Access and equity project

Barriers and enablers associated with access and equity in alcohol and other drug treatment in NSW

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Why we did this research

A key issue for those working in the alcohol and other drug (AOD) treatment sector are the difficulties that clients have in accessing treatment, staying engaged with treatment, and maintaining their positive outcomes in the post-treatment period. This research was undertaken to better understand these issues and to offer insight about how support can be better provided to clients navigating the treatment system.

How we did the research

We used qualitative research strategies to interview 20 clients of AOD services and 15 sector stakeholders. We documented their views about the supports clients need to get into treatment, the factors that help to sustain their engagement with treatment, and the factors that support their maintenance during the post-treatment period.

Commissioned by the Network of Alcohol and other Drugs Agencies, through funding from the NSW Ministry of Health

NADA
network of alcohol and other drugs agencies

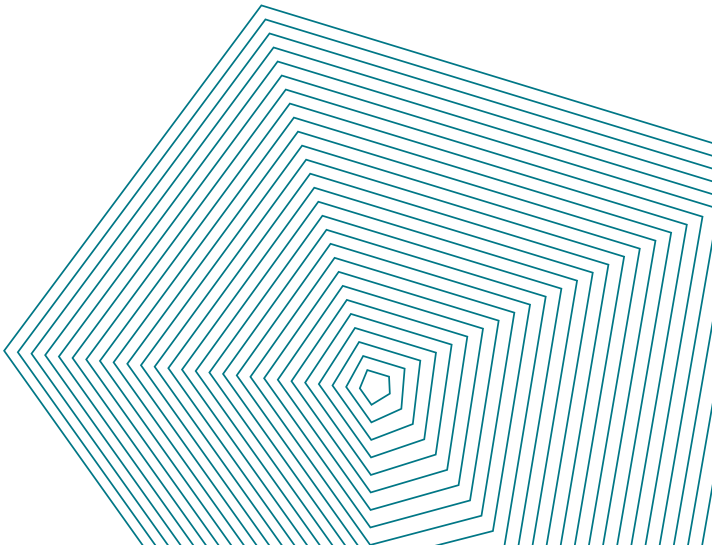
What we found

Successful entry into treatment was supported by:

- websites with detailed and accessible information that permitted the best opportunity for self-matching to treatment
- short waiting lists and flexible, warm and welcoming intake procedures
- families and other support people who could help navigate treatment entry or provide support while a client was on a waiting list
- prior experience with the system and therefore the knowledge and skills needed to navigate re-entry. This suggests that any positive engagement in the referral system, even if it does not result in treatment entry, is worthwhile. If this engagement is warm and welcoming, it can smooth that way for entry next time.

Staying in treatment until completion was supported by:

- services where staff and other clients were warm and accepting
- approaches that valued and supported client self-determination
- services where supportive peer relationships were actively encouraged and seen to be part of the therapeutic journey, especially if peer support could be offered to the range of people that enrol in treatment, including Aboriginal, LGBTQI and other minority-identified clients
- services that offered clean and comfortable physical surroundings
- the quality of relationships with family and friends since, for some clients, improving the quality of family and social life was a motivator to complete treatment
- at a basic level, for some clients, staying in treatment happened simply because treatment facilities offered a rudimentary safety that was not available to them in ‘the outside world’.



Maintaining positive outcomes after leaving treatment was supported by:

- maintaining social connection through self-help groups or formalised ongoing contact with staff, arranged early in the treatment episode.
- sufficient integration and collaboration across the service system in order to ease clients' pathways into stable housing, mental health care and so forth. The inability of clients to navigate the system was sometimes seen as a deficiency on their part (e.g. some clients were viewed as 'too hard'), rather than as a problem with the set-up of services.
- the skills acquired during the treatment period, such as self-care, goal-setting, self-motivation, and help-seeking. However, post treatment outcomes were seen to rest heavily on these individual skills with the assumption being that they could be used by clients to manage their choices and decisions after they leave treatment. This focus on individual skill-building means that 'relapse' can be construed as a failure in personal motivation, which can be experienced by clients as yet another example of their shortcomings, sometimes leading to them 'dropping off' contact with service providers who were often their only source of formal help and support.

Conclusions about access and equity

We found that inequity is most pronounced in the early stages of the treatment journey, when clients are navigating referral pathways. While some clients had friends or family that organised and paid for their treatment entry, other clients got into treatment only through the intervention of police or because it was a court requirement. Inequity during treatment was less evident, although the focus on building supportive peer relationships in the treatment setting was experienced as exclusionary by some clients. The impact of inequity in the post treatment period is less clear and this is because participants appeared to have fewer opinions about best practice in this period. Our observations suggest that the provision of post treatment care depended on the type and quality of the treatment service that the client was leaving, and that while some clients were connected to aftercare during their stay in treatment (this happens, for example, in residential rehabilitation), others received much less intervention and could exit treatment with very little support in place.

Recommendations

Standardise the online presence of services in order to support self-referral and self-determination in service choice.

Online information is used by a wide range of people, including clients, families, caseworkers, police, and social and health workers. Information should include policies on smoking, children, entry criteria, intake procedures, geographic location, rules and responsibilities while in treatment, room-sharing arrangements, aftercare arrangements and so forth.

Strengthen the role of people with lived experience in all aspects of the treatment journey.

People with lived experience bring knowledge and skills about how to navigate treatment entry, and giving care and support to other clients both during and after treatment. Peer support is a strengths-based approach that sends important messages to clients that they are capable of constructive relationships and contributing positively to the treatment journey of others.

Consider ways to increase the size and contributions of the peer workforce.

Options include strengthening consumer participation programs within treatment services, adding outreach to these programs to support clients on their entry pathways, and to increase models offering peer support in the post-treatment period, keeping in mind the diversity of identities and experiences of the AOD client group.

Increase the availability of AOD treatment places.

This will reduce inequities produced by long waiting lists whereby those with more financial and social resources can access immediate treatment or can be supported by family or friends during long waiting periods; but those without these supports are faced with waiting and accepting the offer of any place that becomes available. Waiting lists create situations in which clients must ‘play the game’ and demonstrate sufficient motivation for treatment.

Include families and support networks in a client’s treatment journey, if this is a client’s choice.

Some clients view AOD treatment as a shared journey with collective implications (e.g. for family, partners, friends), rather than as an individual endeavour.

Increase the attention given to staff training and retention.

This is because the quality of the skills and approach of staff, including that they are warm, accepting and have high expectations, is one of the main aspects of positive referral experiences and in keeping clients engaged during the treatment period.

Always consider the quality of the physical environment.

High quality physical surroundings send strengths-based messages to clients that they are worthy, valued and respected.

Consider whether all rules and regulations are necessary.

Overly regulated treatment environments are viewed negatively by clients and send messages that they are untrustworthy. Clients will not return to overly regulated services, if they have a choice.

Continue the work to shift deficit assumptions of people with problematic substance use.

Views that AOD clients lack motivation, self-control, and volition are damaging. These views negatively impact staff-client interactions and, at a more structural level, shape perceptions what is possible in policy and practice.

Recognise the limits of overly individualised approaches within AOD treatment.

Individual skills-development is seen by participants as a key strategy in AOD treatment, but may contribute to clients blaming themselves for their post treatment 'relapse'. Explore system level changes that will better support the broader social challenges that are part of clients' 'relapse' experiences.

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