Improving access to alcohol and other drug care through health and community services

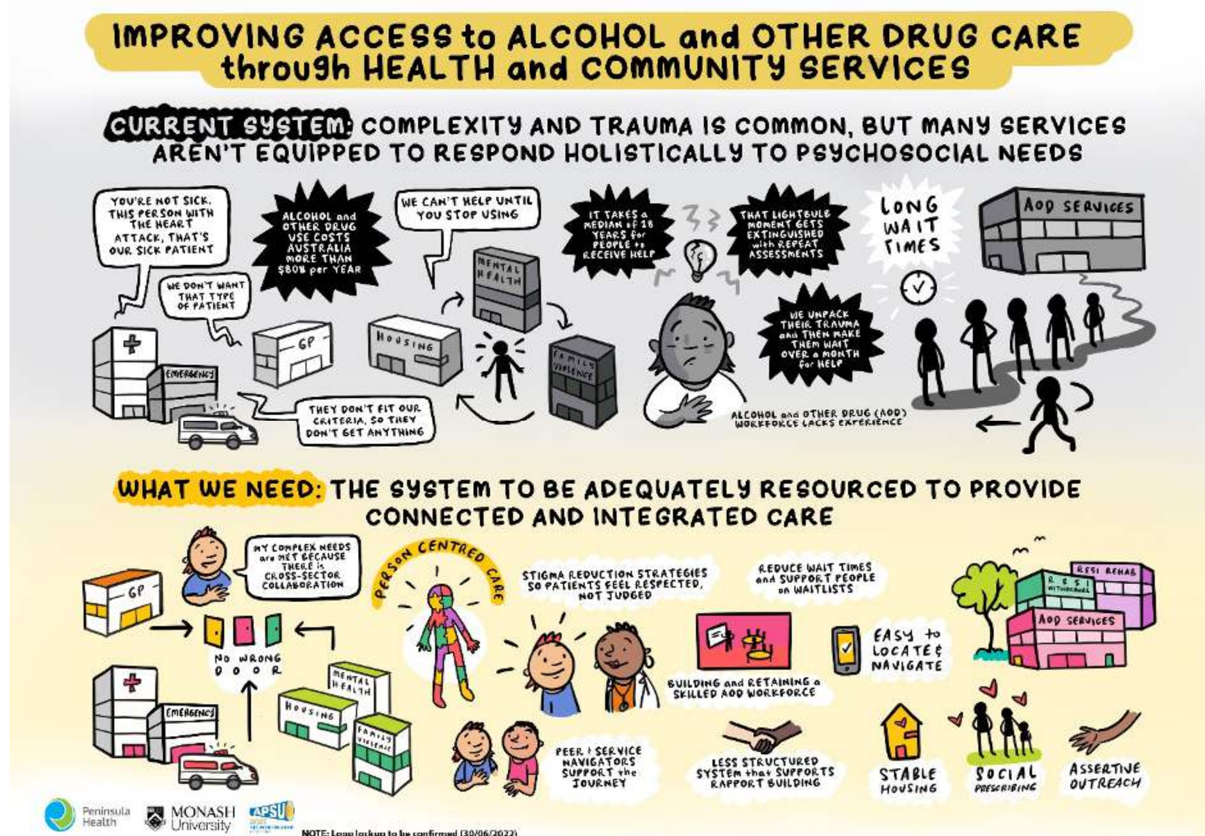
Executive Summary for policy makers

The Frankston Mornington Peninsula region experiences substantial alcohol and other drug (AOD) harm, yet there is currently little understanding of how people navigate AOD treatment (Frankston Mornington Peninsula – Primary Care Partnership, 2021). This study sought to improve treatment journeys by mapping experiences of effective pathways into care, as well as barriers to seeking or remaining engaged in treatment.

This study was a collaboration between Monash University, Peninsula Health and the Association of Participating Service Users. The team conducted a total of 39 semi-structured interviews, 20 with participants with lived experience and 19 with staff from either AOD specialists or broader healthcare services. Twenty-two of these interviews were conducted with an interviewer-dyad consisting of an academic-researcher and a peer-researcher with lived experience. Workshops were conducted before (n=12) and after (n=17) the interview phase to determine research priorities and confirm that the themes identified were accurately summarised.

One outcome of the interviews and workshops was the development of the "Improving access to alcohol and other drug care through health and community services" policy map presented in this document[1]. Through the workshops with people with lived experience, participants reported barriers in locating and receiving responses from services, particularly for women in unstable housing. Stigma among non-AOD staff and inexperienced staff within AOD services represent a barrier to accessing broader healthcare. Workshops with service providers echoed concerns regarding stigma, and highlighted how certain processes and procedures (such as frequency of intake and assessments and long wait times), in addition to a lack of collaborative cross-sector relationships added further barriers.

Recommendations around local service delivery for policy makers were professionally illustrated and were as follows: (1) A less siloed system that supports a 'no wrong door' approach to health care, (2) Stable housing for women, (3) Addressing barriers for older adults (4) Reduced wait times and support people on wait lists, (5) Having peer and service navigators support their treatment journey, and (6) Building and retaining a skilled AOD workforce.



[1] For a complete list of study outcomes please see our webpage https://www.monash.edu/medicine/ehcs/marc/research/current/AOD-PJ

RECOMMENDATION ONE

NO WRONG DOOR/LESS SILOED SYSTEM

CONTEXT: Current barriers create a perception for consumers that there is no right door" through which they might access treatment. Delivery of care between AOD specialist services and other services (mental health, family violence, housing, Emergency Departments) are experienced as fragmented and siloed. People who report using AOD are informed that they are unable to receive broader healthcare services until they cease their AOD use. This means a person who has current AOD use is denied care from other services, creating an incentive not to disclose AOD use, or not seek help from other services.

PROBLEM: There needs to be a fundamental shift in recognition of the role each service has in identifying and responding to AOD use. The narrow lens of a medical model, insufficient supply of material provisions (i.e. house or a withdrawal bed), and AOD use (current or historical), excludes people until AOD use ceases. However, ceasing AOD use with ongoing housing, mental health, or family violence concerns is not a linear process. People with lived experience and service providers reported:

- In ***Emergency Department*** settings, comments overheard by staff about AOD-related presentations suggested they were perceived not to fit the medical model: *"You're not sick. This person with the heart attack, that's our sick patient"* (Service Provider, Female).
- In ***Mental Health*** settings, *"They can look at a client with a substance use issue and say 'Well, no, because they need to address their substance use issue before they get mental health treatment', which flies in the face of what we know about dual-diagnosis"* (Service Provider, Female).
- In ***Housing*** settings, *"… and the thing is when you do go to these services and say you're using, you're frowned upon"* (Consumer, Female).
- In ***Family Violence*** settings, *"I had no choice but to go back to my partner … this is after I'd escaped from him and of course all the shit started again … I have a lot of anger about this"* (Consumer, Female).
- In these settings, ***initial presentation expectations*** and ***intake processes*** *"… weeds out an awful lot of the drug and alcohol type people"* (Service Provider, Female).

As current or historical AOD use is viewed as exclusionary to service access, persons experienced "*… a lot of referrals being thrown round, and you need a referral for this, you need one for that. So, there was a lot of planning and referrals and appointments and stuff like that, but nothing really comes of them … it was kind of just you get pushed around"* (Consumer, Female).

POTENTIAL SOLUTION: Policy and cultural shifts in services so that denying care to a person due to their AOD use is considered unacceptable and discriminatory. Improved early intervention, access to treatment and integrated care for people experiencing AOD related harm through improved AOD screening and delivery of brief interventions in non-AOD specialist services.

RECOMMENDED ACTION: Build non-AOD workforce competency and understanding of AOD issues. Implement policies to ensure that people actively using AODs are not excluded from accessing other services. Implementation and strengthening of AOD screening and brief intervention capability across service settings frequently attended by people experiencing AOD harms (Emergency Department, mental health, family violence), supported by stronger multisectoral collaboration.

STABLE HOUSING for WOMEN

RECOMMENDATION TWO

ADDRESSING BARRIERS TO STABLE HOUSING FOR WOMEN

CONTEXT: In the Frankston and Mornington Peninsula region, women reported entering homelessness unexpectedly/with minimal notice having little or no family support, and experiencing difficulties accessing or engaging with housing and family violence services.

PROBLEM: Women reported:

- They were entering homelessness, with this outcome primarily originating from family violence, eviction, or departmental orders relating to children in their care. *"I had to do* [urine drug] *screens every week and whatnot. So, I failed those, and then I had to leave the house where the kids were. So, I got kicked out, and then I had to find somewhere to stay that day"* (Consumer, Female).
- Changes to AOD use during homelessness which impacted their ability to engage with services. For some, it was decreased drug use "*And so, the thing that went was the drug, it was either going to be me or the drugs that went, and I, for a long time thought it was going to be me … and at the time I wasn't trying to get off drugs, I was trying to find a roof over my head, getting off drugs just came hand-in-hand with it"* (Consumer, Female). And for others, drug use increased *"… and I mean that stuff's the truth because I had to be off my face. I won't lie to you, I had to be off my face to be able to bear living on the street"* (Consumer, Female). However, the case remained that *"How are you supposed to, if you have no home to live in, how are you supposed to address your addiction?"* (Consumer, Female).
- A lack of stable housing and substantial changes in use impacted women's ability to access services. Women reported difficulties accessing services. "*Not to leave someone out on the street when they know damn well that they're on the street, and they have nothing, and nowhere. So those places out there for homelessness and addiction, really there's not much out there, and to be honest it's a dead end"* (Consumer, Female).

POTENTIAL SOLUTION: Women in the region should be able to access safe, secure and affordable social housing without first abstaining from AOD use. Multidisciplinary support provided while working towards recovery or reducing harms associated with AOD use. The Housing First model is centred on providing secure and affordable housing and supporting residents to achieve personal well-being. People access secure housing before support for AOD use and are provided with flexible ongoing support to address problematic AOD use once housed. Evaluations of the Housing First program implementation in Australia have evidenced 90% retention in the program at two-year follow-up and savings to the government of $8,002.00 per person (The Misha Project, 2014). Other evaluations report a reduction in mental health and hospital admissions, 80% retention in the program at 12-month follow-up, and savings of $13,100 per participant (Housing and Accommodation Support Initiative NSW, 2016).

RECOMMENDED ACTION: The Department of Families, Fairness and Housing should invest in the Housing First model for women in the region. This could involve re-purposing existing properties to specifically meet women's needs and supporting partnerships between developers, women's housing and health services, investors, and local governments.

ADDRESS BARRIERS to TREATMENT-SEEKING for OLDER ADULTS

RECOMMENDATION THREE

ADDRESSING BARRIERS TO TREATMENT-SEEKING FOR OLDER ADULTS

CONTEXT: Older adults can be more vulnerable to AOD related harm as they are more likely to have multiple medical conditions/medications, be experiencing physiological changes which impact the metabolisation of AOD, and be experiencing social changes such as isolation and/or a transition in role identity. Participants identified a need for connection through face-to-face interactions within their treatment rather than interactions over the telephone or online.

PROBLEM:

- Technology was a barrier, with preferences for face-to-face interaction. Although they had endeavoured to engage with technology *"… so I've had quite a few frustrating moments with bloody technology. But I've made a point of 'no, I'm not going to let these bamboozle me'"* (Consumer, Female). *"So, we like to sit in front of people, physically, because there's so much communication just through body language and those things"* (Consumer, Male).
- *"Older adults don't want to sit in a waiting room with a 19-year-old ice addict in psychosis"* (Service Provider, Female). *"… you need places to go, you need people to talk to"* (Consumer, Female).
- For older adults with complex medical issues, Emergency Department presentations may be for falls, heart attacks, other sicknesses, or suicide attempts, and there was still the potential for their needs to be overlooked in the context of problematic AOD use and referral to appropriate care. This was evident once they were moved to a medical ward. Reporting was similar for older adult presentations within the primary care setting *"I've fallen over a couple of times and got concussion. But I went to my doctor and he said 'Just go home and rest'"* (Consumer, Female).
- Older adults found interacting with young or inexperienced staff challenging. *"The first couple of chats were pretty good, but I'm starting to feel now … the age is really starting to show. She's a smart kid and all that sort of stuff, but to me it's pretty textbook… she's a lovely kid, but she's a kid*" (Consumer, Male). *"… you can't put 40, 50, 60 years of life into your 20s. No matter how smart you are, you've got to live it"* (Consumer, Male).
- Older adults experience challenges and needs unique to their developmental stage of life and expressed the need for older adult (aged 55 years plus) peer workers in the region. Older adults expressed that *"I don't think you can fully understand unless you have walked the walk"* (Consumer, Female).

POTENTIAL SOLUTION: Providing resources to enable approaches and models of care specifically tailored to older adults. This could include more assertive outreach and a peer workforce dedicated to the needs of older adults. The Older Wiser Lifestyles (OWL) Program is run through Peninsula Health for those in the region. The program provides outreach support, education and counselling services focusing on the impact of AOD in older adults aged 55 or older (Peninsula Health, 2017).

RECOMMENDED ACTION: Resourcing allocation to expand assertive outreach in the OWL program. Testing alternative models of care that are better suited to engage older adults, such as peer navigation targeted toward the specific needs of older adults.

REDUCE WAIT TIMES & SUPPORT PEOPLE on WAITLISTS

RECOMMENDATION FOUR

REDUCED WAIT TIMES AND SUPPORT FOR THOSE ON WAIT LISTS

CONTEXT: There was insufficient staff to meet demand, and after initial intake and assessments, wait times for AOD counselling ranged from four to 10 weeks. To meet the demands of specific population groups defined by funding guidelines, such as forensic clients or those experiencing family violence, staff capacity to meet the needs of voluntary clients from other population groups was reduced, resulting in extended wait times for many voluntary clients. People often received no support after intake while awaiting their comprehensive assessment appointment. Discouragement experienced, inefficient processes, and a lack of support around trauma made people vulnerable to dropping out in the early stages of treatment seeking.

PROBLEM:

- Processing of wait lists can be governed by external pressures (e.g. departmental priorities), or emergency referrals (e.g. a pregnant person using drugs) or forensic referrals may get priority. For those seeking voluntary treatment *"… there are almost two waiting lists"* (Service Provider, Male); from intake to assessment, then assessment to counselling. Funding bodies decide how waitlist priorities change. At different points in time the priority will be the wait list between intake and assessment *"… the departmental focus is that these people haven't been assessed, we at least need to assess them, and so let's pump out assessments, so let's really prioritise that*" (Service Provider, Male). Due to insufficient staff, clinicians then have less capacity to take on new clients, and this wait list grows while resources are diverted to assessments. Then, pressure might shift to reduce wait lists between assessment and counselling. Overall, it was *"… departmental pressures or what-have-you, (that determined) the wait list you sit on the longest*" (Service Provider, Male).
- Funding bodies influenced wait list priorities, but the region had insufficient staff to reduce wait list times. Here concerns were that *"Frankston has always had a significant issue … so it's never been less than four weeks between intake and assessment, and sometimes as high as 10 weeks. So, it feels like there's a real disparity, which feels like a lot of the Frankston Mornington Peninsula clients … who are potentially the most marginalised, have to wait the longest"* (Service Provider, Female).
- Frequent re-assessments placed a toll on the system. *"Assessments have to be redone every three to six months, again putting a massive toll on our funding system, on the care that they receive. It's a torturous process for the clients… to repeat their information"* (Service Provider, Female). "*… it has horrendous implications for our funding, assessments cost $800 ... Why aren't we reviewing that? Why does that person need to do that many assessments? That $800 could have gone towards a bed. … we need to completely overhaul how we perceive services should be delivered in the AOD sector"* (Service Provider, Female).
- Long wait lists, and repeated assessments without support or room for engagement or connection is unethical. *"The process is structured… you'll answer the intake questions, and then you'll wait, and you'll have an assessment, and then you'll wait, and then you'll have counselling, and then, if you want, detox or rehab"* (Service Provider, Female). *"We make or break recovery if we ask the wrong question and leave them vulnerable and sitting with that wound … asking about traumas on assessment is unethical in my eyes, because then there's a month wait… So, you unpack their trauma… and then let them hold back for a month"* (Service Provider, Female).

POTENTIAL SOLUTION: Increase funding for bridging support, including expanding the peer workforce to provide the bridging support. Review assessment processes to make them more streamlined and consumer friendly.

RECOMMENDED ACTION: Adequately resourced workforce of AOD clinicians and peer workers to reduce wait times and provide bridging and service navigation support. AOD assessments to be living documents that can be transferred between services and updated rather than repeated and can follow a person through each service.

PEER & SERVICE NAVIGATORS SUPPORT the WAIT LISTS

RECOMMENDATION FIVE

PEER AND SERVICE NAVIGATORS SUPPORT THE JOURNEY

CONTEXT: For people experiencing AOD harms, services were difficult to locate, and healthcare systems were challenging to navigate, with limited peer workers and service navigators in the region. Participants reported that their treatment journey would've been different if they had had the opportunity to interact with a peer worker either one-on-one or within a group context during the early stages of the treatment journey.

PROBLEM: Participants reported that the opportunity to connect with a peer navigator within treatment-seeking and treatment-engagement stages would be beneficial. *"I feel that a lot more peer support needs to be available … I understand that funding affects everything, and I think support workers and peer support plays a big role in standing beside someone while they're going through a tough time"* (Consumer, Female).

Peer navigator roles and relationships provided a unique form of connection and rapport by:

- Building hope *"… having someone in those early few days I think would have helped. It wouldn't have been as dark as it was. Because it was pretty dark"* (Consumer, Female);
- Building trust and credibility, *"They tend to be far more understanding … the peer workers, they get it"* (Consumer, Male). *"That peer worker down there, it just kind of comes natural to him, and it's not hard, it's not forced. It's just like he's quite interested in what you have to say … it really makes a difference when someone enjoys what they're doing"* (Consumer, Female); and
- Providing a flexible and informal form of access that contrasted access to and relationships with clinicians and other professionals *"I'm not actually connected down there anymore, but I'm connected with them* (peer worker) *still"* (Consumer, Female).

POTENTIAL SOLUTION: Expand the AOD peer workforce in hospitals and in non-AOD services that have a high proportion of clients with co-occurring AOD needs (e.g. mental health, family violence, homelessness services)

RECOMMENDED ACTION: The Victorian Department of Health continue to invest in developing and expanding AOD peer service navigators in non-specialist AOD settings such as hospitals to help reduce wait times. Resource allocation that ensures job stability and long-term employment to build peer workforce, access to peer-specific supervision and build cultural safety in workplace settings so the role of lived and living experience staff is understood and supported. Resourcing allocation that provides peer support for people on wait lists. Adequate resourcing of these staff is recommended to enable a consistent point of contact through wait lists, processes, navigation, and treatment entry.

BUILDING & RETAINING a SKILLED AOD WORKFORCE

RECOMMENDATION SIX

BUILD AND RETAIN A SKILLED CLINICAL AOD WORKFORCE

CONTEXT: Inexperience within the AOD workforce impacted engagement and retention in treatment. Shorter-term recurring funding for tendered service provision contributed to a lack of job stability and resulted in short-term contracts for staff. This leads to skilled staff moving to healthcare roles outside the AOD sector where longer term contracts and job security are on offer. Loss of senior staff can also affect retention of less experienced staff. Similar issues were identified throughout the Victorian AOD sector (Wenzel, 2022).

PROBLEM:

- Participants acknowledged that there would be inexperienced staff, however repeated interactions with inexperienced staff impacted their treatment. "*And then I had a, you know, the same thing, the real session, this little girl with a clipboard who said to me 'Oh, have you had a drink since this morning?' 'Well, yes I have, I've got a drinking problem.' 'Oh (name of consumer) you knew you were coming to see me.' Now, I know that that's inexperience …* (Consumer, Female).
- This was particularly difficult for those experiencing AOD harms over long periods. "*… a lot of people that were in my sort of situation, if they get somebody doing an assessment on them that is just coming out of school, and has had no lived experience, sometimes they can get that attitude of 'Okay, you've read it from a textbook, but you don't understand, necessarily, the pain that's inside me'"* (Consumer, Male).
- Interactions with inexperienced AOD staff impacted engagement in treatment. "*And there was another group that I attended to do with (name of service), and this old guy started asking me very inappropriate questions. There was a young girl, she was only brand-new, and she didn't really know how to run a group, or stop what was happening. And I can remember just getting up and said 'Look I've never been treated like this' I said 'I'm going' and they were begging me to stay because there was going to be a good speaker. And I just said 'No, I'm out of here.' I didn't go back, kept drinking"* (Consumer, Female).

POTENTIAL SOLUTION: Job longevity and stability for clinicians and peer workers. Continued training to build a skilled AOD specialist workforce. Employment of experienced and/or mature age staff with existing depth of experience within workforce.

RECOMMENDED ACTION: Increase resourcing allocation, and enable service delivery structures that facilitate the long-term employment of more clinicians/peer workers in the region. Provide funding for ongoing education and training to build a skilled AOD specialist workforce in the region.

References

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Peninsula Health (2017). Peninsula Health Community Health Older Wiser Lifestyles (OWL) Program https://www.peninsulahealth.org.au/wp-content/uploads/OWL-Older-Wiser-Lifestyle-Program.pdf

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Publications

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- Francia, L, Berg, A, Lam, T, Morgan, K & Nielsen, S (2022). “The peer workers, they get it” – how lived experience expertise strengthens therapeutic alliances and alcohol and other drug treatment-seeking in the hospital setting. Addiction Research & Theory. DOI: 10.1080/16066359.2022.2124245
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- Berg, A, Francia, L, Lam, T, Morgan, K, Lubman, DI, Nielsen, S. Enriching qualitative alcohol and other drug research by engaging lived experience peer researchers in a dual-interview approach: A case study. *Drug Alcohol Rev*. 2023. https://doi.org/10.1111/dar.13724

Visit the **project website** for more outputs such as stigma reduction resources:
https://www.monash.edu/medicine/ehcs/marc/research/current/AOD-PJ