

Exploring experiences and attitudes about health care complaints among pregnant women, mothers and staff at an Opioid Treatment Service

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Abstract

There is little information about managing frontline complaints with opioid-dependent women. Semi-structured interviews were conducted with a purposive sample of 13 opioid-dependent women and 10 staff at an Opioid Treatment Service. A multidisciplinary team conducted a thematic analysis on the transcripts. Difficulties that prevented women making complaints included the anticipation of not being taken seriously, the fear of repercussions including infant removal, and practical difficulties in making written complaints. Staff reported that complaints at the dosing window were often delivered emotively and could be personalised. They had difficulty assessing complaints to determine whether there were substantive health care issues that should be followed up. Women and staff believed that case managers had a role in providing support for the complaints process.

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What is known about the topic?

Few evaluations have been conducted about the management of frontline complaints in the health care sector in Australia. While best practice guidelines exist about managing frontline complaints, there is little information about specific challenges of handling complaints with opioid-dependent clientele groups.

What does this study add?

This study highlights the role opioid treatment services have in receiving health care complaints from this clientele group. It identifies difficulties that opioid-dependent women have in making health care complaints during pregnancy and early motherhood, and difficulties that frontline staff in the opioid treatment service have in receiving and responding to these complaints.

What are the implications for practice?

Case management support for complaint processes has an important role in helping opioid-dependent women overcome barriers to making complaints, by offering an opportunity for confidential, verbal complaints and providing advocacy and guidance within the case management interview. Managers need to institute protective and preventative strategies for staff handling complaints that are delivered emotively. Staff should receive adequate training, debriefing and managerial support in handling complaints with this clientele group. Both staff and women need to be reassured that their rights for the fair investigation of complaints will be upheld.

THE HEALTH CARE sector in Australia has placed an increasing emphasis on complaint processes in the last decade. Complaints have been defined by New South Wales Health as an expression of dissatisfaction by a complainant which may have one or more issues associated with it.¹ Organisational support for improving health service complaint management systems was introduced through the establishment of Health Care Com-

plaints Commissions in each state in the early 1990s.² Their role is to support health services to resolve serious complaints through conciliation, and to promote good practice for complaints handling within health service systems. The Commonwealth government and several state governments have developed policies, standards and guidelines on complaints handling for use in their health care systems.² Policy documents in Australia place an emphasis on recognising consumer rights to access complaint mechanisms, and the contribution of complaints processes to improving health service quality and safety.^{1,3-7} Transparent and sound complaints management also helps to restore consumer trust and satisfaction in the public health care system.^{8,9}

Surveys conducted in Australia report that less than half of consumers who were dissatisfied with health care formally lodged a complaint in these hospital settings.^{10,11} The majority of consumer complaints are expressed informally to frontline staff. This includes clinicians, nursing and allied health staff, and administrative staff. Frontline staff and their managers have a role in documenting complaints, resolving minor complaints at the point of service, and referring more serious or unresolved complaints to designated complaints managers within the health service.^{1,8,10} Frontline staff who receive a complaint should respond by listening to the complainant and showing empathy, identifying the problems and outcomes sought by the complainant, providing an explanation or apology, taking action to implement the solution offered, confirming satisfaction, asking if they want to take it further and making a quick record of the complaint or concern.¹² Health service managers need to support their staff to receive and respond to complaints made at the point of service,² and minimise the barriers to consumers making these complaints.^{1,4}

Good complaints management is needed if complaints are going to effectively contribute to health care improvement and to uphold consumer rights. Fair and effective complaints processes are particularly important for marginalised or disadvantaged groups because they have the potential to identify problems in health care

delivery which have been overlooked by health service providers within these groups, and to redress experiences of discrimination. However, there are specific challenges in managing complaint processes with these groups. Marginalised groups can face barriers to participating in mechanisms for service feedback, including complaints, which are closely linked to the difficulties they have in accessing services.¹³ This can include discriminatory attitudes, and limited capacity of organisations to tailor mechanisms for feedback to the specific needs of diverse groups.¹³ Staff can find it particularly hard to manage complaints with difficult groups, for example, those who demonstrate aggression.¹⁴

Few evaluations have been conducted of management of frontline complaints in the health care sector in Australia. There is a growing body of policies and guidelines that document principles of better practice in frontline complaints handling within Australia.^{3,8,12,14-17} However, few guidelines exist which address the needs of specific marginalised groups.

Qualitative information about consumer and staff experiences of complaint processes can help inform the development of guidelines about best practice in frontline complaints management, where there is little evidence to inform best practice.

There is currently little information about managing frontline complaints processes with opioid-dependent women during pregnancy and early motherhood. An understanding of methadone user perspectives of their service experiences is vital for the development of more effective services.¹⁸ Research documents dissatisfaction with health care among opioid-dependent women during pregnancy and early motherhood.¹⁹⁻²² Complaints processes are likely to illuminate some of these issues. However, difficulties that members of this clientele group experience in accessing health services, such as fear of being judged or of discrimination,¹⁹ may prevent these women making a complaint. In addition, a recent study describing consumer and service provider attitudes to consumer participation in drug treatment services in Australia reported that only

54.2% of consumers who participated in the survey were aware of complaints processes.²³

Within New South Wales, opioid-dependent women who are pregnant have priority access to a methadone program because in many cases this provides safer conditions for the pregnancy.²⁴ Health care during pregnancy and early motherhood is delivered contemporaneously through opioid treatment services and child and maternity services. This paper reports on one component of a qualitative study which described attitudes to consumer participation processes, including complaints, among opioid-dependent women and staff within an Opioid Treatment Service and associated Child and Maternity Services in a hospital setting in New South Wales. It describes the experiences and attitudes of opioid-dependent women in making health care complaints during pregnancy and early motherhood and the experiences and attitudes of staff in receiving and responding to these complaints at the Opioid Treatment Service.

Methods

This qualitative study employed a stratified purposive sampling strategy²⁵ to enable comparison of the opinions of staff and clients of the Opioid Treatment Service.

A total of 13 women and 10 health staff participated in the study. The women had been diagnosed as opioid dependent by the medical staff prescribing their opioid maintenance pharmacotherapy. Pregnant women and mothers were personally invited to participate in the study by the research officer, or a consumer representative. A nominal reimbursement of \$10 was offered for travel expenses. Women were invited to participate in three focus groups, but attendance was very low. As a result, two semi-structured interviews were conducted with two pairs of women. In-depth interviews were conducted with other women who were willing to participate at a time and place that suited them. All staff members at the Opioid Treatment Service were invited to participate in the study. A focus group ($n = 7$) with health staff was conducted. Two semi-structured

interviews were also held with staff who could not attend the focus group. An interview was conducted with the Nurse Unit Manager separately so that the health staff whom she supervised could independently express their views.

Two interview guides addressed interview topics about health care delivery and consumer participation in health care, including complaints. All interviews conducted with staff and with women who agreed were taped and transcribed. When permission was not given to tape the interview, comprehensive notes were taken. Interviewees were offered the opportunity to correct these notes after they had been typed up.

A thematic analysis on the data was performed in two stages. A multi-investigator team, including a consumer, an addiction medicine specialist, and a qualitative researcher read a subset of the transcripts and identified a list of emergent themes from these data. A qualitative researcher then manually conducted an analysis on all the transcripts and interview notes. Participants also completed a questionnaire that had items on demographic characteristics.

Results

Demographic characteristics of participants

Demographic information was collected from 11 of the 13 women who participated. This indicated that the research findings predominantly represented the views of women who i) had more than one child ($n = 10$) (ii) had experience with the child and maternity service within the last 2 years ($n = 10$) (iii) reported English to be their preferred language ($n = 11$) and iv) had experienced the loss of custody of a child ($n = 9$). The amount of time on the methadone program ranged from 6 months to 6 years.

Of the 10 staff members who participated in the study, there were six registered nurses/midwives, one psychologist, two administration officers and a nurse unit manager. Staff participants had an average of 6.1 years (range 1–25 years) of experience working with drug-using mothers.

Women's experiences and attitudes to making complaints

Most of the women who participated in this study reported they had been unhappy with health care experiences within Child and Maternity Services. However, in many instances, they had chosen to remain silent and not to speak to the health staff involved. Some women reported they had complained to frontline staff in the hospital wards and that this had resulted in a verbal confrontation. One woman had officially made a verbal complaint to a nurse unit manager about an incident because she believed this had threatened the life of her baby.

All women participants reported that they had talked to their case managers or other staff at the Opioid Treatment Service about health care experiences at both the Child and Maternity Services and the Opioid Treatment Service. Several had also made official complaints to the nurse unit manager at the Opioid Treatment Service.

Difficulties that prevented women making complaints included practical difficulties in making formal written complaints, the anticipation of not being believed or taken seriously, and fear of repercussions, including infant removal.

Difficulties in making complaints

Some women reported that they did not make a written complaint because of competing priorities they had with their time and because they did not know that a formal complaint service existed at the hospital. A couple of women and staff who participated in the study reported that some opioid-dependent women find it difficult to make written complaints, because they find it difficult to write.

Some people find it hard to write, they have difficulty putting things into words. *Mother*

Most women reported that they believed that health staff would not take them seriously or believe them if they made a complaint about health care because they used drugs. Some participants reported that they were more likely to expect this from staff they do not know within Child and Maternity Services.

Once you've got a name as being a drug user, it doesn't matter what you say, no one is believing you or listening to you, and I also found the more fuss you make the worse it looks for you. If you start yelling or ranting and raving it's like oh, she's off her face, she's an uncontrollable drug user, we expected this from her. *Mother*

Some of the women reported they did not make complaints because they feared the repercussions. They particularly feared infant removal by child protection services.

You're just so scared that they're going to take your baby off you. You just do what they tell you to. It's like they're playing God with it, like any minute they'll just take him from you and you can't do anything about it.

Mother

Some women feared that if they made a complaint at the Opioid Treatment Service, the dosing staff would make life difficult for them while using the facility. Several women also reported they would not make a complaint about other clients at the Opioid Treatment Service because they feared they would take revenge.

I don't know whether I would or wouldn't [make a complaint] because would it affect my dosing or the care I get from [the Opioid Treatment Service] afterwards, like again the repercussions of what would happen, am I going to get treated worse because I've made a complaint — is that staff member going to make my life hard, because I disturbed their life or whatever . . . *Mother*

Staff experiences and attitudes to handling complaints

At the dosing window, staff reported that they received indirect complaints from women about bad health care experiences in the hospital wards and by other staff in the pharmacotherapy unit, as well as direct complaints about their own provision of health care.

While working as case managers, staff also reported that they received indirect complaints about health care. Staff reported that some

women will “debrief” and “ventilate” about an incident with their case manager, but do not want the case manager to officially report the complaint or follow it up. However, other women were happy for the case manager to act on their behalf. Written complaint forms were provided to women, but staff reported these types of complaints were rarely made.

Staff who worked at the dosing window reported that clients in the waiting room can loudly complain about health care they have received, using “pretty extensive vocabularies”. Clients would not necessarily follow this up with a complaint at the dosing window. These staff reported that many of the complaints they receive at the dosing window are delivered emotively, and involve raised voices or the expression of anger. They reported that clients who were “volatile” were more likely to make complaints than other clients. Emotive complaints were likely to be received from a client when they were intoxicated on amphetamines or angry at something else.

Some of them are very volatile and every day can be a new drama or complaint, and next day it will be fine. Whereas another person it's the exception to get a complaint from them. *Drug Health Worker*

Sometimes they are already angry at something else that is going on out there, they walk in like that and it's your bad luck to be on the desk and you are going to have to be dosing them that day, you are just likely to get a complaint. *Drug Health Worker*

Interactions between dosing staff and clientele at the dosing window were often personalised. Some staff who worked at the dosing window reported that clients could get angry at dosing staff when they believe that health care decisions are motivated from a desire to be personally nasty to them. They feared that clients may misuse the complaints system to enact personal vendettas, and that their rights as staff members would not be upheld in the complaints process.

You sometimes have to explain to them that legally you can't do this or do that, and then they seem to step back a bit, and go “OK” —

and at the end of the day you are doing it for their safety, not because you are being nasty or want to be a bitch that day, it's like “this is the reason” and then they step back a bit and it calms them down a bit, and ... *Drug Health Worker*

Assessing and responding to complaints

Staff participants reported that they assessed the complaints they received to determine whether there were substantive health care issues underlying the complaint that should be followed up. Staff reported that they had particular difficulty assessing whether complaints about discriminatory behavior were based on differential treatment or judgmental attitudes.

It depends on the information they give you, and what information you need to sift out whether that is worth acknowledging I suppose or doing something about it, or brushing it off and forgetting about it ... It is not always just a whinge, there are issues, there are things that come out of there and are acted on. *Drug Health Worker*

Some staff reported that they used their knowledge of different clients to decide what information to ignore and what information to respond to. For example, staff members reported that they are less likely to take consumer complaints seriously if the consumer is someone who is “volatile” and inconsistent in their feedback, tells lies, or complains because they “want you to feel sorry for their whole situation”. They reported they would be more likely to take someone's complaints seriously, who hardly ever complained or generally had moderate opinions.

Several women in this study reported that they would be more likely to make a complaint to mainstream services if their Opioid Treatment Service case manager provided support. This could include providing practical help and encouragement in making a complaint, for example, writing a letter; personal support in making face-to-face complaints; and advocacy on their behalf. Women reported that they would be more likely to be believed if their case manager were advocating on their behalf.

If I'd had someone there who I knew believed in me or could have helped me get another file together that I could have shown them . . . someone on my behalf so it's more believable, so it's not just my word against theirs. If I'd had someone there to show me how to do all that.
Mother

Several staff who worked as case managers reported that they believed they had a role in encouraging and guiding women in making complaints, particularly in ensuring that complaints are not based on vexatious or frivolous grounds.

So we need to feel our clients feel they have the right to complaint, but they also have responsibilities for that complaint — so you get that balanced approach. Their responsibilities are to make sure they are not vexatious, frivolous and have grounds — that is a skill as well — sometimes people are just angry about something and they don't know what to do and so they ring up, and because there are no grounds to it, and because there is something they feel they are powerless over — and then nothing occurs from it, because it's somewhat nebulous. So we need to assist our clients to be able to understand how to go about the actual complaints process — that is a real skill in some ways. It shouldn't be, but it is. *Drug Health Worker*

Discussion

The findings highlight the role staff members at the Opioid Treatment Service can have dealing with complaints about their own unit, and supporting and advocating for the women making complaints about health care received in mainstream settings. They also describe barriers that prevent opioid-dependent women making complaints and difficulties that staff have in receiving and responding to these complaints. Health service managers need to identify and implement strategies that address these barriers.

Strategies to support women making complaints

The women in this study described three major barriers to making complaints — fear of repercussions, the anticipation of not having a complaint taken seriously and practical barriers to making written complaints. Fear of retribution,¹¹ and fear of subsequent discrimination when utilising health services^{13,26} have been identified as barriers for making complaints in mainstream population groups. Some of the opioid-dependent women in this study reported that they feared staff would abuse the power they have in influencing child protection outcomes and in controlling access to methadone dosing if they made a complaint. Even in the absence of past experiences of repercussions when making a complaint, opioid-dependent women may expect retribution, which is common in drug-using communities.²⁷ Their fear of infant removal, in particular, acts as a powerful disincentive to making complaints. Women's fears that a complaint will not be taken seriously may arise from prior experiences of discrimination within the community or health service sector.

Practical barriers to making written complaints were heightened among women who had difficulty writing. The ability to make frontline verbal complaints is particularly important in redressing this barrier to making complaints for these women.

Case manager support for complaint processes may help women overcome barriers to making a complaint. Women may find it easiest to make verbal complaints to their case manager, because they regularly speak with them about their health care. Case managers have an important role in receiving complaints from women who fear making a complaint directly to the staff member concerned. The use of case managers as client advocates may give women the confidence to make a complaint when they believe that they will not be heard. Advocates can help to reduce the fear of retribution, to assist clients in dealing with strangers and presenting relevant information, and to ensure the outcomes of complaints investigations are followed through.²⁸ Assisting

women in the process of making a complaint can restore their confidence in their own ability to communicate their needs to others and ask for help.

Case managers can take an active role in supporting women who make complaints about discrimination. Many women will assume that a bad experience in health care is the result of discriminatory treatment, when the problem may have been founded in systemic problems of health care. It is difficult for women to make these assessments. Case managers have a role in helping women understand whether the incidents that occur are a result of policy implementation. Formal complaints processes in which incidents are documented and investigated may help illuminate whether systemic or interpersonal issues contribute to the health care behavior.¹²

In some cases, face-to-face resolution of complaints between service providers and clientele at the Opioid Treatment Service may be required to resolve past relational dynamics so that relationships can be maintained for the duration of time the client is at the health care facility. Face-to-face complaints and conflict resolution can be challenging when there is emotion attached. Opioid-dependent clients may be fearful that they will be treated in the same way as they have been in the past by other service providers who had been discriminatory or disrespectful. Both service providers and clientele may find it difficult to speak face-to-face with a person with whom there has been miscommunication or unresolved conflict. In these situations, a mediator can be helpful in guiding the interaction and diffusing the emotion that persists from the past interaction.^{1,17,29,30}

At the point of service entry, consumers need to be given appropriate guidelines for making complaints,⁴ which make explicit their rights and responsibility as clients of health services.¹ Opioid-dependent women are entitled to know they have a right to complain and that their complaints will be heard. However, they may also need guidance about delivering complaints in a respectful way. While women should be informed of the consequences of not meeting their client responsibilities, they need to be

reassured that this does not invalidate their right to complain about the health care they have received.

Information about complaint processes should address women's fears. Women need reassurance that their children will not be removed simply on the basis of making a complaint. Information sessions for women about child protection guidelines and regulations would be useful. Women should be informed that they will not lose their dosing rights because they have made a complaint. The circumstances in which these dosing rights are removed also need to be explained. Opioid-dependent women, who fear the possibility of staff retribution, need to be assured that their complaints will remain confidential. Those who remain fearful about making a complaint can be informed that complaints can be made anonymously, but that this limits the investigation of specific complaints.^{3,12}

Strategies to support frontline staff responding to complaints

The findings suggest that there are specific barriers to staff engaging with and responding to informal complaints with this clientele group. Staff members can find it difficult to receive feedback when it is negative, emotionally charged, confrontational, and personalised, and may find it difficult to handle these complaints in a fair and equitable way. Staff may adopt protective responses in handling these complaints, for example, dismissing the complaint or assessing the validity of the complaint on the basis of character, rather than assessing the complaints on a situation by situation basis. They may have difficulty separating out the content of the complaint from its affective dimensions, and assessing complaints about insubstantive issues such as offensive interpersonal interactions or discriminative health care behaviour.

Staff need to ensure that their response to complaints that are delivered emotively is non-discriminatory. Staff can find it difficult to remain calm in the face of verbal abuse, particularly when clients complain directly about their behaviour or personalise complaints about health serv-

ice delivery. If a staff member is unable to remain objective, they should refer the complaint to another staff member or provide the client with information to take the complaint further.

Dosing staff need to be reassured that they will be appropriately protected when they are exposed to aggression. Managers need to ensure they implement policies in responding to aggressive behaviour and that staff receive appropriate training in dealing with aggression. Debriefing support for staff may be helpful in diffusing emotions of an encounter, and preventing the incident affecting long-term dynamics between the service provider and client. Managers can also support staff in implementing policies. The policies within which dosing staff are required to operate should be explained to clients so that they understand when a policy is being implemented. Managers can speak to clients who challenge the implementation of these policies, and indicate their support for staff. Staff may need to be reminded that they have a responsibility to treat other clients well, even if they had a number of aggressive encounters at the dosing window that day.

Preventative strategies could be introduced to help prevent emotional encounters with women. Up to 45% of opioid-dependent women can be expected to suffer from borderline personality disorder, compared with 2% in the general population.³¹ This is associated with emotional dysregulation and inconsistent interpersonal communication styles,³² and can contribute to emotional volatility in encounters with methadone clients. Anger that is attached to the experience of unmet health care needs arising from communication difficulties between women and staff may also contribute to emotive encounters between women and staff. Case managers can have a role in skilling women in communicating with health care staff, particularly in addressing difficulties in emotional expression and impulse control (anger) that can be experienced by members of this clientele group.

Complaints training for frontline health staff who work with opioid-dependent women needs to be tailored to their specific needs.¹ Training about communication and dispute resolution

should include skills in de-escalating highly emotionally charged situations without sidelining the client concerned. Staff members would also benefit from background information about the dynamics of communication between service providers and stigmatised groups, for example, the impact of consumer expectations of forthcoming discrimination¹⁹ or about stereotypical assumptions that staff may hold about clientele³³ on miscommunication and conflict. Frontline staff may need specific guidance about the circumstances under which a complaint should be referred on for more formal assessment, and documenting complaints with this clientele group. For example, they may need guidance about when to record complaints that they perceive to be a “whinge”,³⁴ and how to comment on extraneous issues perceived to be attached to the complaint when documenting a complaint.

Ensuring fair outcomes

Health care providers can find it very stressful to face the investigation of a complaint about their delivery of health care.^{12,35} Health service managers need to ensure that staff members know that their rights for fair investigation of complaints will be upheld. The investigation of complaints about discrimination need to address both interpersonal and systemic health care issues, as accusations of discrimination can be unfounded. Fair and transparent handling of complaints is also important for women with a history of discrimination. The restoration of relationships with service staff may be achieved through mediation or an explanation that the cause of the bad experience is due to systemic rather than interpersonal issues. This can help rebuild trust and engagement between women and health service providers. Fair outcomes to complaint processes can contribute to the reintegration of mothers on the methadone program into the fabric of mainstream society by altering beliefs that they will always be discriminated against by service providers.

Limitations of the study

This research describes the opinions of women who were more stable and less likely to be using

illicit drugs. Opioid-dependent women who are less stable and more marginalised from health care services may experience additional difficulties in making complaints. Most of the women in this study had experienced the loss of custody of their children. Women who had not experienced this may have different attitudes to complaints. Because of the small sample size, it cannot be claimed that the women and staff members are representative of all pregnant women, mothers and staff in opioid treatment services in Australia. Rather, it provides an insight into the experiences within a particular Opioid Treatment Service and points to issues that are likely to arise in similar service settings in Australia.

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Competing interests

The authors declare that they have no competing interests.

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