diverse range of settings. Of particular relevance to the work of psychologists is the evidence that people with mental health problems are more likely to use alcohol and other drugs (Sawyer et al., 2000), and AOD issues are present in some way for many people accessing health and mental health services, even if substance use is not the presenting problem.

Many of the problems associated with AOD use are amenable to prevention, early intervention or effective treatment (e.g., Hawks, 1995; Miller & Hester, 1995; Bien, Miller, & Tonigan, 1993). In the last decade and a half, there has been substantial growth in the quantity and quality of research undertaken on the prevention and treatment of AOD-related harm. A variety of biological, behavioural and social science disciplines, including psychology, have contributed to this research. As a result, there is now an extensive knowledge base to draw upon to assist in determining appropriate responses to AOD issues.

Despite the availability of evidence-based AOD interventions, many workers in the health and community sector, including psychologists, seem reluctant to respond to AOD-related harm (e.g., Roche & Richards, 1991; Roche, 1991). Furthermore, psychologists appear to be under-represented among attendees of AOD training (e.g., Albery et al., 1997), and for many of those who do respond to AOD issues, evidence suggests that research is rarely used to guide practice (e.g., Grol & Grimshaw, 1999; Berggren, 1996; Ferrence, 1996; Pearcey & Draper, 1996).

Research and prevention

Within the harm reduction framework adopted by the Commonwealth Government's *National Drug Strategic Framework* (Ministerial Council on Drug Strategy, 1998), there is a focus on both preventing the uptake of drug use and reducing the harm associated with AOD use. Psychologists work in many different contexts within their communities and have expertise to contribute at many diverse points across the harm reduction framework.

Prevention and early intervention activities need to identify people at risk of substance use and those beginning to experiment with substance use and abuse. At the same time, it is also essential to identify the factors that protect individuals and communities against substance misuse. An important area for psychological research is to investigate the ways in which genetic, environmental and learned behaviours contribute to substance use, along with the extent to which these influences interact with each other.

Evidence-based preventive interventions need to be further developed and evaluated. To date, prevention programs have frequently focused on controlling access to substances and educating people as to their harmful effects. The success of these many and varied interventions is widely debated, particularly in terms of the high cost of supply-reduction strategies. There is also disturbing evidence that some well-intentioned drug education programs implemented in schools to prevent the uptake of harmful drug use are associated with an increase in drug use behaviour (Wallace & Staiger, 1998; Hawthorne, Garrard, & Dunt, 1995). Psychologists operating in community, educational and organisational settings are well placed to contribute to the development and evaluation of effective preventive interventions that incorporate a bio-psycho-social perspective on behaviour and behaviour change.

Treatment

When AOD issues are the main presenting problem, specific services are available - at least in most urban areas. These services are staffed by workers who have specialised in AOD work, some of whom may be psychologists,

many more of whom have been trained in other disciplines. Yet many of the people who present for treatment to other, non-AOD specific services will also have an AOD issue to a greater or lesser extent. Comorbid AOD use may present in different forms, including:

- recreational drug use that is currently causing little or no harm, and is unrelated to the presenting issues;
- increased use of otherwise recreational drug use in response to other life stressors, with potential risk of harm from excessive use or dependence;
- co-existing substance abuse or dependence that may be contributing to, or exacerbating, the presenting problem;
- recovery from a past AOD problem, that relates somehow to the presenting problem; or
- concerns about a family member or friend who is using drugs in a way that is impacting on the client's well-being.

In service delivery settings, people with mental health problems become more vulnerable to substance use through attempts to self-medicate their symptoms with licit and illicit drugs, as well as through lifestyle changes related to their mental health problems (Dixon et al., 1991). Consequently, substance use problems are more common among those diagnosed with psychiatric disorders and mental health problems than among the general population (McLennan, 1998; Jablensky et al., 1999; Hambrecht & Hafner, 1996), and comorbid AOD issues can impact substantially on the treatment of these clients. Some of the potential problems include: masking of symptoms, making an accurate diagnosis more difficult; exacerbation of psychotic, depressive and anxiety symptoms; increased suicide attempts; reduced compliance with treatment regimes; reduction in the effectiveness of prescribed medication; poorer treatment outcome; and increased psychosocial problems, including financial problems, legal difficulties, housing problems, family disruption and difficulty developing or maintaining a network of supportive relationships. Although people with mental health problems may use substances for the immediate benefits of relief from emotional discomfort and loneliness, or to reduce the side-effects of prescribed medication, in the longer term substance use often has harmful consequences (Ritson, 1999; Jenner, Kavanagh, Greenaway, & Saunders, 1998).

Many clients accessing psychological services are therefore likely to have some issues related to licit or illicit drug use. To ensure that these clients receive effective support and assistance it is necessary that all psychologists have the capacity to deal with basic AOD issues. This does not imply that all psychologists need to become specialist AOD workers; it means that they need to have the skills, training, confidence and support from their professional and work organisations to deal effectively with general concerns and complaints regarding AOD. It also means that they need to know when the AOD issue requires specialist skills, and how and where to refer.

Barriers to involvement by psychologists

A common response of psychologists who come into contact with AOD issues is to request a specialist AOD worker. The reasons for this are varied, including:

- a lack of familiarity with AOD issues and a belief the work requires specialist skills or knowledge that they do not have and their training did not prepare them for;
- the belief in the stereotype that substance using clients - and illicit drug users in particular - are amongst the most difficult and chaotic to work with, given the frequent focus on issues such as intoxication, non-compliance, potential violence, homelessness and criminality;
- the expectation that repeated relapse is common, and the work would therefore be difficult, time consuming or otherwise unrewarding; and
- a belief that referral is the most appropriate response and is preferable to offering clients a potentially ill-informed service.

Avoidance of working with AOD issues is also evident on an organisational level. Despite its prevalence, many organisations involved in health and well-being do not see AOD as part of their core business. This is evident in

the lack of services addressing AOD in their policies and procedures, as well as the lack of training provided to staff to give them the skills to deal with AOD issues (Rose & Gallagher, 1999). Consequently, staff members often conclude that they have neither the competence nor the expectation to work with such problems, and when significant AOD issues are noted (and they may not be if the issue is not adequately covered in the assessment), the client is generally referred to a specialist. As a result, the client may miss an opportunity to receive assistance from the referring agency only to be placed on a waiting list of a drug and alcohol agency, as few areas have sufficient AOD specialists to provide immediate treatment, particularly in rural and remote regions. Lack of immediate treatment may mean that the intervention opportunity is lost at that point.

Opportunities for greater involvement

Psychologists have many of the basic skills necessary to respond effectively to AOD-related harm. The core competencies for psychologists, as described in the APS paper *Competencies for Psychologists* (1996), are sufficient for any psychologist to intervene effectively in relation to AOD issues, provided those competencies are supplemented with some specific applications from the AOD field. The bio-psycho-social conceptual framework that most psychologists work within is appropriate for preventive, treatment, community and policy settings. Psychologists are also already familiar with diagnostic criteria, such as those outlined in DSM-IV, including diagnoses of substance dependence and abuse.

A growing understanding of comorbidity, and of dual diagnosis in particular, creates an opportunity to address limitations of current practice on both an individual and an organisational level. The high prevalence of AOD comorbidity necessitates routine assessment for substance use problems among all those accessing mental health services, as well as routine assessment for mental health problems among those in treatment for substance use disorders. This requires close partnerships between services in the mental health and AOD fields, which entails shared understanding between professionals working in these fields.

However, to enable all psychologists to respond effectively to AOD-related harm there is a need for appropriate education and training specifically focussed on applications to AOD issues for students in psychology courses, and for opportunities to engage in ongoing professional development for those who are already in the workforce. Although there has been progress in recent years, AOD education and training has been limited in most psychology departments, and is often restricted to familiarising students with DSM-IV diagnostic criteria and some of the psycho-pharmacological effects of various substances. Areas where more emphasis is required include the early identification of AOD problems, knowledge of appropriate interventions, and a thorough understanding of the nature of behavioural change, which are often not adequately covered in psychological training.

In addition to education and training, the broader concept of workforce development is also relevant. While acknowledging the value of appropriate training for individual workers, workforce development takes a systemic approach that includes organisational change as a necessary part of ensuring an evidence-based approach is taken in addressing drug-related harm on all levels (Roche, 2002). While psychologists are well-qualified to assist with the process of workforce development, its importance needs to be recognised by psychology as a profession for such contribution to be most effective.

In summary, the potential involvement of the discipline of psychology in the AOD field is considerable, yet currently is not fully realised. Substance use is a public health issue that affects all levels of Australian society, from individuals and families, to workplaces and whole communities. Effective interventions in this area require a population health approach that recognises the complexity and multifactorial nature of the issues, and that operates through partnerships between all the interested disciplines and sectors. The *National Drug Strategic Framework* (Ministerial Council on Drug Strategy, 1998) outlines key national policy objectives for focussing national attention and action in the AOD

arena. The strategy is subtitled *Building Partnerships*, and the major platform is that AOD issues are best addressed by the development of strong intersectoral links among all relevant sectors, including psychology. The next section of this document considers how the competencies for psychologists apply to the AOD area, and how these may to be augmented to give all pre-registration psychologists the basic skills to deal competently with AOD issues.

COMPETENCIES FOR PSYCHOLOGISTS AND THEIR APPLICATION TO AOD ISSUES

The following section provides a summary of each of the eight competencies for psychologists, along with a discussion of supplementary material that will promote an effective response specifically to AOD-related harm. It is designed to be read in conjunction with the APS paper, *Competencies for Psychologists* (1996).

Competency 1 Discipline knowledge

This set of competencies is concerned with the knowledge base in the discipline of psychology required for adequately investigating, describing, explaining, predicting and modifying human behaviour, cognition and affect. It provides the foundation upon which the other competencies depend.

The key competencies are:

- 1.1** Demonstrate knowledge about the theories, major data, and methods of enquiry which relate to the bases of behaviour, cognition and affect
- 1.2** Demonstrate knowledge about the theories and data which underlie the major forms of psychological interventions
- 1.3** Display knowledge of the major methods of psychological investigation and techniques of measurement
- 1.4** Display ability to apply psychological knowledge
- 1.5** Update discipline knowledge.

It cannot be emphasised enough that AOD use is just one of many human behaviours and, as such, the core discipline knowledge of psychology is highly relevant to working with AOD use issues. Training in the areas of behaviour, cognition, emotion, human development, biology and systemic processes can be applied to the specific area of substance use behaviours, although training in specific theories and practice that are well-researched within the AOD field would be of benefit to all psychologists, whether they work within the AOD field or not. The companion document to this paper, *A Psychological Approach to Substance Use* (in preparation), shows how psychological theories within a bio-psycho-social framework provide the foundation of an understanding of alcohol and other drug use.

Knowledge and skills that are of particular value, and not generally part of postgraduate training programs, include: understanding and applying Prochaska and Di Clemente's (1984) Transtheoretical Stages of Change model; proficiency in the technique of Motivational Interviewing, which can be integrated into a variety of intervention approaches; and an understanding of the concepts of harm minimisation and strategies for harm reduction. Furthermore, an understanding of risk and resilience at the individual, family and community level is also essential to working within a population health approach, which acknowledges the complex and multi-factorial nature of the causal pathways to substance use. This knowledge provides the foundations for working within the AOD field, whether the focus is on treatment, prevention, education or policy development. In relation to updating and applying discipline knowledge, two pre-requisites for effective professional practice are: the identification of effective interventions across the entire spectrum from prevention to treatment and relapse prevention; and the use of effective dissemination and implementation strategies to ensure the adoption of evidence-based interventions in practice (e.g., Ferrence, 1996; Grimshaw, 1996; Roche, 1991). There is a continuous production of research that can guide practice in the AOD field. If new research findings are to be effectively translated into practice, the need to ensure the most appropriate and rapid mode of dissemination is paramount.

The usual form of disseminating research is to publish in appropriate journals; although an important and necessary function for researchers, is not always the most effective means of disseminating innovative information. Practitioners, for example, do not always have the time to identify, locate and retrieve relevant

journal articles. The length of time from submission for journal articles to be published is a further problem, with some research often taking well over twelve months before it reaches its primary audience. Specifically, psychologists and those in decision-making positions require a method of innovation dissemination that is prompt and enables the translation of innovation into practice.

Realistically, such information dissemination would best occur through a variety of means to increase awareness of these issues, such as written material, attendance at training and conferences, improved utilisation of secondary consultation services offered by AOD specialists and Internet resources. The recently formed APS *Psychology and Substance Use Interest Group* could play a major role in the transfer of knowledge to practice. Appendix 1 provides a list of useful source material to enable psychologists to keep updated on AOD issues.

Competency 2 Research

This set of competencies is concerned with the skills required to add to the body of knowledge underlying the science and practice of psychology.

The key competencies are:

- 2.1** Identify research problem
- 2.2** Design research investigation
- 2.3** Conduct research investigation
- 2.4** Evaluate research findings
- 2.5** Communicate research outcome.

These key competencies are particularly important as they apply to the AOD field, as evidence-based practice is essential in a field that is plagued by ideologically and morally driven understanding, practice and policy. Research skills attained in psychology training can be transferred directly to research in the AOD field. Training in research practices of objectivity and scepticism, critical examination of the evidence, and evaluation are particularly important in an area such as AOD, where hidden assumptions and moral judgements are common and can influence outcome assessments and subsequent recommendations.

Particular knowledge and skills that are useful in this area and are not generally part of a psychology training program including awareness of current research activities pertaining to AOD-related harm, and awareness of ethical issues concerning research with licit and illicit drug users, especially around issues of privacy and protection of both participants and researchers from potential legal action.

It is also important for psychologists to also have an awareness of the differences in the operationalisation of key variables among different professions that are engaged in research within the AOD field. For example, it is not uncommon for research to identify participants with any single lapse back into substance use as having “failed” to achieve a successful outcome. Yet a psychological understanding of the processes of change would suggest that lapses into former behaviour are a normal part of the change process and therefore would not automatically constitute an unsuccessful outcome. For example, when Hulse and Basso (1999) allowed for some periodic use of heroin during treatment with naltrexone, they found 60% of participants were still on naltrexone at six months, whereas other studies that equated any lapse with a failed outcome reported substantially lower rates of positive outcomes. Therefore an understanding of the different assumptions made about AOD use would be beneficial in critically analysing others’ research, and in developing valid research proposals that reflect the reality of substance use and the processes of behaviour change in our community.

Competency 3 Framing, measuring and solving problems

This set of competencies is concerned with the organisation and planning involved in systematic psychological assessment, evaluation and problem solving with individuals, groups, organisations and the community.

The key competencies are:

- 3.1** Define the problem
- 3.2** Gather and evaluate data
- 3.3** Determine strategies
- 3.4** Implement ongoing evaluation.

Clearly, all of these competencies are fundamental in addressing any presenting behavioural concerns, including AOD use. However, postgraduate programs would benefit from specifically relating these competencies to AOD use. Foremost, psychologists in training need to carefully consider their own perspectives on AOD issues, which can have a major effect on the framing of problems. While self-reflection and awareness of values and beliefs are a core part of psychological training, it is worth directly evaluating the assumptions relating to substance use in particular, as unexamined beliefs are in most danger of being accepted as fact that does not warrant further consideration.

The functional aspect of AOD use would also be worth addressing in postgraduate training. While the term alcohol and other drug *problems* has widespread use and acceptance both in the clinical literature and in more general usage in the community, a more behavioural understanding of substance use would suggest that people and communities have substance use solutions, where the problems either precede or follow substance use (Crowley, 2001). For example, when people use substances to gain relief from negative affect or self-defeating cognitions, they may then accumulate further difficulties as a result of the substance use, whether those problems are physical, psychological, social, interpersonal, legal, or financial. Being able to place the substance use in the broader context is an essential part of assessing AOD use and selecting appropriate interventions, and is a core component of Motivational Interviewing (Miller & Rollnick, 2002). This broader understanding of AOD use allows for more comprehensive assessment and greater efficacy in evaluating the outcome of any intervention.

Taking a broader view of substance use than simply focussing on only the problematic consequences of use also encourages psychologists to take a more balanced approach to AOD issues within the context of a holistic assessment of needs. Just as psychologists can address the issue of AOD use too little in their work, over-focussing on the behaviour of AOD use can also be problematic. For example, reinforcing a client's self-view as a "drug user", where their substance use takes priority over other aspects of their behaviour or identity, can serve to distract both the client and the clinician from what may be more central issues.

For the AOD field, familiarity with DSM-IV criteria for substance dependence and abuse is only a first step in defining a problem. There are a number of specific assessment tools, such as the AUDIT (Saunders et al, 1993) that are useful to be aware of; the AUDIT in particular is a brief questionnaire that was primarily developed for the General Practitioner setting. It is worth noting there is a lack of more specialised assessment tools to reliably and validly assess individuals in needs of early intervention, before a fully developed diagnosable disorder is evident, or to determine valid indicators relating to risk and resilience for working in both preventive and treatment contexts.

Yet it is psychologists' skill in conducting a comprehensive assessment that is of fundamental value to AOD work, including: substance use history; patterns of use and triggers for use; factors associated with periods of reduced or ceased use; resources for initiating and maintaining change; and the relationship between the use and other significant aspects of the person's history, current life or social environment. Knowledge of the nature and

context for changes in the person's pattern of use, along with risk and protective factors, can provide clinically valuable information that may be used in generating meaningful change, and overcoming obstacles to change, whether that involves a reduction in substance use or not.

In terms of selection of strategies, there are characteristics shared by effective psychological therapies in the AOD area and other mental health interventions, notably:

- individuals are provided with an understandable model of their disorder;
- each therapy has a well-planned rationale and is highly structured;
- plans for producing change are made in a logical sequence;
- therapy encourages independent use of skills to promote change;
- change is attributed to the individual's rather than the therapist's skill; and
- the individual develops a greater sense of self-efficacy.

Of particular concern is the need to identify issues that may require liaison with medical personnel or a specialist detoxification service. Many clients may require medically supervised use reduction programs and the psychologist needs to know when and where to appropriately refer, and then have the ability to work in partnership with these services (see Competency 7 – Professional & community relations).

Competency 4 Service implementation

This set of competencies covers the steps involved in the planning, design, provision and evaluation of psychological services to the discipline, and to individual, group or organisational clients and other interested parties.

The key competencies are:

- 4.1** Establish professional relationships
- 4.2** Explore nature of service required
- 4.3** Negotiate service contract
- 4.4** Investigate identified issues relevant to delivery of service
- 4.5** Develop/plan preventative or remedial services
- 4.6** Implement preventative and/or remedial service
- 4.7** Evaluate impact of services.

Psychologists are well-placed to contribute to service development in a climate of increasing awareness of AOD issues, identification of evidence-based interventions, and increasing focus on workforce development needs in relation to addressing AOD issues. The National Centre for Education and Training on Addiction (NCETA) has identified that the AOD field would benefit from workforce development to ensure the ability of the AOD field to provide high quality responses to AOD issues, and to encourage skilled workers to enter and remain within the field. In particular, Roche (2002) highlighted the importance of service and program development that was based on research and evidence-based practice, along with identification and implementation of approaches that support the staff and key relationships involved in conducting the work.

While the skills of Competency 4 are clearly relevant in the development of the AOD workforce, they are also of great value in ensuring the needs of people with AOD issues are respected in a wide range of settings in which psychologists work, many of which are not specialist AOD settings. However, knowledge of the philosophy of harm minimisation and the strategies of harm reduction that underpin current AOD practice is an important part of ensuring the service implementation skills are used to greatest effect.

While the concept of reducing harm is implicit in much of the work that psychologists engage in, its explicit nature in the AOD field may initially seem at odds with the training and practice of those outside the AOD field. Without more detailed understanding of the concept of harm minimisation, it can be tempting to equate the idea

of reducing harm into simply reducing use. Yet as Lenton and Single (1998) highlight, “the central defining characteristic of harm reduction is that it focuses on reduction of **harm** as its **primary goal** rather than reduction of use per se... Harm reduction is not in conflict with abstinence as a possible strategy for reducing drug-related harm ... but it gives priority to the more immediate and practical goal of reducing harm for users who cannot be expected to stop using at the present time”.

Strengthening links between AOD and non-AOD services is therefore especially important, as facilitating partnerships between the various disciplines that work in the AOD area will provide a common basis for approaches in the field. Further training in the concept and practice of harm minimisation in psychological training would also clearly be of value, as would an awareness of the multi-faceted nature of the AOD field and the varied sources of valued input into service development and delivery.

AOD specific content aside, services to people with AOD issues generally incorporate the recommended strategies that are already foremost in most clinical and counselling postgraduate programs in psychology. A definitive work on treatment approaches for AOD dependence by Jarvis, Tebbutt and Mattick (1995) presents a range of strategies that are appropriate whether the client’s substance use goal is moderation or abstinence, and that are already familiar to psychologists, including:

- problem-solving skills training;
- drink-refusal skills training (exploring body language and tone of voice through therapist modelling and role play);
- assertiveness training;
- communication skills training;
- cognitive restructuring;
- relaxation training;
- behavioural self-management;
- couples therapy; and
- relapse prevention.
-

This list could also include self-esteem development, anger management, emotional regulation training and treatments aimed at assisting the client to develop a healthier or more stable sense of identity.

Prevention and education in relation to AOD issues are also growing areas of need where psychologists are capable of contributing to service development. This will often require working within educational and community settings, developing both professional relationships and an understanding of the nature of these sectors. Interventions at the levels of individuals, groups, organisations, and whole communities are necessary to effectively impact on such an important public health issue as AOD-related harm. Consequently, psychological training needs to enable psychologists to apply a bio-psycho-social model within these contexts and be able to anticipate and identify the multiple impacts of their interventions using a wider systems approach.

Competency 5 Professional, legal and ethical approach

This set of competencies is concerned with the legal and ethical aspects of professional psychological practice, as well as an ability to apply informed judgement and current scientific principles in the workplace.

The key competencies are:

- 5.1** Recognise boundaries of service provision
- 5.2** Behave in accordance with ethical and legal regulations such as the APS Code of Ethics and relevant registration legislation
- 5.3** Behave in a responsible and autonomous fashion
- 5.4** Manage professional activities
- 5.5** Maintain and update knowledge base.

A specific aspect of the AOD field is the illicit nature of much substance use, and this sets the area apart from most other areas requiring psychological interventions. Psychologists working in the field generally need to be cognisant of the relevant legal factors, and stay informed of changes in legislation related to criminal charges and also to potential diversionary treatment options. Psychologists working in settings where treatment is mandated by the courts need to understand both their legal responsibilities and the possible effects of non-voluntary treatment (Hall, 1997).

As noted in Competency 2, awareness of ethical and privacy factors are also paramount in the design and conducting of research into AOD related issues, especially those involving illicit drug use. However, it is also important to be mindful of the stigma of any substance use, whether licit or illicit. Given the potentially damaging consequences of any disclosure of participants' substance use or even involvement in the research, it is essential to ensure that ensuring adequate measures are taken to maintain participants' confidentiality.

Psychologists also need to continually monitor their own assumptions and boundaries in terms of maintaining ethical and professional standards. For example, clients may disclose engaging in activities while under the influence of the drug, or in order to acquire the drug, that the practitioner finds distasteful or abhorrent. Issues of mandatory reporting may apply. Psychologists need to be very clear regarding who their actual client is and make apparent their professional boundaries.

Competency 6 Communication

This set of competencies deals with communication by psychologists with their individual or organisational clients, other psychologists, other professionals and the public.

The key competencies are:

- 6.1** Communicate effectively and appropriately
- 6.2** Appraise research and communicate information to wider audiences
- 6.3** Communicate information about relevant psychological services to potential clients.

As in any area of psychological work, it is important to resist adopting a style of communication that may come across as false, ignorant or ingratiating. People heavily involved in a drug-using lifestyle and young people experimenting with drugs develop ever-changing jargon with multiple terms for substances and the implements

of administration. Psychologists should be sure that they have a clear understanding of the meaning of any terms they may use when communicating, or risk losing credibility. The best course may be to refrain from using any term oneself if in doubt, and to ask the meaning of unfamiliar terms in an open, non-defensive manner. It is equally important to refrain from adopting an ideological or moralising stance, which is likely to destroy professional credibility and/or damage the client-therapist relationship. In communicating with individual clients, it is essential to be non-judgmental and non-threatening, and to discuss AOD issues in the psychologist's normal manner of communication.

Evidence shows that the quality of the therapeutic relationship is fundamental in the determination of treatment outcomes for AOD problems, and that process is just as important as content in interventions in this area (Orford, 1999). It is important to adopt a style of communication that adds to a client's sense of empowerment; minimising the role of "expert" in the therapeutic relationship is vital. Furthermore, clients will often expect their psychologist to know little about the day-to-day life of a regular or heavy substance user and are likely to respect an honest admission of ignorance rather than pretence of familiarity.

Communication with other professionals in the AOD area involves dealing with a range of professionals with differing backgrounds and perspectives: other psychologists, medical doctors, psychiatrists, social workers, counsellors, welfare workers, youth workers, nurses, school counsellors, teachers, police officers, corrections workers, lawyers, judges, and many more. Good communication is facilitated by understanding these many different perspectives and their implications, from sociological to medical models.

While only psychologists who specialise in the AOD area might be expected to be fully conversant with the abundant literature from these many different areas, a general understanding of the approach of other disciplines is valuable to all psychologists. For example, communication with medical staff will be enhanced if the psychologist has a reasonable level of familiarity with:

- the major psychoactive drugs and some of their short and long-term effects;
- the salient aspects of drugs commonly used in medical interventions in this area, such as naltrexone, methadone, and the benzodiazepines;
- the nature of tolerance and withdrawal;
- the DSM criteria for substance abuse and dependence;
- criteria associated with a judgement regarding to the appropriateness of in-patient withdrawal (medical or non-medical) or outpatient withdrawal; and
- signs and indicators of AOD-related psychological impairment (especially cognitive impairment).

An excellent reference for expediting communication with medical professionals is the *Handbook for Medical Practitioners and Other Health Care Workers on Alcohol and Other Drug Problems* (Health, 1994). This book covers concepts and definitions and specifies, for each drug, the physical, psychological and social complications. It also covers: drugs in pregnancy; intoxication and overdoses; detoxification and management of withdrawal; a multicultural approach; HIV/AIDS and drug use; and details of information and counselling services.

For communicating with the public, AOD issues are often contentious in the community and frequently draw more heat than light, especially those related to illicit drug use. Psychologists, whether they be specialists in the area or not, have an opportunity to model patterns of communication which reflect attitudes of tolerance, moderation and understanding, and which place the emphasis on AOD problems as essentially psycho-social and health problems rather than legal or moral issues.

Competency 7 Professional and community relations

This set of competencies addresses the knowledge, skills, and attitudes involved in establishing and maintaining effective relationships with clients, other psychologists, and members of professional and non-professional groups.

The key competencies are:

- 7.1** Adopt independent or team approach as appropriate
- 7.2** Engage the client or clients
- 7.3** Clarify roles and responsibilities in consultation with other team members
- 7.4** Accept and initiate supervision of projects or people as appropriate
- 7.5** Apply knowledge to community.

Many of the issues considered under Competency 6 also apply here, and the interdisciplinary nature of the AOD field highlights the importance of these competencies. Working in a multi-disciplinary team, or in partnership with other services and sectors, is generally essential for effectively intervening in terms of both prevention and treatment in relation to AOD use. It is also essential to recognise that AOD issues do not occur in isolation, but have a complex and multi-factorial aetiology that is determined at biological, psychological, social and community levels. The skills required to work within a multi-disciplinary context are not always effectively covered in current psychological training and require greater emphasis.

Working effectively with and within communities is a skill that is increasingly being recognised as essential to improve well-being (Health, 2000), and is also not necessarily well covered in most psychology curricula. It is particularly important that Australian psychologists understand the issues related to working within a multicultural context, and specifically working with indigenous communities and individuals. For example, when working with persons from Aboriginal and Torres Strait Islander backgrounds, the psychologist should clearly understand that AOD use and consequent harms are not simply a question of individual problems of pathology, but are inextricably bound up with community, historical and cultural context. The relative importance of personal independence versus community interdependence varies between the Anglo-Australian and indigenous communities, and this difference has profound implications for the nature of interventions around AOD use in indigenous communities. Likewise, the values and expectations around AOD use in Anglo-Australian communities are also often different from those found in other cultures within Australia.

Competency 8 Influence and change

This set of competencies addresses the role of psychologists as agents of change at individual, group, organisational and community levels. It covers their influence in adapting psychological principles to assist clients to achieve positive outcomes, to promote the implementation of appropriate recommendations and to show leadership.

The key competencies are:

- 8.1** Provide direction in individual, group, organisational and community change
- 8.2** Identify career opportunities in the profession and develop new applications of psychological knowledge.

The opportunities for psychologists to be agents of societal change are considerable, whether or not they are specialists in the AOD area. When communicating with individuals and groups, formally or informally, the psychologist has the opportunity to present a balanced appraisal of major issues related to AOD use. Even where psychologists feel they lack specific AOD-related knowledge, they can make a valuable contribution by discussing AOD issues with compassionate, non-judgmental and non-sensational language, and by highlighting the complexity of the issues and the humanity of people using substances. There are frequent opportunities for such input, given the substantial focus in the media and the community on matters such as: safe injecting rooms; the needle and syringe program; the methadone maintenance program; rapid detoxification procedures; use of acamprosate for alcohol dependence; and alcohol use in indigenous communities.

Psychological training needs to provide examples of awareness of the impact of language and the importance of non-judgemental approaches specifically within the AOD field. For example, the term “safe injecting facility” is preferable to the more sensational and emotive term “shooting gallery”, just as “people who use heroin” rather than “junkies” redirects the focus to problem behaviours rather than problem individuals.

Psychologists can also contribute to the discussion on policy issues, such as the most appropriate balance between interdiction and intervention funding. Psychologists not in the AOD field are still trained in the processes of coping and change, and have relevant and important contributions to make to debates on AOD issues.

Psychologists can help direct attention from the drugs themselves, back to people and communities, social and emotional needs, and the facilitation of change. In so doing, psychologists also have a role to act as advocates for such change, whether through work with individuals, groups or communities, especially where current practice results in inadequate responses to people presenting with issues or other forms of injustice.

Australia is regarded by the international community as a leader in interventions, research, and policy in the AOD area, not least because of our early espousal and implementation of the philosophy of harm reduction. APS psychologists can further contribute to that established good reputation by becoming as informed as possible on AOD issues salient in the communities in which they live and work.

EDUCATION AND TRAINING RELATED TO AOD FOR PSYCHOLOGISTS

It is clear that psychologists already have many of the basic skills to enable them to take a more active role in the AOD field, and that they have a great deal to offer in the many diverse contexts in which they work. Therefore, a consequent issue is how to encourage greater activity by the psychology profession in the field, whether this is directly as AOD specialists or indirectly from other specialisations within psychology.

In terms of education and training, there are two possible ways by which to encourage psychologists to work more effectively with AOD issues, and potentially to enter employment within the AOD field: 1) the addition of AOD applications to current curricula; and 2) the development of specialist AOD courses. The APS Working Group on Substance Use argues that supplementation to current curricula is the preferred direction, although the development of specialist courses for those psychologists who specifically want to provide services in this area is also worthy of consideration. However, the priority is to ensure that all psychologists have basic skills in dealing with AOD issues because many people who access psychologists in their varied roles have AOD issues. Furthermore, while the competencies for psychologists already provide most of the basic skills for psychologists to be effective in relation to AOD issues, the addition of some specific AOD applications to current curricula would give psychologists both the skills and knowledge to provide a valuable contribution to the field as well as the confidence and encouragement to do so.

General principles identified as important for delivery of effective AOD education and training can be summarised as follows (Cranfield & Stoneman, 1996):

- integration of AOD issues within all relevant components of curricula;
- conceptualisation of AOD problems and treatment within their historical, socio-economic, cultural and political context;
- teaching on specific AOD issues to reflect the extent of problems nationally;
- critical self-examination and reflective practice as a prerequisite for education and practice;
- curricula that adopt effective responses from all relevant disciplines and transcend traditional specialities;
- curriculum development to reflect best practice models of inter-professional and inter-disciplinary care and intervention; and
- education programs that highlight a comprehensive range of intervention goals, including the principles and practices of harm and risk reduction.

These principles could be integrated into pre-registration training for psychologists without much difficulty. It should also be noted that National Competency Standards have been produced by the Australian National Training Authority for alcohol and other drugs work (Australian National Training Authority, 1999). These describe specific competencies for AOD workers at various levels within community service and health contexts. While they do not apply specifically to psychologists, they would be useful as a guide to the types of supplementary material that could be added to psychological training curriculum.

Finally, the most effective education and training programs are likely to have limited impact if highly skilled and motivated graduates enter environments that do not legitimise or value the skills. Education and training programs need to be reinforced by the broader workforce development advocated by NCETA, to ensure organisational and professional support for psychologists working the AOD field. Such strategies include organisational practice that encourages ongoing professional development, staff support and mentoring, and opportunities for career development (Roche, 2002). The APS *Psychology and Substance Use Interest Group* is a first step in providing psychologists who have an interest in AOD issues with greater support to work with AOD-related concerns. Table 1 lists the Terms of Reference for the Interest Group. The Interest Group and its membership may also become a valuable resource in determining the ways in which the psychology profession can better develop and contribute its skills in the area of reducing AOD-related harm in our community.

Table 1: Terms of Reference for the APS Interest Group on Psychology and Substance Use

1. To facilitate communication among psychologists interested in substance use issues.
 2. To promote professional activities and practice, information sharing, research and discussion related to the psychology of substance use.
 3. To provide a network of APS psychologists able to respond, as deemed appropriate by the APS, to emerging issues related to substance use.
 4. To promote the role of psychologists as practitioners, researchers and commentators in relation to substance use issues.
 5. To generate and maintain links with organisations that have a focus on psychology and substance use, within Australia and internationally, who are congruent with the aims of the APS and the Interest Group.
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REFERENCES

- Albery, I. P., Durand, M., Heuston, J., Groves, P., Gossop, M., & Strang, J. (1997). Training primary health care staff about alcohol - a study of alcohol trainers in the UK. *Drugs - Education, Prevention & Policy*, 4(2), 173-186.
- Australian Institute of Health and Welfare (2000). *1998 National Drug Strategy Household Survey*. AIHW: Canberra.
- Australian National Training Authority (1999). *Alcohol and Other Drugs Work National Competency Standards*. Australian National Training Authority: Melbourne.
- Australian Psychological Society (1996). *Competencies for Psychologists*. Australian Psychological Society: Melbourne.
- Berggren, A. (1996). Swedish midwives' awareness of, attitudes to and use of selected research findings. *Journal of Advanced Nursing*, 23(3), 462-470.
- Bien, T.H., Miller, W. R., & Tonigan, J.S. (1993). Brief interventions for alcohol problems: a review. *Addiction*, 88, 315-36.
- Commonwealth Department of Health, Housing, Local Government and Community Services (Health) (1994). *Handbook for Medical Practitioners and Other Health Care Workers on Alcohol and Other Drug Problems*. Australian Government Publishing Service: Canberra.
- Commonwealth Department of Health and Aged Care (Health) (2000). *Promotion, Prevention and Early Intervention for Mental Health - A Monograph*. Mental Health and Special Programs Branch: Canberra.
- Cranfield, S., & Stoneman, P. (1996). *Substance misuse. Guidelines for good practice in education and training of nurses, midwives and health visitors*. Prepared on Behalf of Working Groups commissioned by the English Board for Nursing, Midwifery and Health Visiting, English National Board.
- Crowley, M. (2001). Empowerment: Helping vulnerable individuals enhance their degree of control. *Psychotherapy in Australia*, 7, 12-17.
- Dixon, L., Haas, G., Weiden, P., Sweeney, J., & Frances, A.J. (1991). Drug abuse in schizophrenic patients: Clinical correlates and reasons for use. *American Journal of Psychiatry*, 148, 224-230.
- Ferrence, R. (1996). Using diffusion theory in health promotion: the case of tobacco. *Canadian Journal of Public Health. Revue Canadienne de Sante Publique*, 87(Suppl 2), S24-7.
- Grimshaw, J. M. (1996). Towards effective professional practice. *Therapy* 51(3), 233-6.
- Grol, R., & Grimshaw J. (1999). Evidence-based implementation of evidence-based medicine. *Joint Commission Journal on Quality Improvement*, 25(10), 503-13.
- Hall, W. (1997). *The role of legal coercion in the treatment of offenders with alcohol and heroin problems*. NDARC Technical Report No. 44.
- Hambrecht, M., & Hafner, H. (1996). Substance abuse and the onset of schizophrenia. *Biological Psychiatry*, 39, 1-9.
- Hawks, D. (1995). The contribution of the National Drug Strategy to the prevention of alcohol related harm. In P. Dillion (Ed.), *The National Drug Strategy: The First 10 Years and Beyond*. Proceedings of the Eighth National Drug and Alcohol Research Centre Symposium, November, 1995 (pp. 44-52). NDARC Monograph No. 27.
- Hawthorne, G., Garrard, J., & Dunt, D. (1995). Does Life Education's drug education program have a public health benefit? *Addiction*, 90, 205-215.
- Hulse, G.K., & Basso, M.R. (1999). Reassessing naltrexone maintenance as a treatment for illicit heroin users. *Drug and Alcohol Review*, 18, 263-269.
- Jablensky, A., McGrath, J., Herrman, H., Castle, D., Gureje, O., Morgan, V., & Korten, A. (1999). *People Living with Psychotic Illness: An Australian Study 1997-8. National Survey of Mental Health and Wellbeing, Report 4*. Commonwealth Department of Health and Aged Care: Canberra.
- Jarvis, T., Tebbutt, J., & Mattick, R. (1995). *Treatment Approaches for Alcohol and Drug Dependence: An introductory guide*. Chichester: Wiley.

- Jenner, L., Kavanagh, D., Greenway, L., & Saunders, J.B. (1998). *Dual Diagnosis Consortium 1998 Report*. The Dual Diagnosis Consortium: Queensland.
- Lenton, S. & Single, E. (1998). The definition of harm reduction. *Drug and Alcohol Review*, 17, 213-220.
- McLennan, A. (1998). *Mental Health and Well-being: Profile of Adults*. Australian Bureau of Statistics: Canberra.
- Miller, W.R., & Hester, R.K. (1995). Treatment for alcohol problems: Toward an informed eclecticism. In *Handbook of Alcoholism and Treatment Approaches: Effective Alternatives*. (2nd Ed.) Allyn & Bacon: New York.
- Miller, W.R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing People for Change* (2nd Ed.) Guilford: New York.
- Ministerial Council on Drug Strategy (1998). *National Drug Strategic Framework 1998-99 to 2002-03*. Commonwealth of Australia: Canberra.
- Orford, J. (1999). Future research directions: A commentary on Project MATCH. *Addiction*, 94, 62-66.
- Pearcey, P., & Draper, P. (1996). Using the diffusion of innovation model to influence practice: a case study. *Journal of Advanced Nursing*, 23(4), 714-21.
- Prochaska, J.O., & DiClemente, C.C. (1984). *The Transtheoretical Approach: Crossing the Traditional Boundaries of Therapy*. Malabar, FL: Krieger.
- Ritson, B. (1999). Alcohol use and mental health. Paper presented to the Department of Health and Aged Care, July 9, Canberra.
- Roche, A. (1991). Dissemination of interventions for drug and alcohol problems in primary care settings - an examination of 3 models. In White, J. (Ed.) *Drugs in Society*. Adelaide, DASC, 232-241.
- Roche, A.M. (1998). Alcohol and drug education and training: A review of key issues. *Drugs, Education, Prevention and Policy*, 5(1), 85-99.
- Roche, A.M. (2002). Workforce development: Our national dilemma. In A.M. Roche & J. McDonald (Eds.) *Catching clouds: Exploring diversity in workforce development for the alcohol and other drug field*. National Centre for Education and Training on Addiction (NCETA): Adelaide.
- Roche, A., & Richards, G. (1991) Doctors' willingness to intervene in patients' drug and alcohol problems. *Social Science & Medicine*, 33, 1053-1061.
- Rose, J., & Gallagher, K. (1999). *Organisational Change Through Action Learning: A Practical Guide to the Practice Development Drug Management Project*. WA Drug Abuse Strategy Office: Perth.
- Saunders, J.B., Aasland, O.G., Babor, T.F., de la Puente, J.R., & Grant, M. (1993). Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption. *Addiction*, 88, 791-804.
- Sawyer, M.G., Arney, F.M., Baghurst, P.A., Clark, J.J., Graetz, B.W., Kosky, R.J., Nurcombe, B., Patton, G.C., Prior, M.R., Raphael, B., Rey, J., Whaites, L.C., & Zubrick, S.R. (2000). *The Mental Health of Young People in Australia*. Mental Health and Special Programs Branch: Canberra.
- Wallace, S.K., & Staiger, P.K. (1998). Informing consent: Should 'providers' inform 'purchasers' about the risks of drug education? *Health Promotion International*, 13(2), 167-171.
- Appendix 1: Resource material for psychologists working in the AOD field

For a national email distribution list on drug related issues in Australia:

ADCA Update email list (contact owner-update@ilanet.net.au for more information) - ADCA also provides fee-paying members with *Drug Contents*, which allows members to select a number of articles per year from regular listings of the contents of the most recent journals in ADCA's collection

For a comprehensive website on Australian alcohol and other drug information:

Australian Drug Information Network (ADIN), see <http://www.adin.com.au>

For keeping up-to-date with statistics on drug use:

1998 National Drug Strategy Household Survey, published August 1999, Australian Institute of Health & Welfare, Canberra

For pamphlets on the effects of various drugs:

CEIDA, see <http://ceida.net.au> for free downloadable copies

The Australian Drug Foundation in Victoria, phone 1800 069700 or see <http://www.adf.org.au/>

For in-depth, comprehensive discussion on specific aspects of substance use:

The National Drug Strategy Monograph Series, e.g., Number 32 - Models of intervention and care for psychostimulant users, produced by the National Centre for Education and Training on Addiction

<http://www.health.gov.au/pubhlth/publicat/drugs.htm>

National Drug and Alcohol Research Centre Monograph Series, ordered from (612) 9385-0333, or see <http://ndarc.med.unsw.edu.au/ndarc.nsf>

For review, informed opinion, and research in Australia:

Drug and Alcohol Review, official journal of the Australian Professional Society on Alcohol and other Drugs, c/o. National Drug & Alcohol Research Centre, University of New South Wales, for more information (612) 9385-0333, or see <http://ndarc.med.unsw.edu.au/ndarc.nsf> - workers in the h AOD field can also join the multi-disciplinary APSAD

For an excellent overview of the roles that drugs play in societies:

Gossop, M. (1996). *Living with Drugs*. (4th Ed). Ashgate Publishing Co: Vermont.

For a comprehensive overview of policy, prevention and treatment in Australia:

Drug Use in Australia: A harm minimisation approach. (1998). Edited by M. Hamilton, A. Kellehear and G. Rumbold. Oxford University Press.

For information on prevention issues:

Drug Info Clearinghouse, see <http://druginfo.adf.org.au>

For a comprehensive guide to treatment approaches:

Jarvis, T., Tebbutt, J., & Mattick, R. (1995) *Treatment Approaches for Alcohol and Drug Dependence: An introductory guide*. Wiley: Chichester.

For a comprehensive guide to Motivational Interviewing:

Miller, W.R. & Rollnick, S. (2002) *Motivational Interviewing: Preparing People to Change* (2nd Ed.) Guilford: New York.

For a comprehensive guide to screening instruments in the alcohol and other drug area:

Dawe, S., & Mattick, R. (1997). *Review of Diagnostic Screening Instruments for Alcohol and Other Drug Use and Other Psychiatric Disorders*. AGPS: Canberra.

Teesson, M., Clement, N., Copeland, J., Conroy, A., & Reid, A. (2000). *The Measurement of Outcome in Alcohol and Other Drug Treatment: A Review of Available Instruments*. NDARC Technical Report No 92. For more information (612) 9385-0333, or see <http://ndarc.med.unsw.edu.au/ndarc.nsf>

For information on education, training and workforce development issues:

National Centre for Education and Training on Addictions (NCETA), see <http://www.nceta.flinders.edu.au>