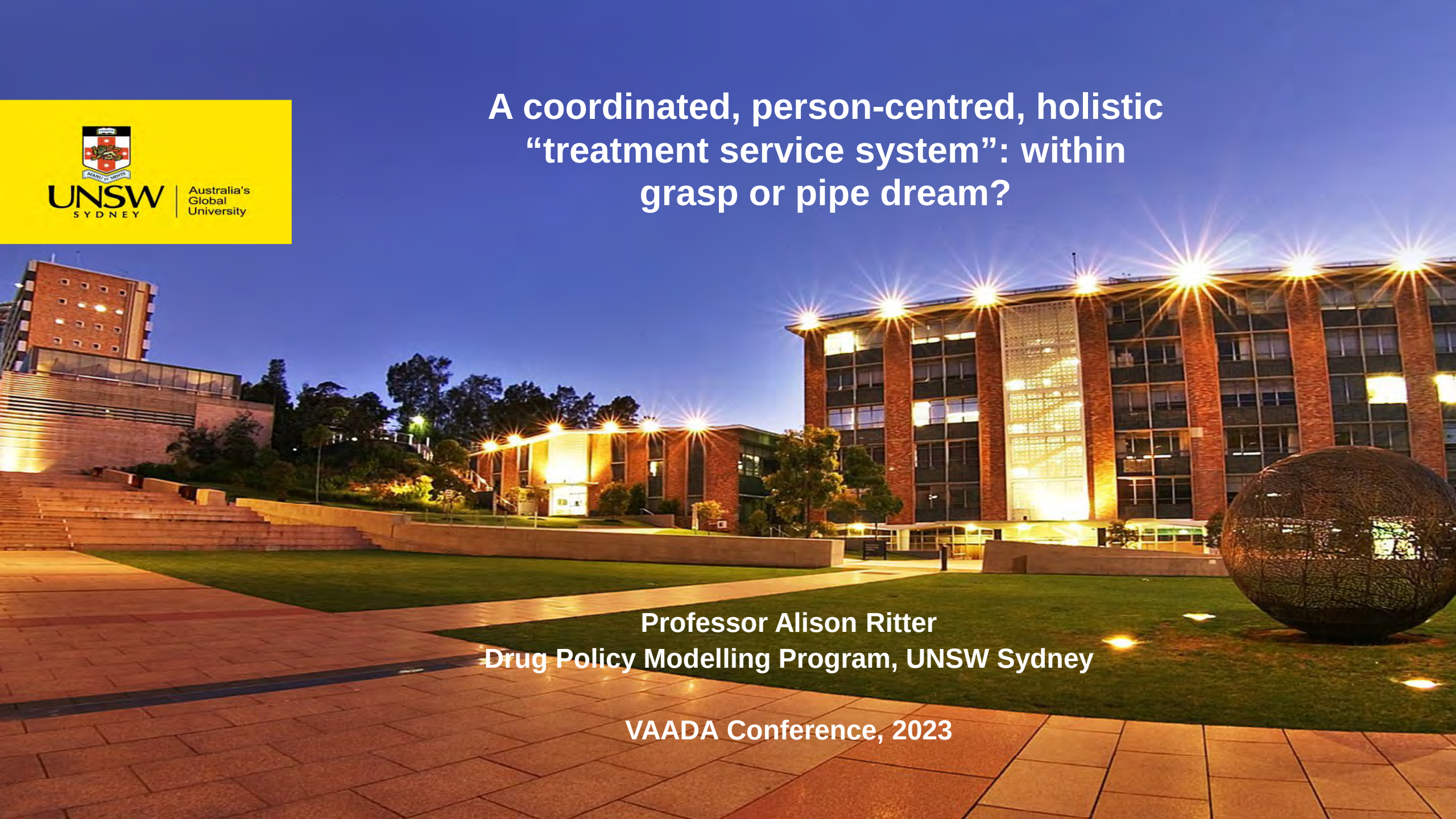
A coordinated, person-centred, holistic “treatment service system”: within grasp or pipe dream?



Professor Alison Ritter
Drug Policy Modelling Program, UNSW Sydney

VAADA Conference, 2023

Introduction

Aims

- Summarise the history – where we are today is a product of where we came from
- Present some ‘treatment systems’ diagrams
- Explore key ‘sticking points’

History of the Victorian AOD treatment system

1964 – St Vincent's hospital the first alcoholism clinic

1970s/80s – Charitable organisations providing care/support but bulk of AOD treatment in hospitals and MH services

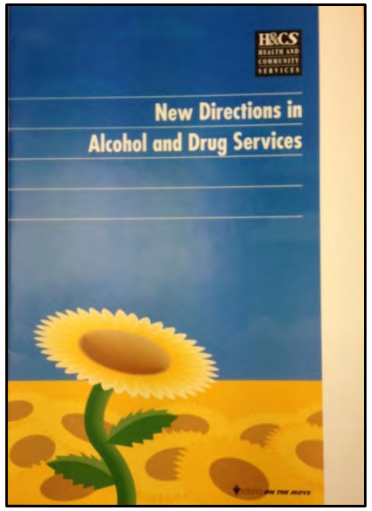
1988 – Government MH and AOD tertiary treatment system (Gresswell Rehabilitation Centre, Pleasant View Centre, Smith Street Clinic)

1990 – Gresswell and SSC closed, due to 'budget pressure', and government service renamed: Drug Services Victoria, single site

- What happens when your “AOD treatment system” is only have 1 big, govt AOD treatment centre?
- More reform required:
  - Geographically isolated (Preston)
  - Cost and budget pressure: “Physical and clinical infrastructure of government services which resemble a hospital in staffing terms but not in clinical services, therefore operating at a higher cost…” (p.2)
  - Inequities of regional funding & poor regional planning
  - The NGOs “tended to be small and poorly coordinated, with inconsistent service standards” (p.1)
  - International research: outpatient, community-based treatments as cost-effective
- And: significant context changes
  - Jeff Kennett, 1992
  - New public management
  - Purchaser-provider split (AOD among the first)

“New directions” - 1994 major reform

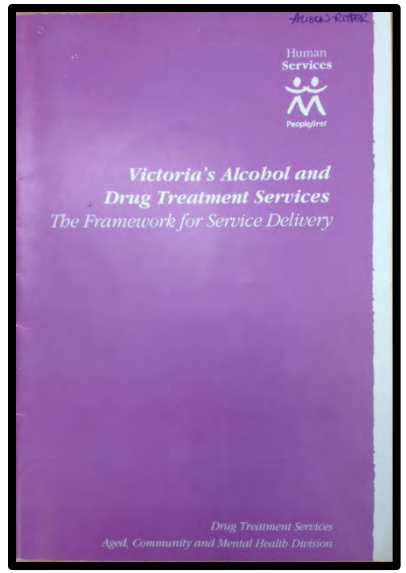
- Closure of Drug Services Victoria (Pleasant View Centre)
- Establishment of Turning Point Alcohol & Drug Centre
- A reformed NGO AOD treatment sector
- AOD treatment now all NGO, majority to be community (outpatient) care

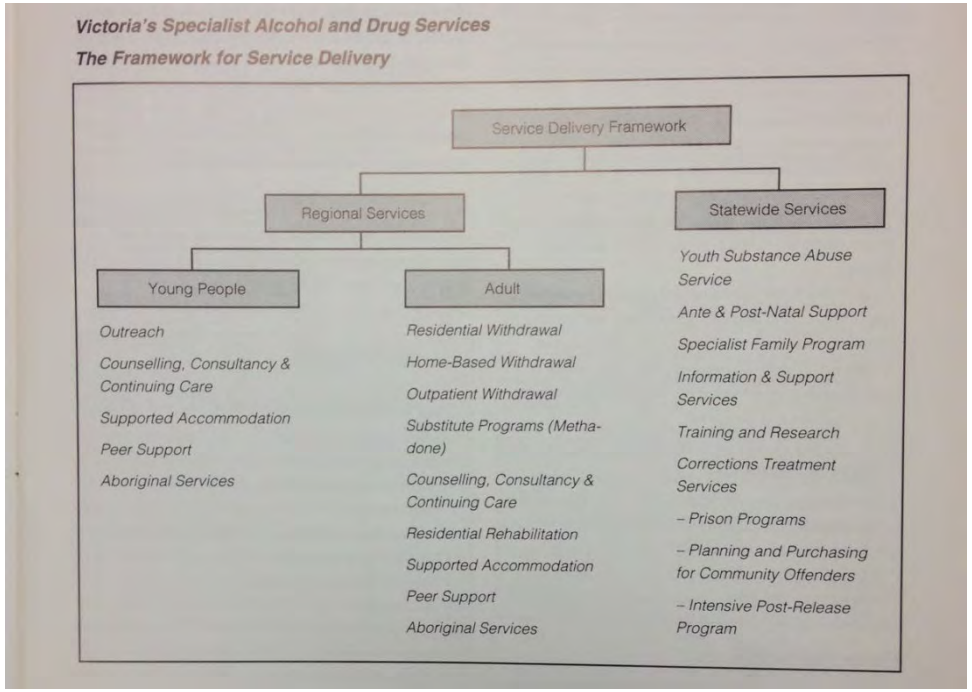


Turning Point, 1995, outside original premises (Smith Street)

What followed (1995 onwards)

- In light of these major shifts from government to NGO, the structure of AOD treatment system changed dramatically
- Great deal of bureaucracy as govt becomes the 'purchaser' of services
- Purchasing policies needed (unit cost funding..)
- Service specifications become important
- Accountability (counting, monitoring etc)





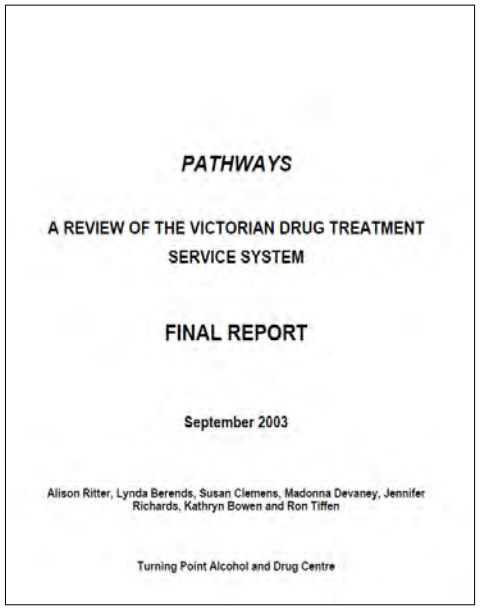
- NGO sector flourished….

Trouble at mill: 2002-2004 reviews of the “system”

- Impetus: concerns about lack of agreement about what ‘AOD treatment’ is, unmet demand, poor access to the system, and service silos
- A competition between highly individual NGOs, no statewide system(s), no care coordination

A number of recommendations (2003):

- Treatment be clearly defined (“primary goal reducing or ceasing drug use”), and identify as a specialist system
- Focus on more serious and complex (and esp alcohol)
- New system for access and entry (“central intake units”)
- Updated service types (incl no stand alone withdrawal services)
- “We recommend that resources not be expended in capacity enhancement of other care systems”


PATHWAYS

A REVIEW OF THE VICTORIAN DRUG TREATMENT SERVICE SYSTEM

FINAL REPORT

September 2003

Alison Ritter, Lynda Berends, Susan Clemens, Madonna Devaney, Jennifer Richards, Kathryn Bowen and Ron Tiffen

Turning Point Alcohol and Drug Centre

Outcome from those reviews: A “blueprint”

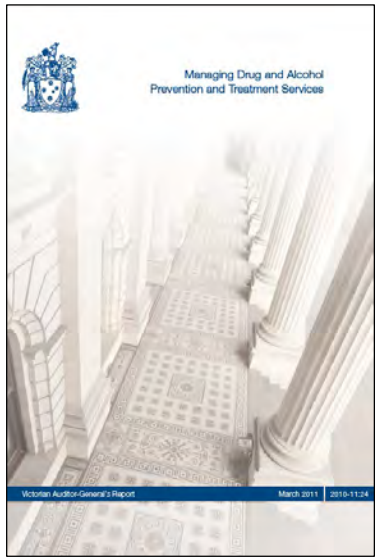
- The blueprint document (2008)
- “New Blueprint for Drug and Alcohol Treatment Services 2009-2013”
- Based on service systems reviews (2003, 2004) attempt to deal with overly bureaucratic requirements, poor coordination and fragmentation
- System to become:
  - “client-centred” and
  - “service-focussed”
- Six priority areas: each area accompanied by detailed plans
  - Prevention
  - Improving access
  - Excellence and quality
  - Client-focussed
  - Children and families
  - Young people
- More bureaucratic?

An auditor-general's report (2011)

- Victorian Auditor-General's Report (March 2011)
- *Managing Alcohol and Drug Treatment Services.* www.audit.vic.gov.au/reports_publications

  – "the Department has **no** assurance that the service system objectives of effective case management and continuity of care for clients and consistent, high quality services, are being achieved" (VAGO, March 2011, p. vii).

  – A focus on the episode of care funding mechanism



A “roadmap” (2012) and a “framework” for reform (2013)

- The Roadmap (June 2012): New Directions for Alcohol and Drug Treatment Services: A roadmap.
- The treatment system has become “overly complicated and hard to use” (p.1)
- Solutions: person centred, family inclusive and recovery oriented
  - Accessible, easy to navigate
  - Of a high-quality and based on evidence
  - Integrated early intervention
- The Framework for Reform (Aug 2013)
- New Directions for Alcohol and Drug Treatment Services: A Framework for Reform.
- Based on the 2012 Roadmap, the Framework set out a plan for reform:
  - Six core treatment types
  - Recommissioning services for joined up pathways and for quality (central telephone intake, regional/area intakes, standardised screening and assessment)
  - Future planning based on needs
  - New funding model (shift from unit costs to ABF – DTAU)

Since then, more reviews….

- Royal Commission into Family Violence (2016)
  - Limitations in responses to DFV: high demand, lack of resources, services not equipped, lack of perpetrator interventions.
  - 227 recommendations, several pertaining to AOD services (eg Rec 98 specialists in DFV in AOD services)

- Royal Commission Vic MH System (RCVMHS) (2021)
  - A “broken” system, people being turned away, crisis-driven model, “missing middle”
  - Goal: “A responsive integrated system with community at its heart”
  - 65 recomm’s. 3 pertaining to AOD: EDs (Rec 3, 8); ensure all MH & WB services provide integrated treatment care and support for those with MH and AOD (Rec 35); a statewide specialist service (Rec 36)

- **Current “system”** specified in: Victorian AOD program guidelines (2018)
  - Principles and objectives
  - key service delivery requirements
  - minimum performance and reporting standards for funded AOD programs and services

Themes arising

1. Tensions between a focus on tertiary, secondary and primary prevention
2. System navigation, access/entry, linkages
3. Fragmentation, poor coordination, connection with other systems (FDV, MH)
4. Treatment quality, and ensuring evidence-based care
5. Purchasing framework
6. Planning challenges (inequities, catchments, regional funding formulae)

So, similar concerns and problems all driving towards ideal solution:

coordinated, holistic, person-centred treatment service system

This pipe dream, what might it look like?

The pipe dream – a "system"

- Canada…

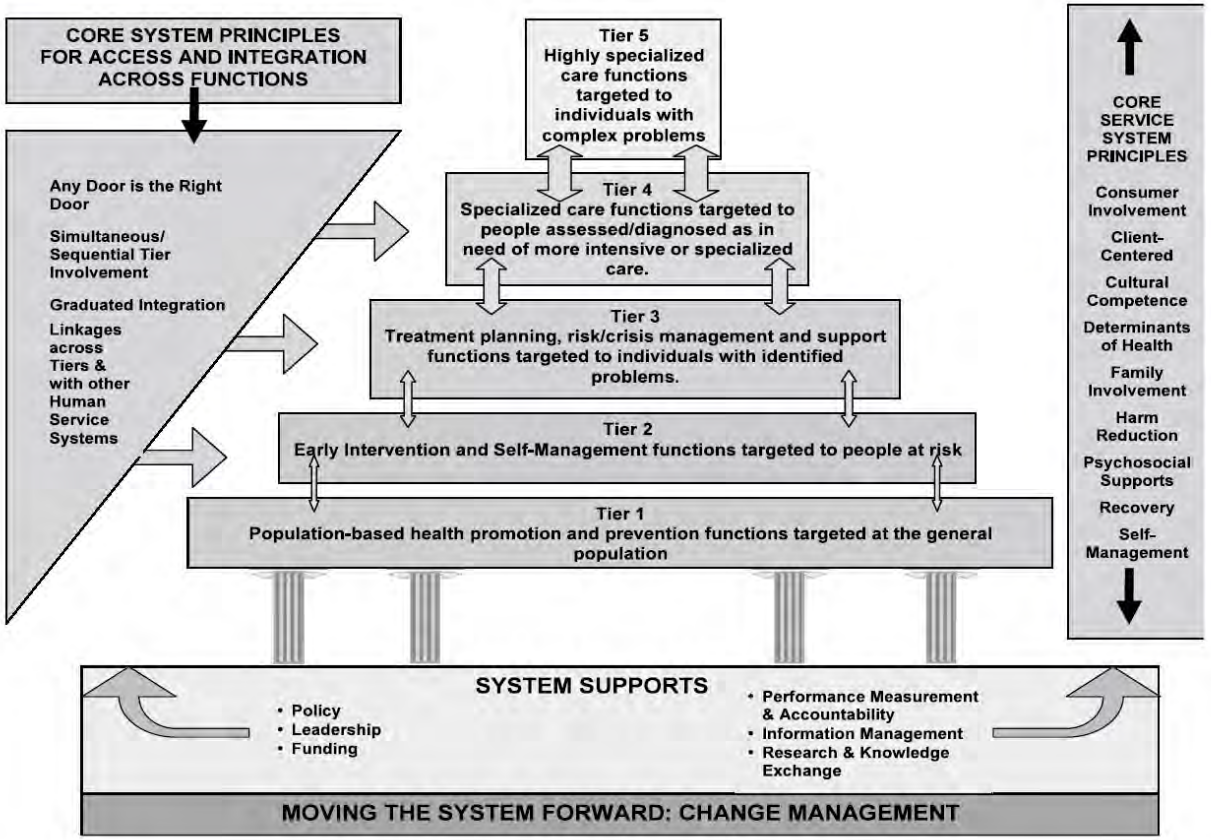
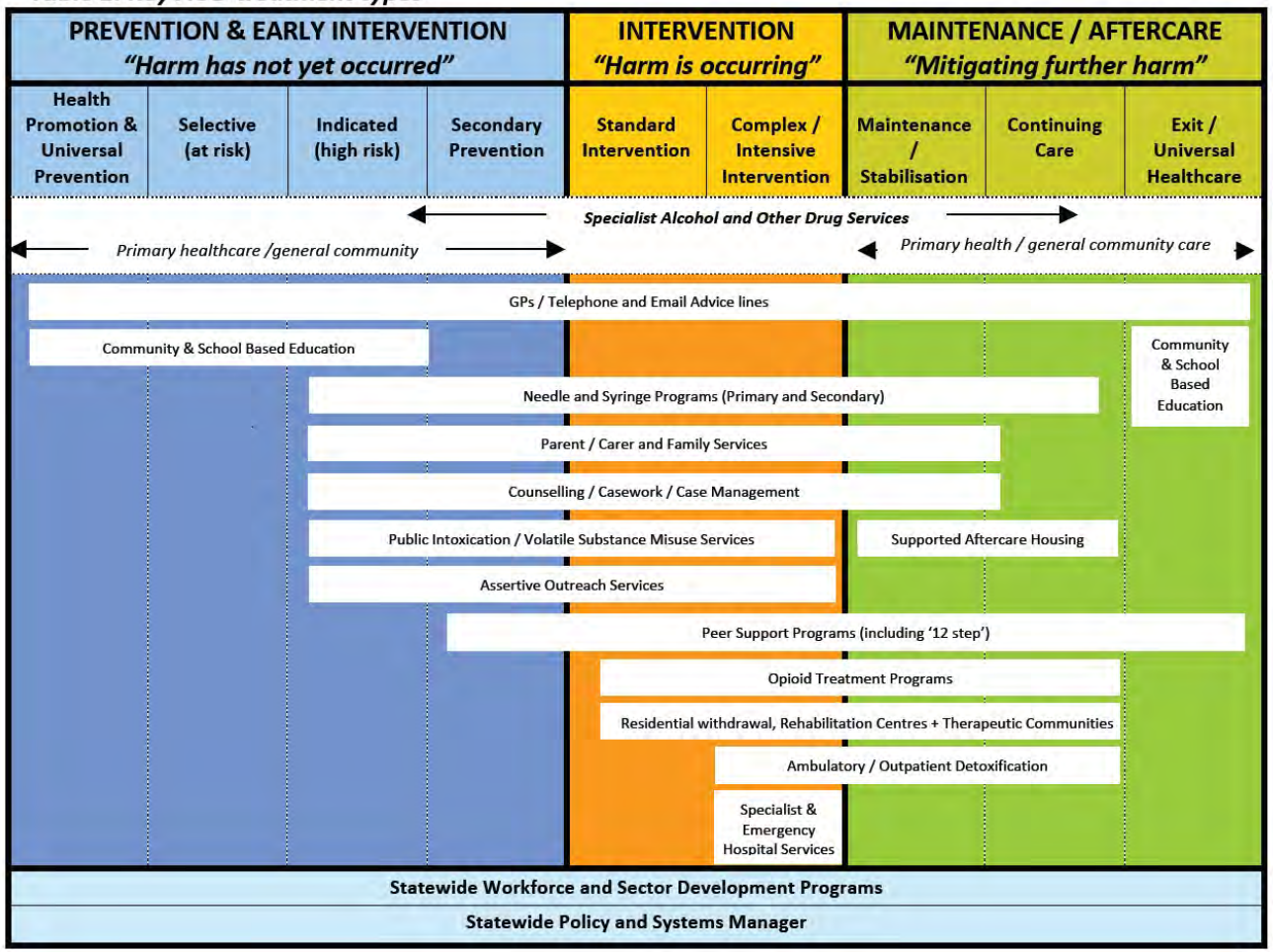


Figure 10. Ontario integrated tiered framework for mental health, substance use and problem gambling services and system supports.

- Queensland

Table 1: Key AOD treatment types



- United Nations / WHO

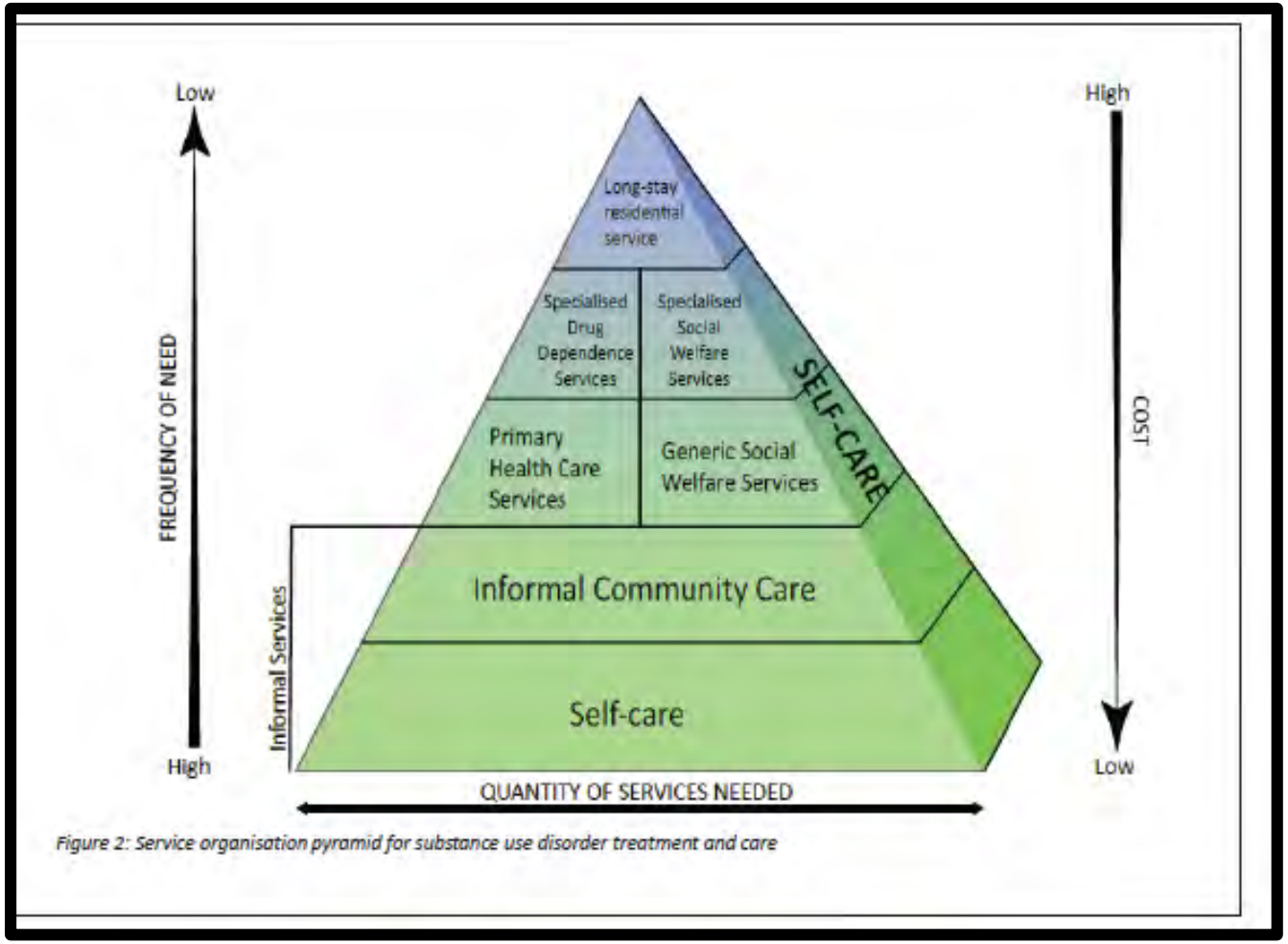
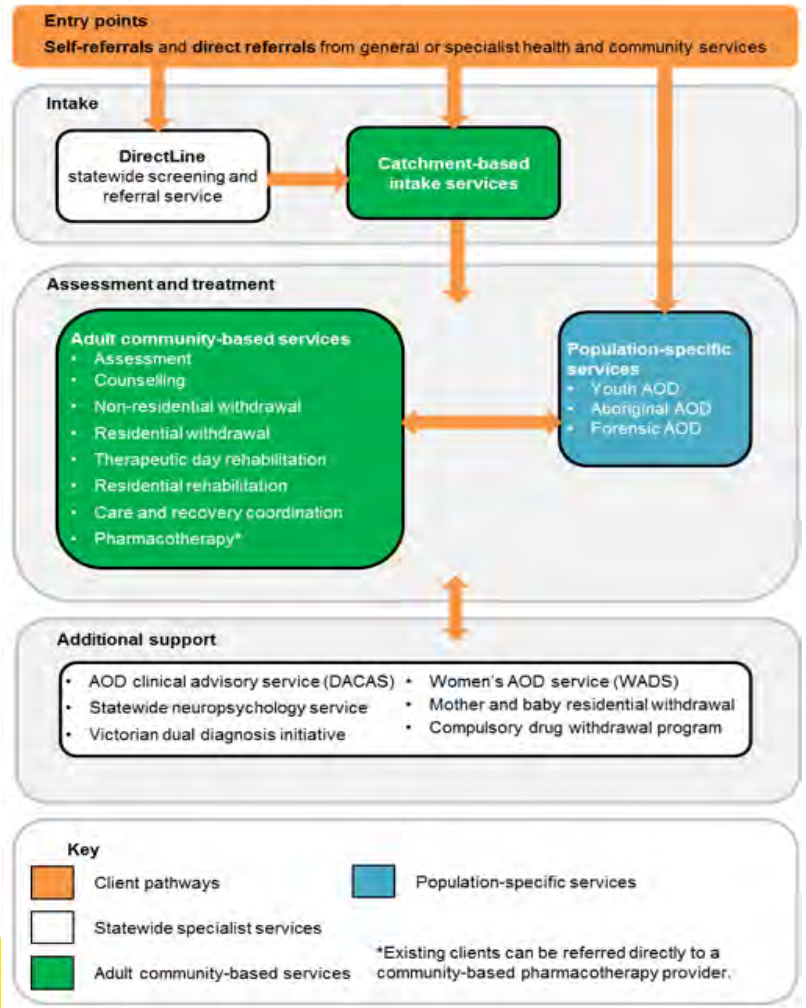


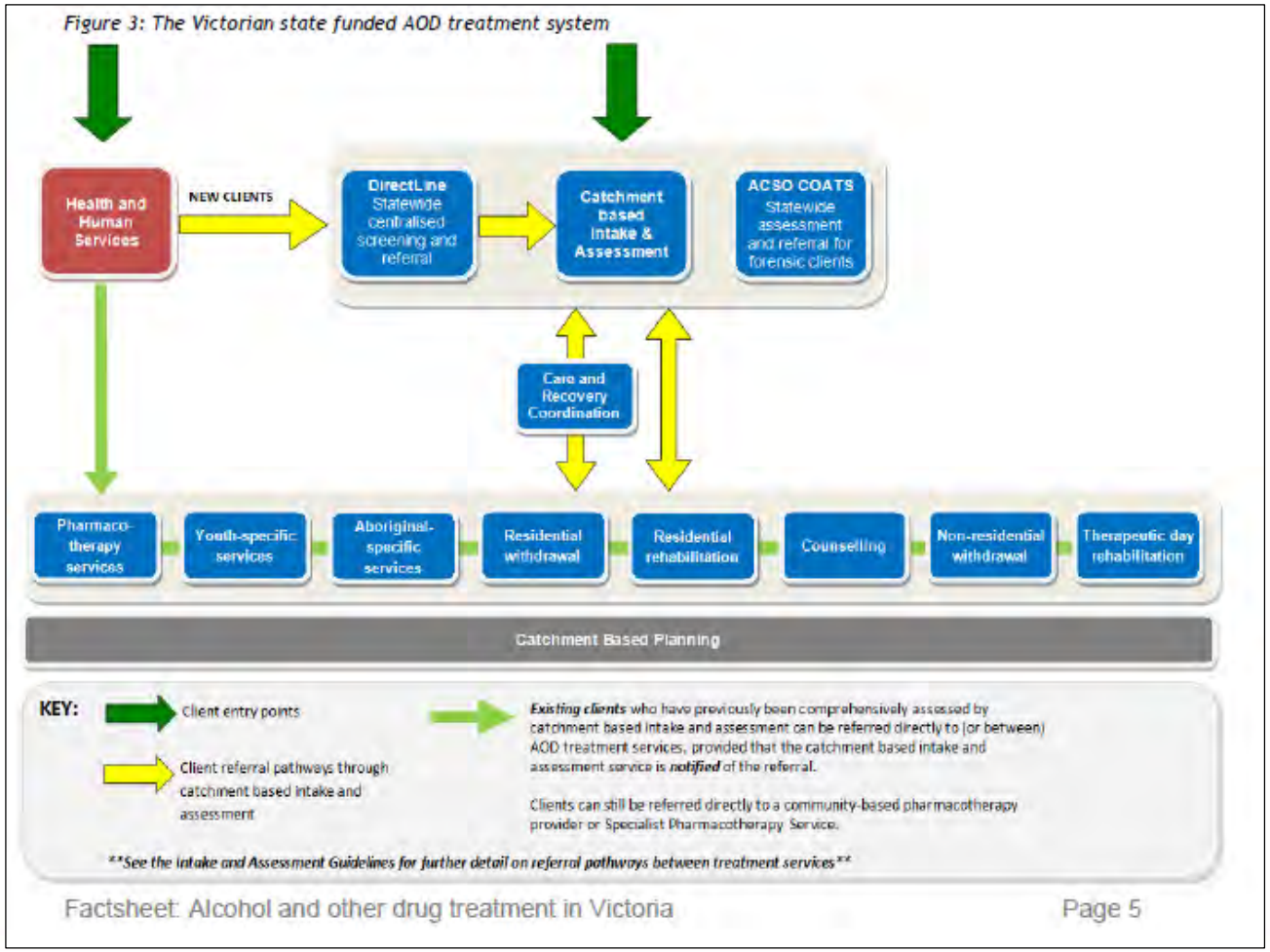
Figure 2: Service organisation pyramid for substance use disorder treatment and care

- Victoria?

Figure 3 AOD treatment system components



Or?



All the above, just the “treatment system” – getting more in there…..?

- Other systems of care
- Institute of Medicine:

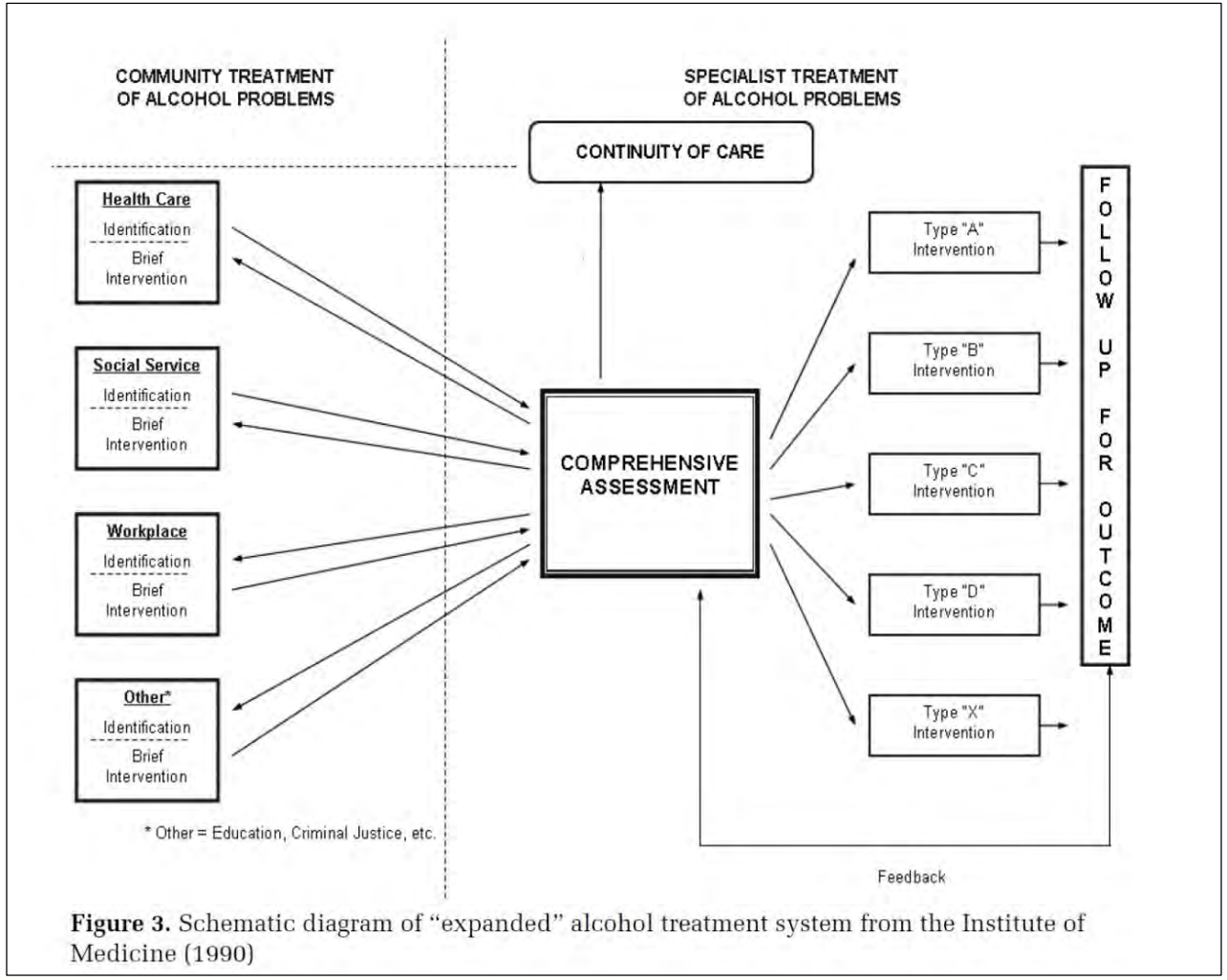
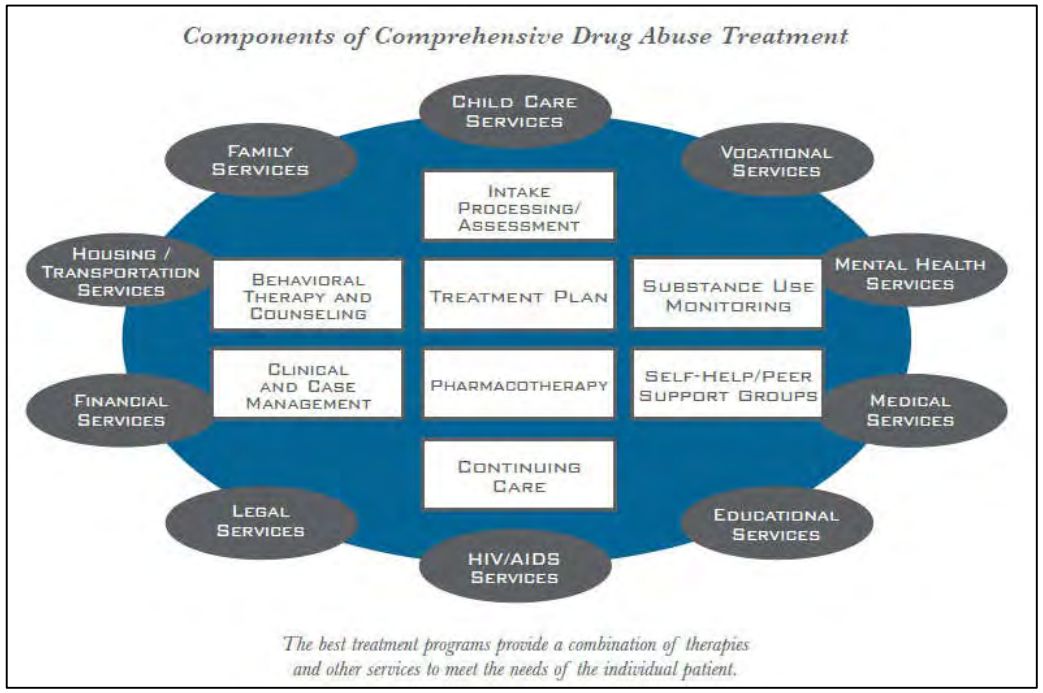
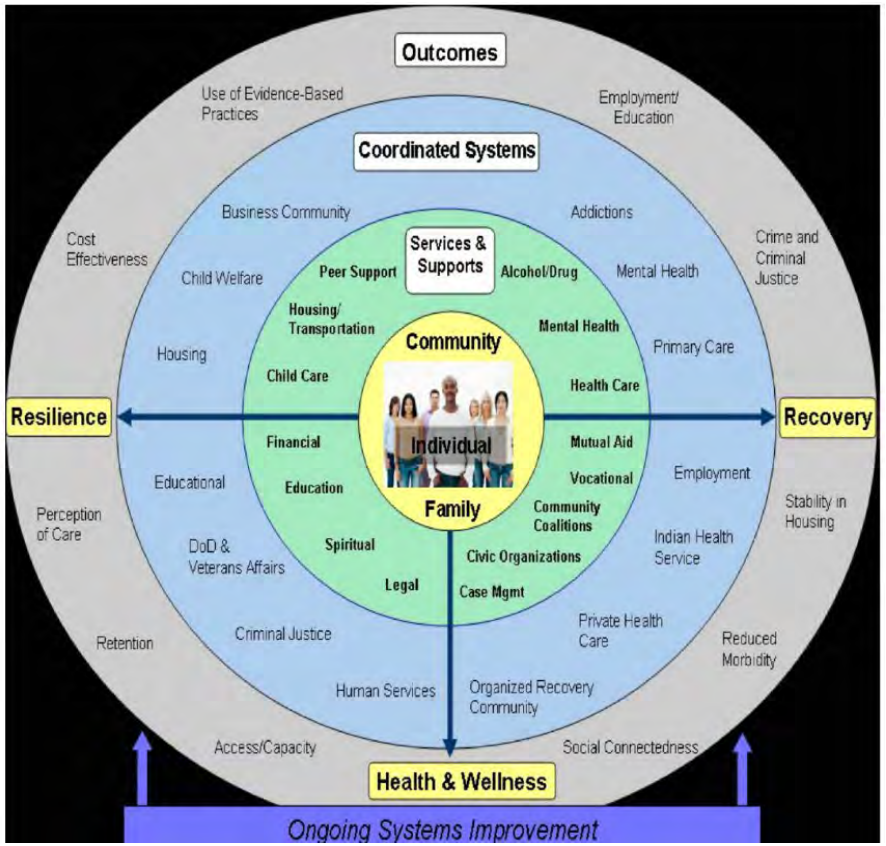


Figure 3. Schematic diagram of “expanded” alcohol treatment system from the Institute of Medicine (1990)

- USA: National Institutes of Drug Abuse (NIDA)

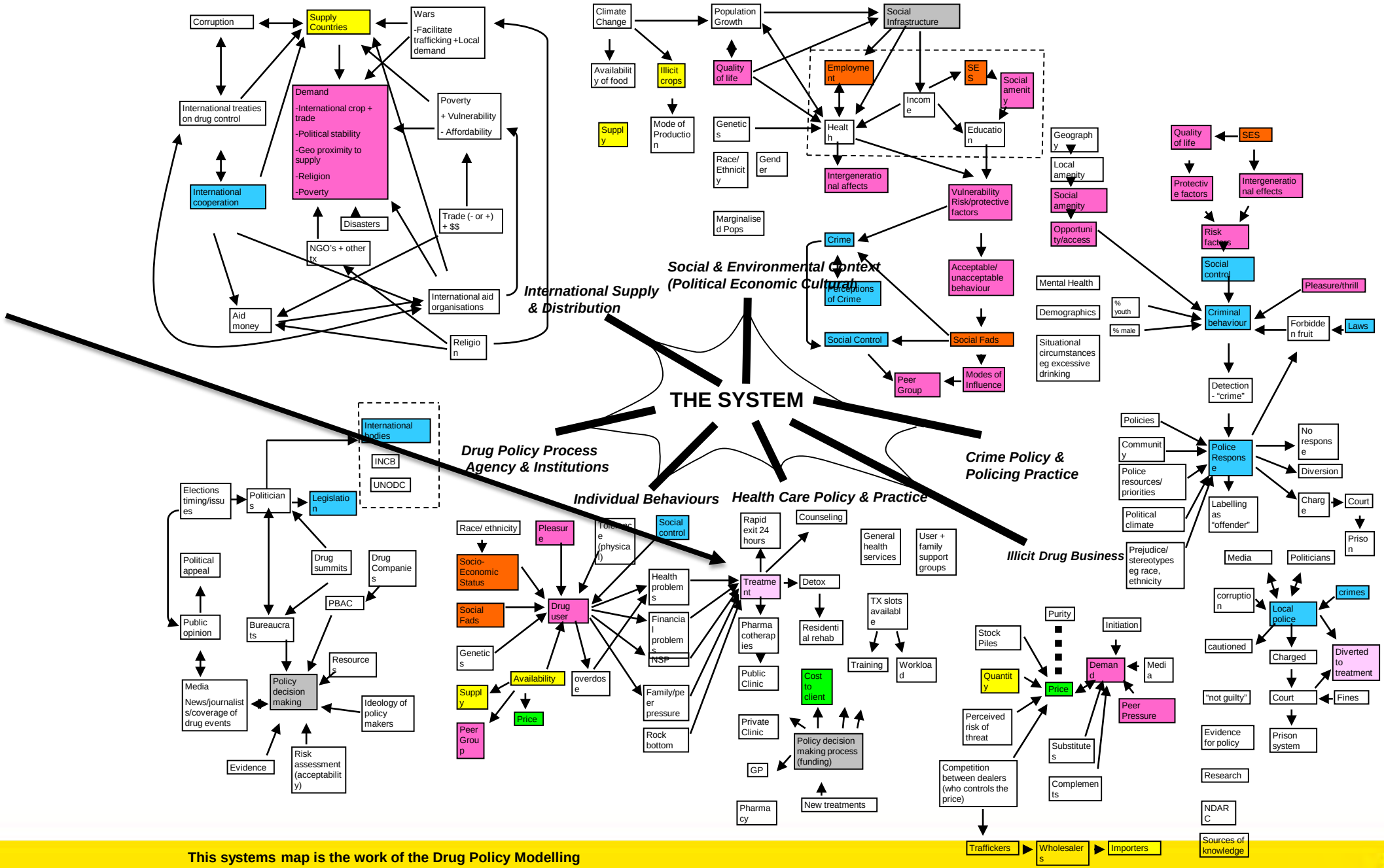
USA: DHS for Greene County, Pennsylvania





Even bigger systems diagram…..

- Legal framework
- Availability and access to substances (alcohol regulations, black market)
- Socio-political context



This systems map is the work of the Drug Policy Modelling Program (DPMP) and is a work-in-progress! http://www.dpmp.unsw.edu.au

UNSW SYDNEY

OK, so we are not going to get a systems picture easily…..

- “setting the cat among the pigeons”

- “[you could] illustrate the AOD sector as like an octopus – there is a core/central aim of the AOD treatment sector (head), however approaches, interventions, programs, funding, patient pathways come from all different directions (tentacles)”

- Even if we could draw it, would we agree on what needs to be in it?
- Some sticking points…..

Sticking points…

1. Defining what's in scope for "treatment"
2. Specialist system
3. Mental health
4. Social welfare needs
5. Workforce
6. Funding, funding streams, funding processes
7. Participation in design

- Many of the above are inter-related
- Others as well (not enough time):
  - Criminal justice system
  - Competing interests
  - Policy frameworks and policy context
  - Changing epi of drug use and harms

Defining what's in scope for "treatment"

- Specific AOD treatment interventions:
  - Withdrawal
  - Counselling (MI, RP etc)
  - Residential rehabilitation
  - Pharmacotherapies
- Case management and care coordination
- Screening and brief interventions: focus on early intervention
- Harm reduction: NSP, naloxone, SCS etc
- Self-help (49.8% for alcohol: Mellor et al., 2021)

- **Where are the boundaries to "AOD treatment"?**

Mellor, R., Lancaster, K. & Ritter, A. (2021) Examining untreated and treated alcohol problem resolution in an Australian online survey sample. *Drug and Alcohol Review* http://doi.org/10.1111/dar.13257

Specialist system?

- Agreement that it's a specialist treatment system
- BUT
  - Mostly AOD treatment does not operate as a specialist system (eg referral and discharge summaries)
  - Commissioning & purchasing models are social-welfare
  - Funding levels are more similar to social-welfare
  - Workforce approximates social-welfare
- AND
  - Not all AOD treatment is specialist, eg SBI
  - Not all AOD treatment is provided in specialist settings (eg OAT)

- **How to reconcile with being a "specialist system"?**

Ritter, A. & van de Ven, K. (2019). Alcohol and other drug treatment commissioning and purchasing: Is it health care or social-welfare? *Drug and Alcohol Review, 38,* 119-122. doi: 10.1111/dar.12871

Mental Health

- We all know the stats:
  - General population: 14% to 28% dual diagnosis
  - MH treatment services: 11% to 71% have AOD dx
  - AOD treatment services: 70% to 90% have MH dx
- Different populations? (Lee & Allsop, 2020): MH services treat severe MH; AOD services treat a different population (depression, anxiety, PTSD, personality disorders)
- But shifts in MH system (beyond acute) to “missing middle” (RCVMHS)
- Integrated, sequential, or parallel treatment models (evidence equivocal)

- **Is treating someone’s mental health problem part of AOD treatment?**

Lee, N. and Allsop, S. (2020) Exploring the place of alcohol and other drug services in a successful mental health system. Melbourne: 360Edge.

Social welfare needs

- Person-centred AOD treatment responds to the needs of the client
- Housing, legal aid, FDV, employment….
- Likely to be the things that matter to recovery

- Specialist AOD treatment ~ meeting social welfare needs
- Role of ‘coordination’ between systems of care and support
- Funding for ‘coordination’: at client level, at service level, at system level

- **Does being holistic and person-centred mean responding to all needs?**

Workforce

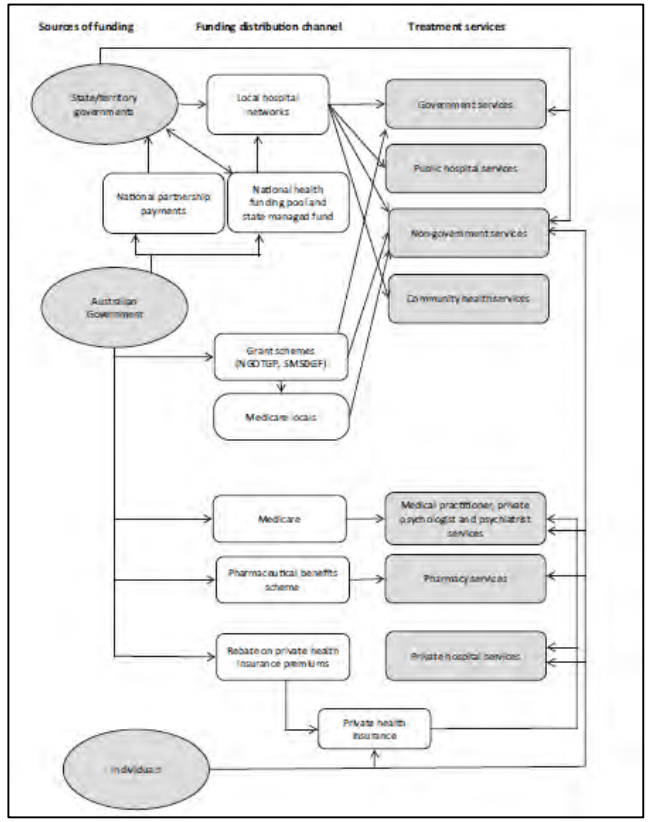
- Aside from the obvious – to attract, retain skilled workforce
- Multidisciplinary teams
  - Psychologists, social workers etc
  - Medico's, nurses
  - AOD workers
  - Peer workers
  - Other?
- Links back (again) to what the system should be, to be:
  - Coordinated
  - Person-centred
  - Holistic

- **Given loose system boundaries, what kind of workforce do we need?**

Funding, funding streams, funding processes

Funding centrally connects with a “person-centred, holistic and coordinated AOD treatment system”

- Funding amounts: completely inadequate
  - Connects to what is in and out of the system
  - How well the system functions as a system vs a good system poorly resourced
- Funding streams:
  - The funding diagram = “bowl of spaghetti that the dog got at”
  - Lack of harmonisation between funders
  - No shared processes
- Commissioning: competitive tendering, contracting, performance monitoring…



Chalmers, J., Ritter, A., Berends, L. & Lancaster, K. (2016) Following the money: mapping the sources and funding flows of alcohol and other drug treatment in Australia. *Drug and Alcohol Review*, 35(3), 255-262. DOI: 10.1111/dar.12337

Participation in design

- Sticking points – ouch, ouch, ouch
- No right answers (no wrong answers)
- Differences of opinions, perspective, worldviews

- Participation in design
  - Multiple voices
  - Tolerance for ambiguity

- Opportunities for participation
  - VAADA project: service system design (Jan-Jun 2023)
  - V-DASPM project (Jan-Oct 2023)

Conclusions

- A coordinated, person-centred, holistic “treatment service system”: pipe dream or within grasp?

- Pipe dream?
  - Complex system, without clear boundaries, multiple dimensions
  - Many sticking points
  - No consensus (and we can’t draw it!)

- Within grasp?
  - Appetite and willingness to think through the complexities
  - Ability to tolerate ambiguity
  - Look after clients (providing what is needed, when its needed), with care and compassion

Thank you

Professor Alison Ritter
Drug Policy Modelling Program, Director
Social Policy Research Centre
UNSW, Sydney, NSW, 2052, Australia

E: alison.ritter@unsw.edu.au
T: + 61 (2) 9385 0236

Website: http://bit.ly/sprc-dpmp

Book

Drug Policy

By Alison Ritter

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Pages	188
eBook ISBN	9781003224501

Royal Commission Vic MH

Recommendation 35: Improving outcomes for people living with mental illness and substance use or addiction

- The Royal Commission recommends that the Victorian Government:

  1. by the end of 2022, in addition to ensuring there is at least one highest-level emergency department suitable for mental health and alcohol and other drug treatment in every region (refer to recommendations 3(3) and 8(3)(c)), ensure that all mental health and wellbeing services, across all age-based systems, including crisis services, community-based services and bed-based services:
     - a. provide integrated treatment, care and support to people living with mental illness and substance use or addiction; and
     - b. do not exclude consumers living with substance use or addiction from accessing treatment, care and support.