

2015 Adams-deCrespigny-Harvey Oration

A personal perspective on the ‘Many Faces of Addiction’

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[First slide – after title slide - Botanical gardens, Christchurch]

Tena koutou katoa Greetings

He mihi nui ki te manawhenua o tenei rohe - acknowledgement to the traditional owners of the land of this region

My acknowledgement to DANA for the privilege of delivering the 2015 Adams-deCrespigny-Harvey oration

My acknowledgement to Australia DANA nurses who have influenced my addiction nursing practice; in particular Charlotte deCrespigny, Jennifer Holmes, Robin Murray and Meredith Adams.

I acknowledge my New Zealand DANA colleagues; in particular Louise Leonard – our pioneering Nurse Practitioner, Moira Gilmour (Nurse Specialist on the Nurse Practitioner pathway) and Steph Anderson (Nurse Specialist).

I am of Scottish, Irish, English and Welsh descent. My grandparents settled in Canterbury in the South Island of New Zealand.

I live in Christchurch with my partner Doug Sellman. We have four adult children between us, two boys and two girls and one grandchild, Emil, who lives in Germany.

[Faces slide 2]

I commenced psychiatric nursing in the 1970's in a large New Zealand psychiatric hospital followed by general nursing training. I “fell” into working in the addiction field in the 1980's during an early phase of community mental health service development. Health promotion activities were closely linked with treatment which was community orientated, autonomous and flexible. John Dobson, a pioneering psychiatrist was a mentor. John combined an evidence informed approach with pragmatism and an individualised harm reduction approach. During this time I held a number of therapist/counsellor, clinical management and leadership roles within addiction services. In the 90's I was re-structured which opportunistically led to being involved in the establishment of the inaugural specialist youth mental health outpatient service which incorporated an alcohol and other drug team. Subsequently, as Director of Mental Health Nursing Practice I continued to attempt to influence a greater consideration of alcohol and other drug issues within the broader mental health care system. In the late 90's I was also employed as a clinical/academic member at the National Addiction Centre (NAC), University of Otago, Christchurch. The Centre's mission which was to improve treatment for people affected by addiction in Aotearoa New Zealand (later prevention was added) and my nursing philosophy have underpinned my clinical, teaching, research and service roles. More latterly I have been involved with NAC colleagues Doug Sellman and Ria Schroder in a research project focused on using an addiction paradigm

in researching and developing a support network for, and with, people with obesity. From listening to the people involved in this project for over more than five years – it is evident that people who struggle with compulsive eating share some similar experiences with those who struggle with challenges related to substance use and other behavioural addictions.

Back to the beginning

As a young psychiatric nursing student I witnessed a man arriving on foot (having walked from the City Mission night shelter) to the alcohol treatment day programme on the psychiatric hospital campus. The programme started at 9am, the man arrived about 9.10am. The Charge Nurse looked at the man and said words to the effect... “You are late, clearly you are not motivated enough. Try again tomorrow”. The man left, head down, mumbling under his breath.

One of tenets of this and many other, mainly residential/day programmes of the time was that in order to change a person had to reach ‘rock bottom’, assisted in treatment by a variety of confrontation techniques; some skillfully delivered and of therapeutic value, others much less so. As a family member of a very talented person who struggled with alcoholism, and who sadly died in her early 50’s, I also experienced the impact of this approach and became interested in **motivational interviewing (MI)** [slide 3] pioneered by Bill Miller and developed in partnership with Steve Rollnick.

The difference this approach made was remarkable. Motivational conversations in the spirit of MI are, in my view, a respectful and more strategic approach to assist people to explore their ambivalence about changing substance use and other addictive behaviours and run less risk of violating human rights. Come back when you are more motivated is no longer an appropriate therapeutic response.

An increasing awareness of the **neurobiology of addiction** [slide 4] helped me to understand that for many people who attend treatment services, ceasing use of a substance on which they have become severely dependent is not a simple matter. Over time executive functioning and ‘free will’ are eroded.

A consumer colleague who has provided input to medical student teaching with me over many years makes a point about what for her is the “insanity of addiction” – the compulsivity to use opioids that over-rode her love for her children, her partner and her parents. She also makes the point that for her more than expecting to “be touched and saved” was required. **Epiphanies** [slide 5] do occur but what is needed for many people who enter addiction treatment services is a whole lifestyle change and this takes time – months to years versus days to weeks – with lapses and relapses not uncommon.

I have had a particular clinical and research interest in opioid dependence, the people who are affected by opioid dependence, their experience of treatment and client outcomes, and the treatment services provided; in particular opioid substitution treatment (OST) and **therapeutic communities** [slide 6]. The option of transition into a therapeutic community while receiving methadone has been an important initiative. A number of individuals I have known who, when younger and receiving OST, would not consider the value of entering a therapeutic community but who subsequently make the decision to do so. Timing, context and phase of life are important influencing factors.

When I started working in the area of OST I was struck by the low expectations of what people receiving this treatment could achieve. Low expectations were reflected within addiction treatment staff and amongst the client group, underpinned, I believe, by **stigma** [slide 7] associated with injecting drug use and methadone treatment and a moral perspective. It will be interesting to see how buprenorphine is perceived in the longer term as well as the longer term public perception of the increasing number of people who become dependent on prescription opioids.

I was interested in the findings of research studies that demonstrated how service related factors could influence client outcomes. In my PhD research interviews I asked participants to rate their treatment progress and then asked them how they thought their case manager would rate their progress. While there was congruence between responses for many participants, for others there was not. A common theme amongst those who provided different ratings was reflected in the response from a woman who said that her life had been good but more recently she had experienced a number of personal and financial issues all at once, and now felt like her life was out of control. However, she perceived her case manager, the third she had had over a period of months would probably say she was stable – as her urine test results were ‘clean’. She commented “**...it is hard to trust when you have changing people**”. [slide 8] Of note was the high value placed on having a trusting long term relationship with one health professional by current clients receiving ongoing OST from their general practitioner (GP). The Ministry of Health in New Zealand has a goal of 50% of clients receiving ongoing OST within primary care settings; hopefully in the not too near future from Nurse Practitioners and nurse specialists as well as from GPs.

Two years ago I met two men and had contact with their family members, one who had been involuntarily discharged from OST for ‘other drug use’ and another who had ‘jumped’ before he was pushed. Early last year I was contacted by a mother of a young woman trying to make sense of her daughter’s apparent suicide by overdose. What this grieving mother was most distressed about was that she felt the service “did not know really know my daughter” despite her daughter having been with the service for a number of years.

The themes of these stories were similar and reflected many other stories – a perceived abstinence philosophy, treatment focused on urine test results, an overemphasis on organisational risk, not listening to clients, families and the concerns of others, and a disempowered client group. It was difficult for staff including social workers and nurses who tried to speak up and voice their concerns and who faced continual ethical dilemmas. The ongoing impact led to some staff leaving the service. I am mindful of Charlotte de Crespigny’s oration on “Courage”. It takes courage to speak up. Subsequently, an external review was commissioned by the Ministry of Health and significant changes have been initiated which have resulted in a changed philosophy and greater input from consumers. I was pleased to be asked to chair the Action Group charged with overseeing the implementation of recommended changes and to be able to facilitate, with a new service manager and nurse consultant, a process that has enabled a positive way forward. This situation reminded me that OST services remain vulnerable to changes in philosophical approach in the context of changing clinical leadership and political climate.

I share Jennifer Holmes’s view of the importance for long-term addiction treatment service clients of monitoring outcomes that are broader than substance use and I have been involved

in the development of a New Zealand outcomes measure. Ensuring that this is conducted with clients in ways that are **meaningful to both the client and practitioner will continue to be a challenge** [slide 9].

The need to address the use of terminology such as ‘clean and ‘dirty’ remains. Both to challenge stigma and in re-orientating OST treatment approaches to be person, family and wellbeing focused. Such an approach is important for people whose opioid dependence was established in the context of illicit injecting drug use as well as for those who have developed a problem as a result of overuse of prescribed opioids.

I can trace my concern about the welfare of children back to my nursing experience in paediatrics. Babies were admitted under a label of ‘failure to thrive’ and were also admitted as the result of abuse. Reflecting back, a proportion will have suffered from foetal alcohol effects. It is estimated that 600 and maybe up to 3000 babies are born with **foetal alcohol spectrum disorder** annually in New Zealand. [slide 10] Whilst awareness of the harms associated with alcohol has increased and brief interventions continue to be emphasised, our current politicians remain reluctant to enforce meaningful environmental changes (such as has occurred for nicotine), continuing to frame heavy drinking as an individual problem.

Influenced by visiting Jennifer Holmes in Sydney in the 80’s when she was involved in an OST programme for pregnant women and women with very young children, I established a parenting group at a community cottage. Childcare was provided by a woman volunteer who was ascribed grandmother status by the children. The goals were empowerment of women as parents and more broadly as women, and participation in community life; what today would be referred to as citizenship. A number of years later I met one of the women who had attended this group who is now a health practitioner. While her fear of this aspect of her life being exposed remains; on reflection she felt what was important to the women who came to the group was to be treated as a ‘normal woman’, to be validated as being able to be a good parent, and to believe that they could achieve in their lives.

In the last decade ‘**recovery**’ [slide 11] has entered the OST treatment discourse. I became interested in the perceptions of recovery and wellbeing held by people receiving OST who were discharged to GP care following a significant period of stabilisation in a specialist service setting. With my colleague Ria Schroder and consumer advisors and peer interviewers we conducted a study to investigate how life was for clients receiving GP Care and what their perceptions of recovery and wellbeing were. Recovery was not a useful term for some and provoked confusion for others. Some perceived recovery as a personal journey over time. Some perceived recovery and wellbeing to be separate concepts, some as intertwined. Themes that emerged were normality (living a normal life, being, feeling normal), psychological wellbeing (feeling good about self), healthy life, and **abstinent or not** (drugs, opioid medication) [slide 12]. While I think that the term recovery is a ‘good’ umbrella term and the client experience of being ‘in limbo’ or ‘parked on methadone’ or other opioid substitute medication reflects low quality care and signals that more can be done to assist people to reach their goals and potential – in my view this is on a platform of harm reduction – not giving up what has been achieved under this approach and risking excluding those individuals with high risk behaviours.

A few years ago I spent some time talking with a man who had had a number of acute admissions to a mental health service. He had bipolar affective disorder, said he found

cannabis and alcohol more helpful than the medications he was prescribed, which he did not adhere to following discharge. It became clear that he did not perceive the links between his substance use and his mental health issues, that his views on medications had not been explored, nor had his partner or his parents, to whom he was close, been actively involved in his treatment.

Whilst there is still a considerable way to go, **the co-existing problems ‘push’ in New Zealand** [slide 13] has gained momentum. There are examples of very good services and growing numbers of addiction and mental health practitioners who have greatly enhanced their knowledge and skills and, in addition, there is a greater awareness and acceptance of the potential helpfulness of a range of medications.

A woman I met as a therapist on the NAC Treatment of Alcohol and Mood Study had never had treatment for depression paired with treatment for alcohol dependence. Her experience was that it was the antidepressant medication and exploring the links between her depression and her drinking that made the difference. She was able to gain and maintain sobriety, was working on her fitness and nicotine dependence and said “I have got my life and my family back”. However, what made the difference for an older man I saw in this same study was admission to hospital for a heart related event and being told he needed urgently to take care of his physical health. The need to address clients’ physical health has become increasingly acknowledged.

Finally, the importance of the approach to **nurses who experience substance use problems.** [slide 14] I was reminded how far we have come through contact with a highly experienced nurse who had accessed drugs from her area of work over a considerable period of time before she was discovered. What impressed me was her report of the health approach taken by her Nursing Leader in consultation with Nursing Council. As New Zealand DANA members we have had initial discussions about developing an information and support network for nurses with addiction issues.

So back to the present. How can we as nurses help people who come to our services for help to ‘get it’ and make positive changes in their lives. This is a fundamental question that continues to intrigue me. Certainly by having an understanding of addiction and the dynamic interplay between substance use and other compulsive behaviours, mental health and physical health issues, but also through gaining an in-depth understanding of a person’s life context and what is important to them – **their values and perceptions** [slide 15] of recovery and wellbeing. It is not sufficient to just focus on symptom or substance use reduction. A broader focus on quality of life, wellbeing and citizenship requires a compassionate, person and family centred approach, and a developmental and lifestyle orientation; utilising a range of clinical, counselling and coaching approaches and interventions, inclusive of peer support and wider health and social systems.

[final slide 16] **In the future** I hope to see further development of the strategy that all nurses have a role in interventions that address the continuum of substance use and behavioural addictions from prevention and health promotion to assisting those with the most complex problems. Specialist nurses and nurse practitioners will work in an increasing range of services and across systems and have direct client care and consultation roles. While there is an important role for DANA in providing a supportive addiction nursing network and, in collaboration with other nursing and professional bodies, continuing to strengthen clinical

and policy leadership there is also a need to be more actively involved in advocacy and, alongside consumers, to develop a strong political voice.