Reforming treatment system bias

Understanding treatment bias through secondary data analysis

Shifting Landscapes: VAADA 2023

Implicit bias in treatment

Implicit bias… bias that sits outside conscious awareness…

Implicit bias can influence judgement & unintentionally contribute to discriminatory behaviour (Sabin, 2022)

Questions for consideration

Do we see our treatment system clearly?

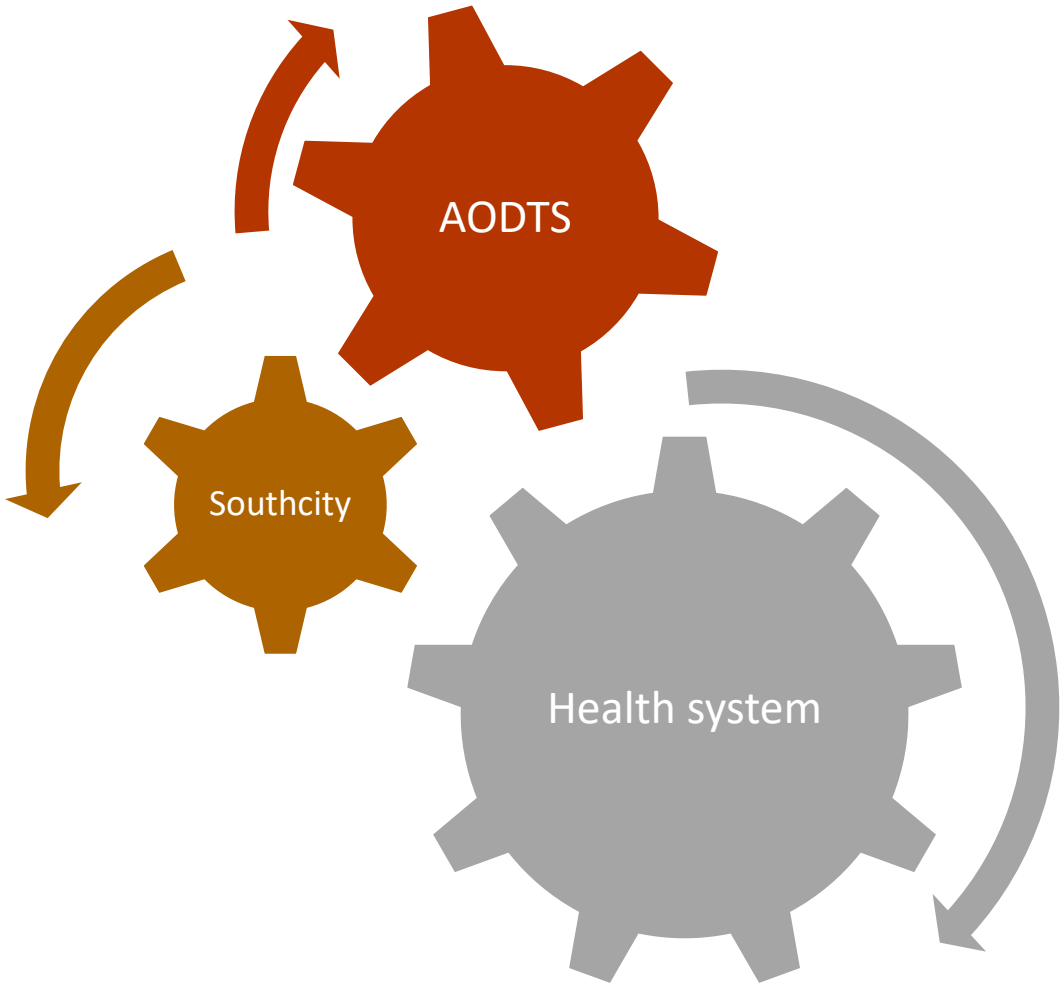
Are we focused on what we already do, instead of what we could, or should do?

Are we too busy recovering from reforms to CQI?

If we focused on data, would the system look different?

Southcity Clinic

- Publicly funded
- AMAH auspiced since 2017
- Sits between community AOD, general practice & tertiary care
- Non-typical substance using cohorts
- Navigation, linkage & referral



Southcity Clinic SPS

4.12.2 Specialist pharmacotherapy services

Specialist pharmacotherapy services provide a consultative service to community-based pharmacotherapy prescribers seeking expert opinion about the management of patients with complex issues. Prescribers may also refer complex clients to receive secondary consultations at these services. Five specialist pharmacotherapy services are located through metropolitan Melbourne, however the service is open to all eligible Victorians.

4.12.2.1 Purpose

To support pharmacotherapy providers to provide services to clients with complex psychosocial needs and drug dependencies.

4.12.2.2 Target group

The target client group is adults and young people on a program whose needs cannot be met solely by their regular pharmacotherapy prescriber. These include clients with:

Southcity AMAH Integration journey

Referrals from across psychiatry

- In-reach into inpatient psychiatric units
- In-reach to Monash SECU
- Referrals from community, CATT, CYMHS, aged, pain, ABI, other AMHS
- Primary & secondary consultations, shared care

Referrals from medical services

- In-reach to medical wards (ADLOW)
- Gastro ++
- HIV liaison
- MSHC
- Consultation Liaison-Addictions

Brief harm reduction interventions

Treatment planning & negotiating complex admissions

SSDTA coordination

Vic AOD treatment data

1. Too much treatment
2. Not enough treatment
3. Can’t get treatment

1. Too much treatment

- Multiple treatments often required before individuals maintain recovery (Kelly, 2019; Li, 2010).
- Treatment “journeys”: cumulative, stage-dependent learning (Kelly, 2019; Li, 2010; Manning, 2017).
- Treatment repeaters trending towards recovery
- Treatment repeaters not responding... the “frequent fliers”

AIHW: local patterns of service use

3 cohorts:

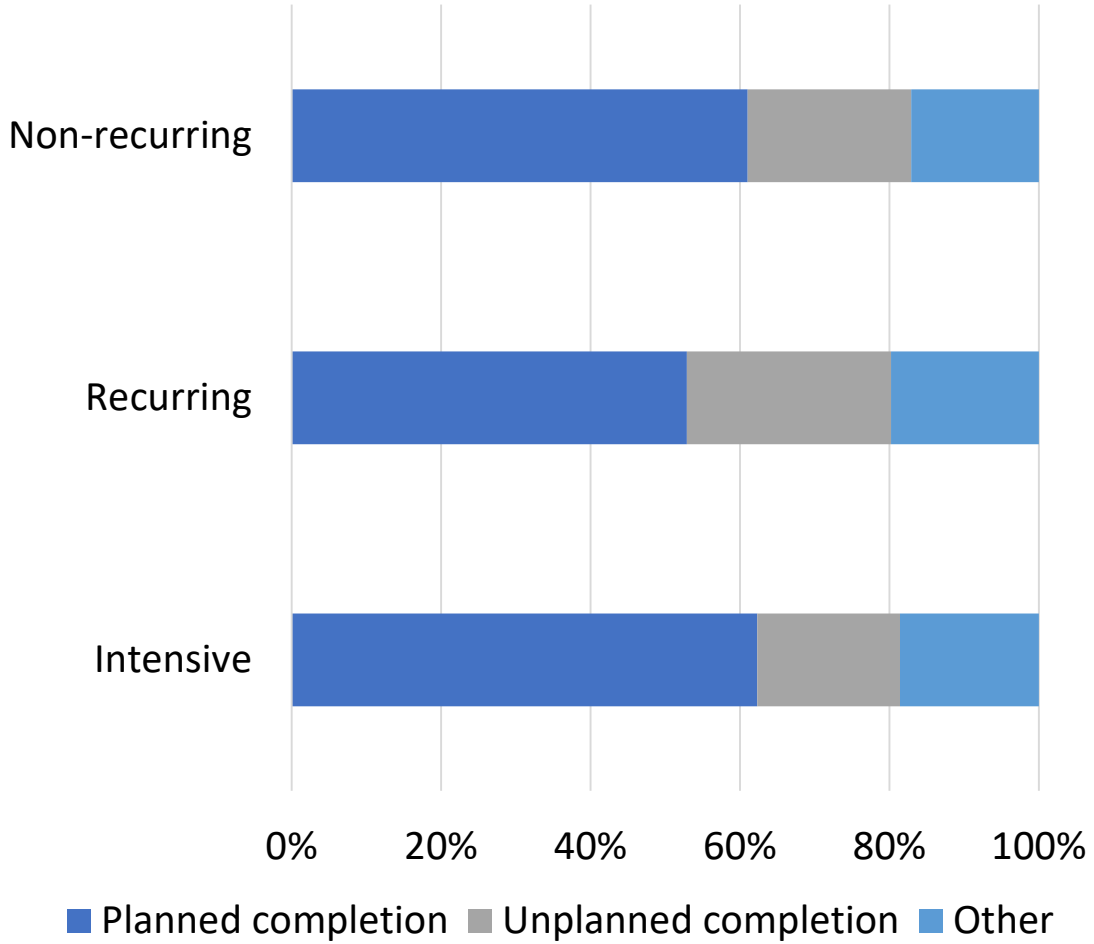
- non-recurring treatment (90%)

  treatment in less than 3 years
- recurring treatment (6.8%)

  < 7 closed episodes across at least 3 years
- intensive treatment (3.2%)

  7+ closed episodes across at least 3 years

Intensive treatment cohort

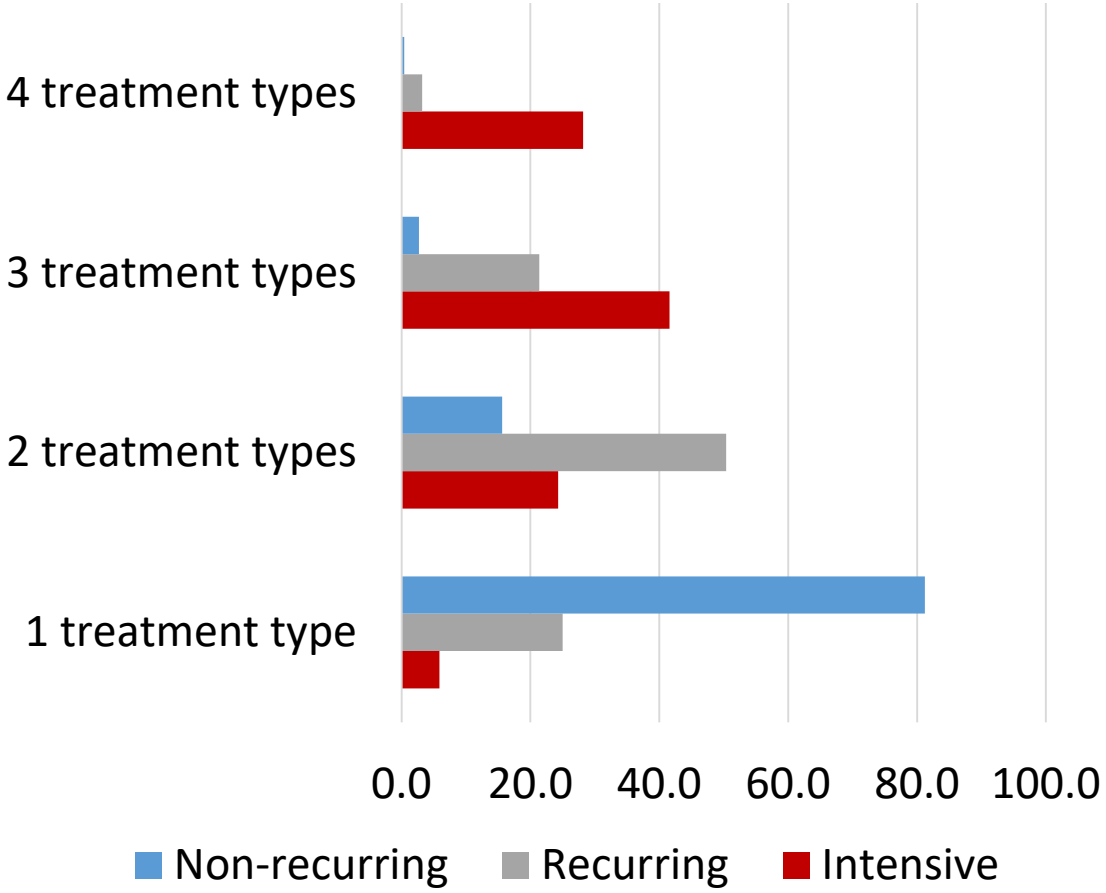


Intensive cohort =

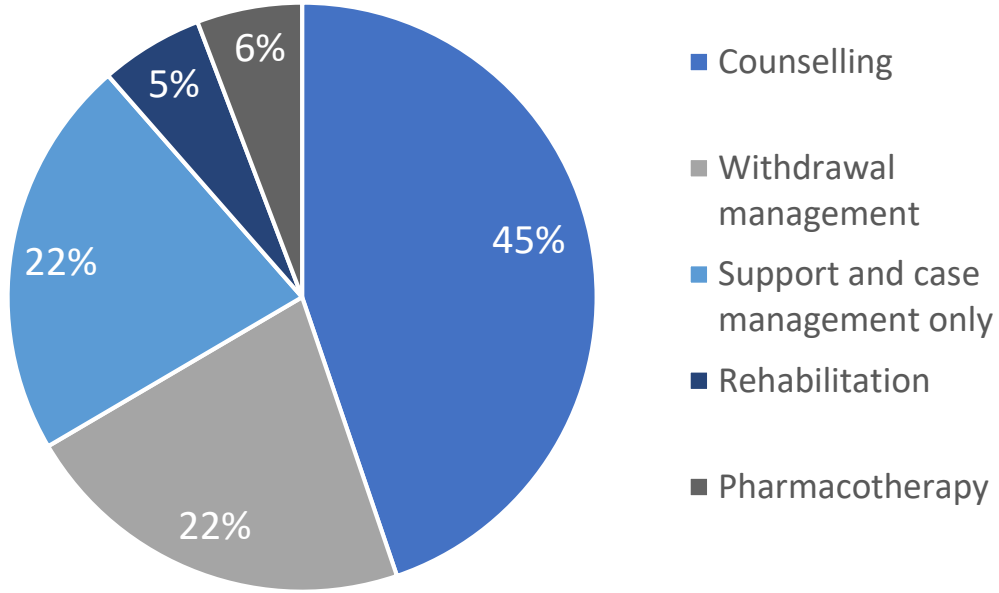
- 3.2% of clients
- 16% of episodes
- 60% planned completion
- Multiple combinations of treatment types
- Commonly alcohol +
- 10+ episodes/year (801 ppl Vic)
- 5+ agencies/year (805 ppl Vic)

Proportion of episodes by reason for cessation and treatment received, all episodes, 2014/15 to 2018/19

Proportion of clients by number of main treatment types and treatment received, 2014–15 to 2018–19 (per cent)



Clients who received treatment services in each year 2014-15 to 2018-19 by main treatment type, Vic (minus assessment)



Treatment outcomes research:

- Earlier, longer & more stable treatment: better outcomes
- Retention & completion: better outcomes
- Disjointed, interrupted and frequent treatment: worse outcomes

(Hser, 2004; Manning, 2017, 2019; Marel, 2019; McKetin, 2012, 2018).

What does it mean if our intensive treatment cohort is completing treatment?

What does it mean if the PDOC amongst the intensive cohort is alcohol?

Intensive treatment & alcohol use

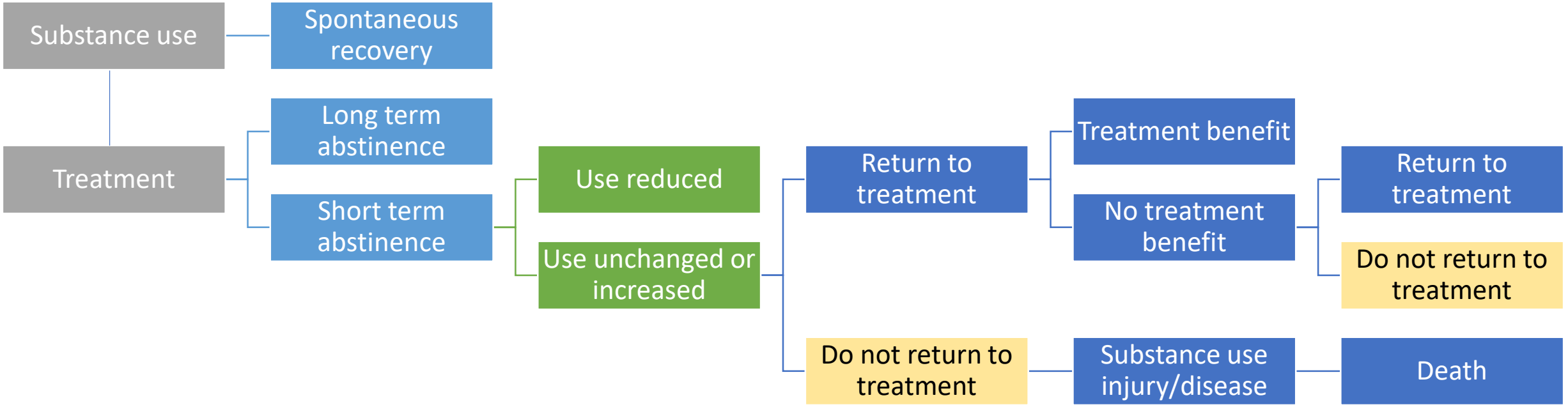
Risk factors for alcohol related brain injury:

- 40 y.o. +
- 10 yrs heavy alcohol
- Poor nutrition
- Multiple medical detoxes

Executive function disturbances

- Difficulties planning, organising, problem solving
- Difficulties with practical goal setting
- Difficulties coping with changes, even small changes in normal routines
- Difficulties learning new information, procedures, or instructions.
- Difficulties with abstract thinking i.e. consequential thinking
- Rigid ‘concrete thinking’, rigid, repetitive behaviour patterns

Substance use & treatment careers

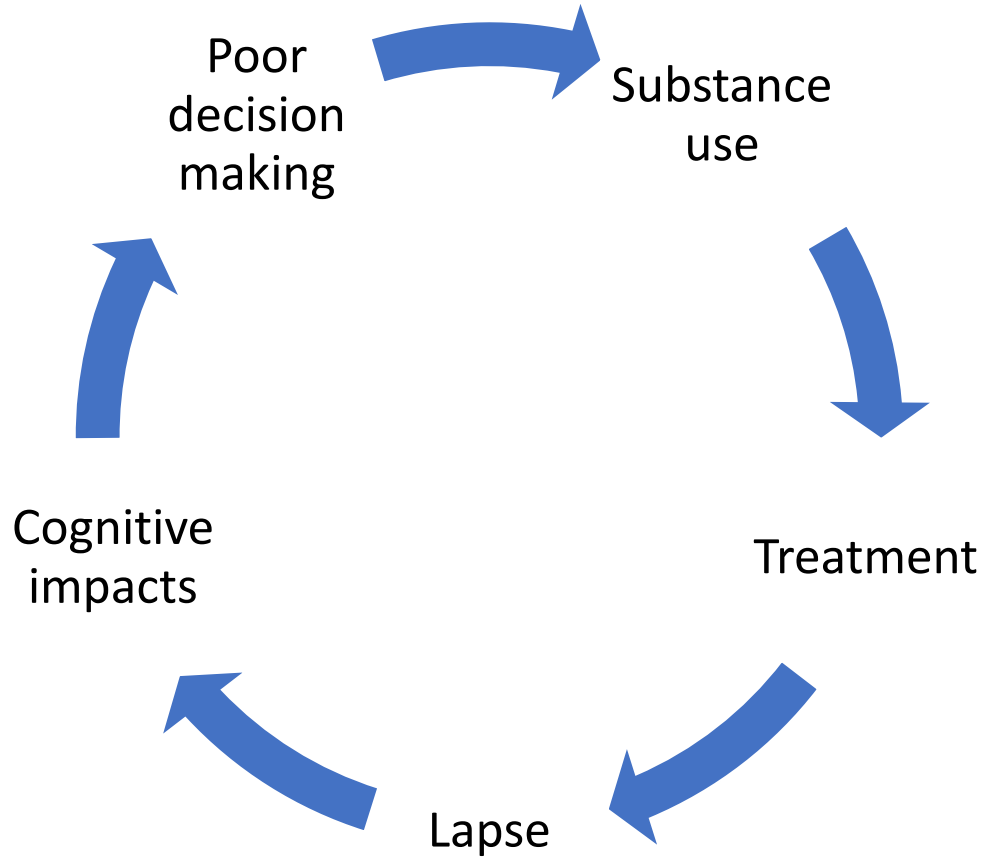


Treatment harms: risk v benefit

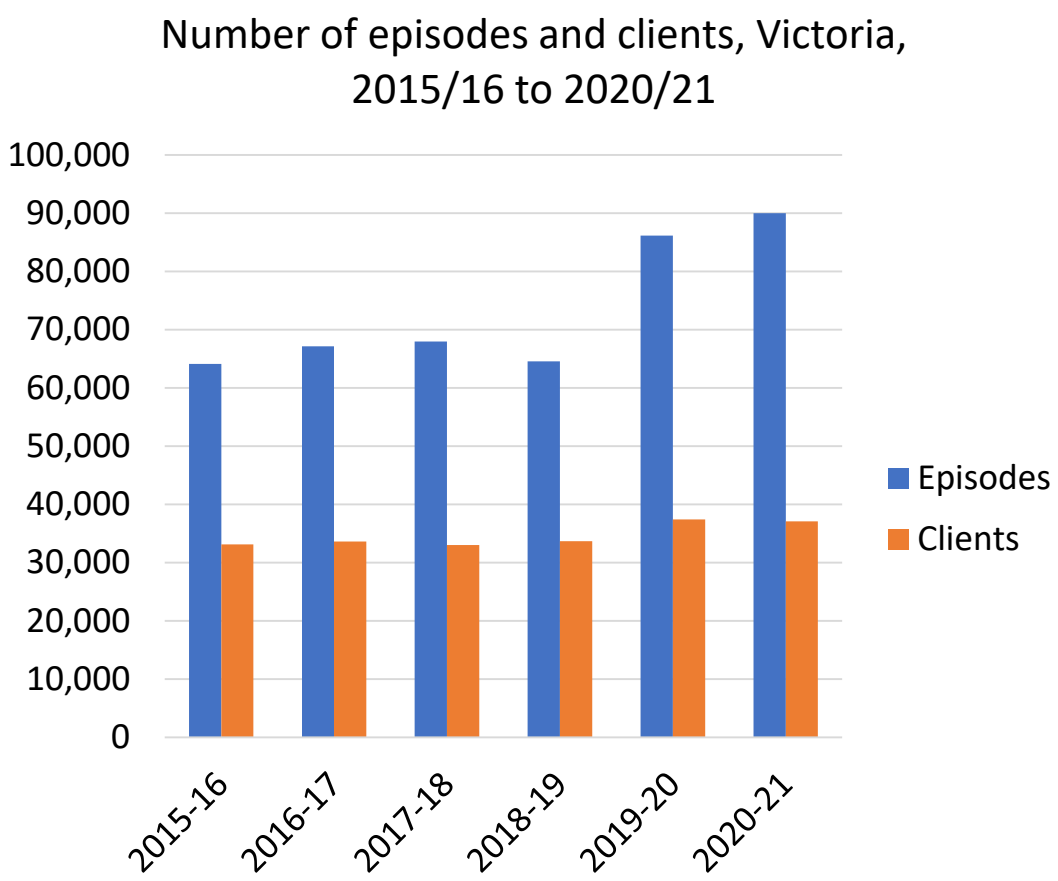
Containment vs likelihood of post treatment lapse

- Increasing withdrawal severity
- Overdose (fatal & non fatal)
- Psychosis
- Cognitive impacts
- Social & emotional impacts…
  - Motivation, enthusiasm & hope (suicide)
  - Treatment ‘immunity’
- Cohort & staff morale
- Impact on recovery capital

(Kelly, 2019; Laudet & White, 2008)



2. Not enough treatment



How do we know who's NOT coming?

Population level data

- Hospital separations ✓
- Ambulance call out data ✓
- Wastewater analysis ✓
- Deaths ✓
- SSDTA
- Exclusions (declined referrals)

Hospital separations x AOD episodes

AIHW Admitted patients

Why did people receive care?

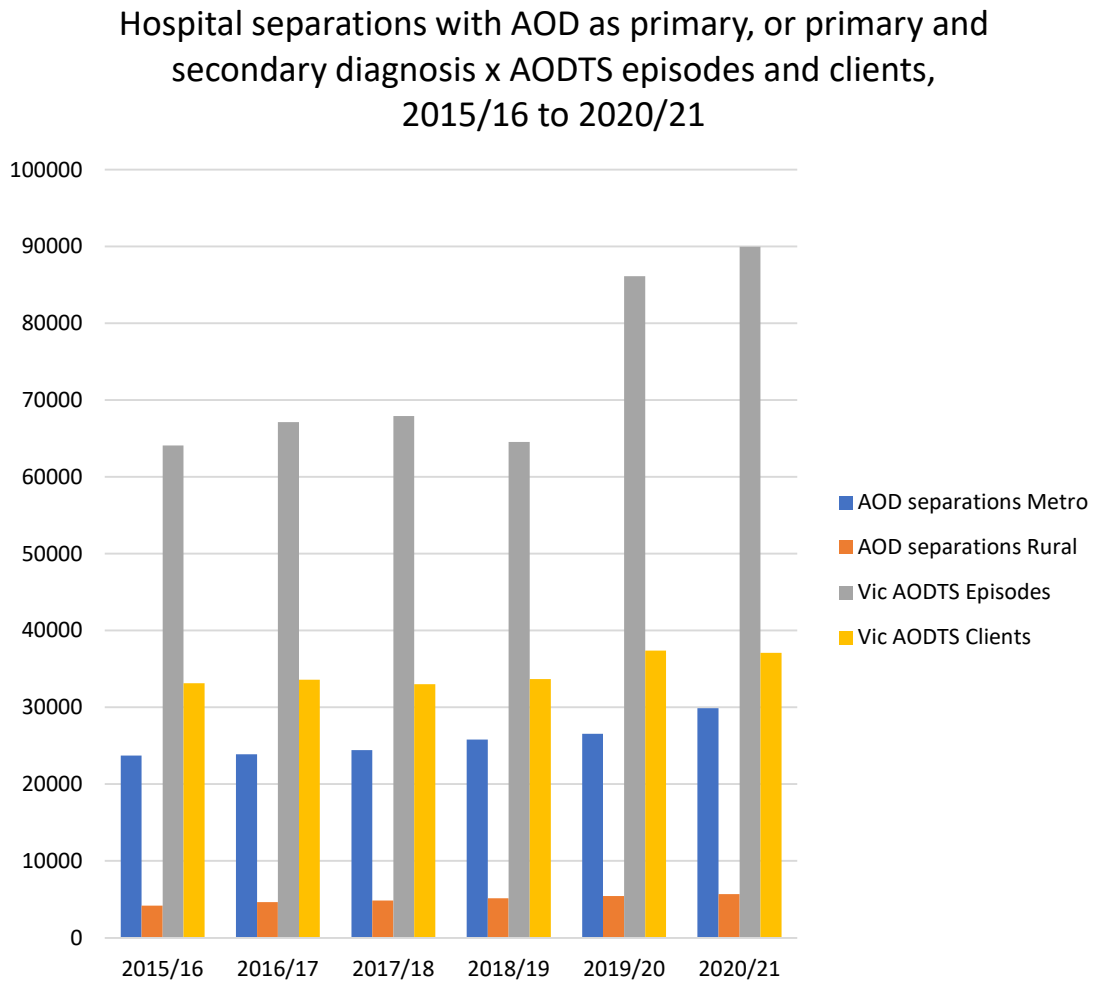
- Minus secondary AOD diagnoses
- Minus ED

AIHW AODTS annual report

State and territory summaries, Vic, 2022

- Episodes includes assessments

How do we know if we overlap?



Ambulance attendances, by selected drugs, months, Victoria, 2015 to 2021

AIHW interactive data/AOD related ambulance attendances, 2023

Range over 6 years

~ 80-150 opioid analgesics

~ 150-350 heroin

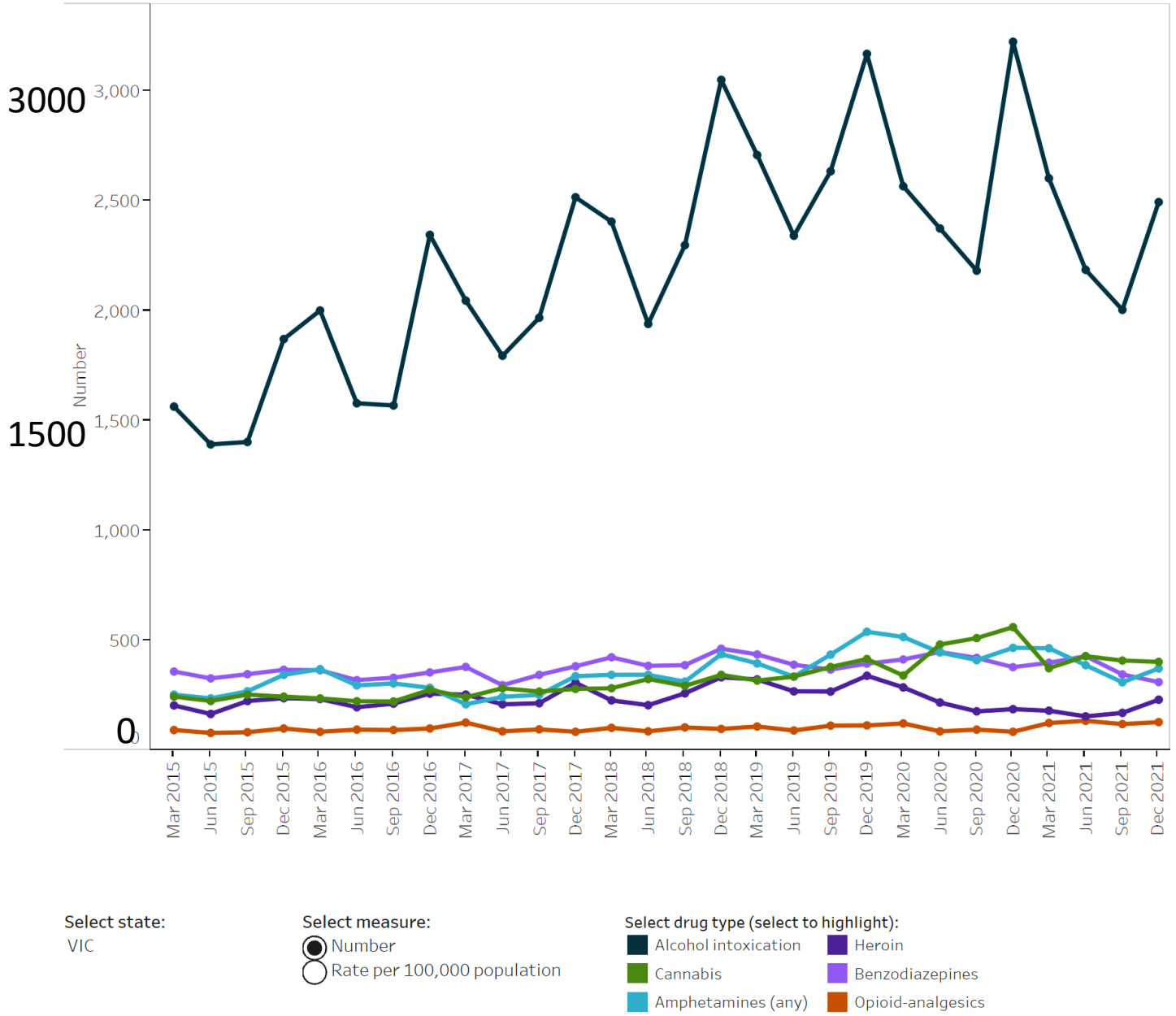
~ 350-460 benzos

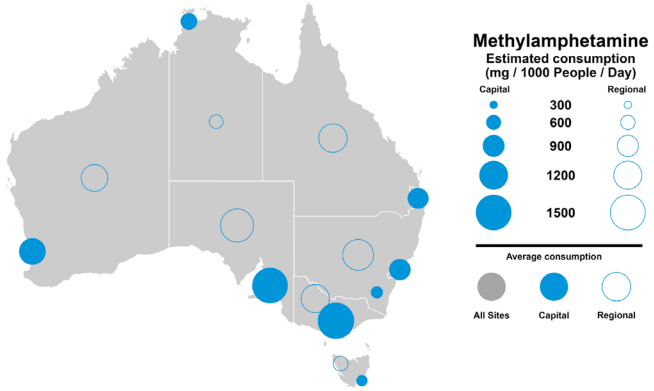
~ 240-560 cannabis

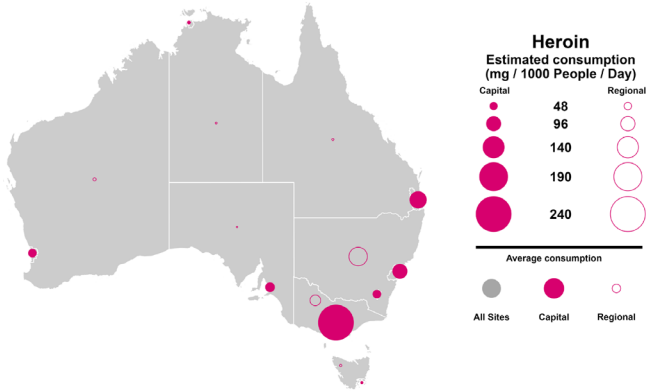
~ 250-540 amphetamines

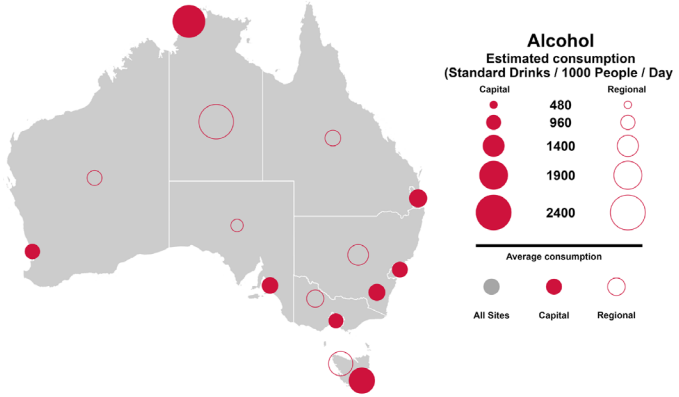
~ 1,391-3,222 alcohol intoxication

How do we know if we overlap?









Wastewater analysis

Melbourne:

- Highest methylamphetamine, heroin and ketamine,
- Second highest cocaine

Regional Victoria:

- Highest ketamine
- Second highest heroin and oxycodone

(ACIC National Wastewater Drug Monitoring Program #17)

Less heroin users in treatment

Blame pharmo?

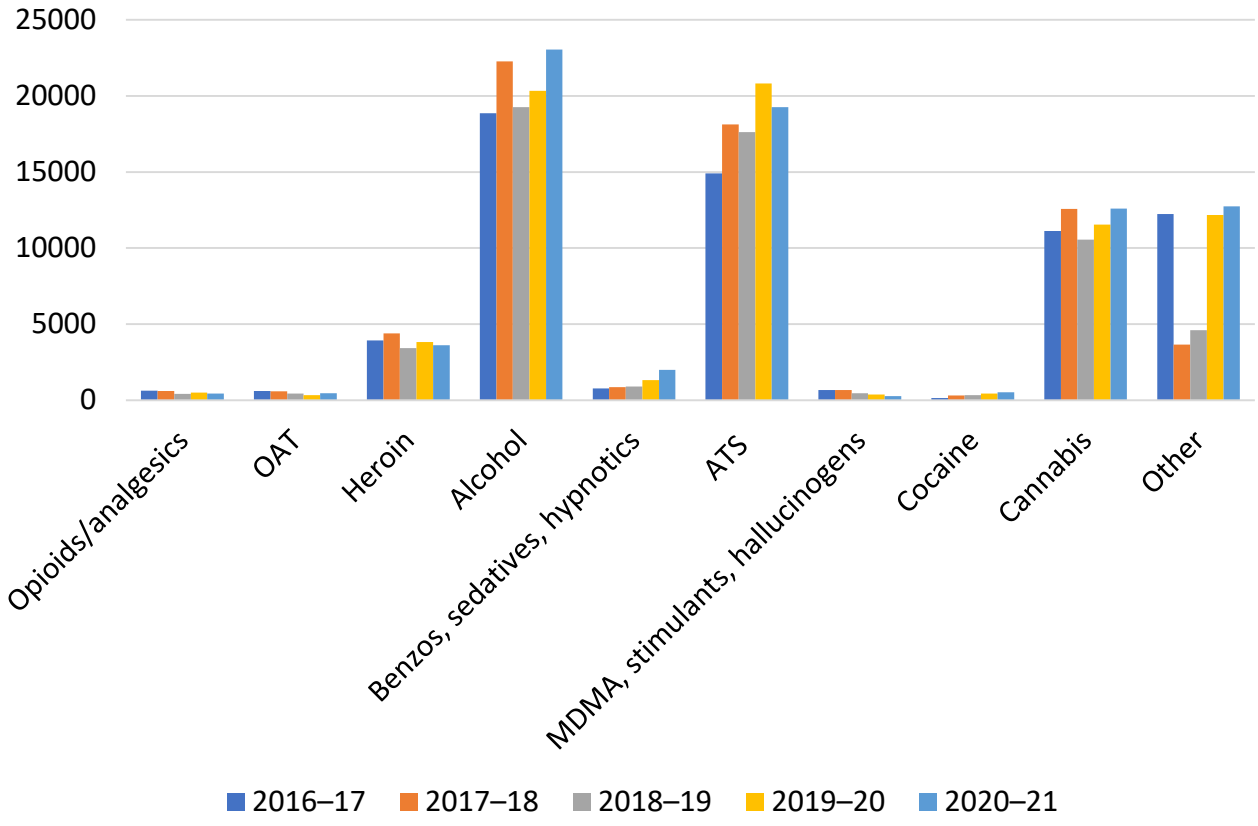
- OAT levels stable

Admission requirements for opioid users

Ppl who don't want pharmo

- *Cost, inconvenience, trade one addiction for another etc*

Table Drg.1: Closed treatment episodes for own drug use, by principal drug of concern, states and territories, 2016-17 to 2020–21



**other includes NOS*

2023 Prescriber crisis

Wastewater: ↑ heroin

2019-23 prescriber exodus

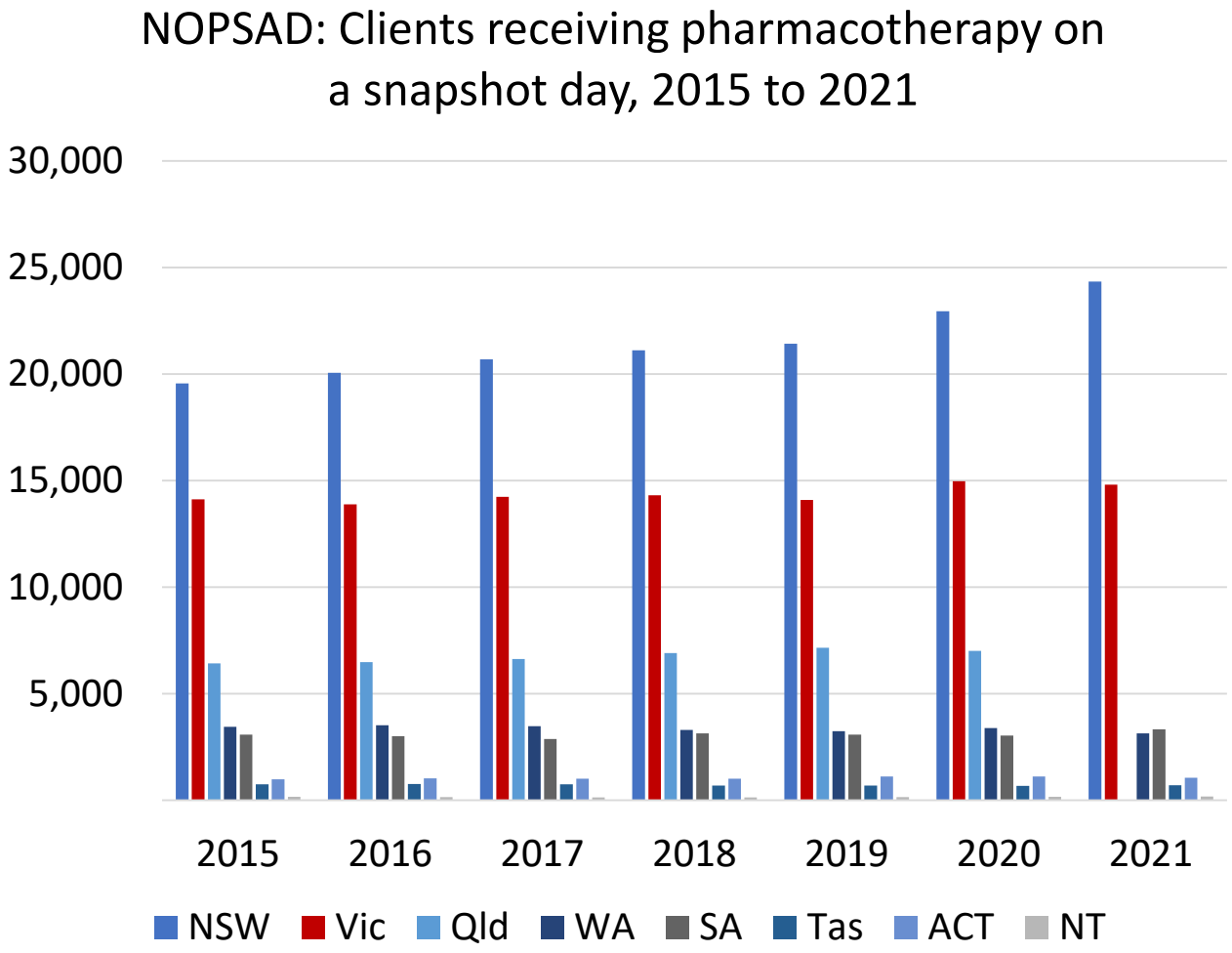
↓ bulk billing Drs

↑ evidence of market forces

cherry picking, price gouging

GP prescribers: poorly integrated with AODTS

Medical lens on treatment



Public drunkenness data

41,347 offences (2014 to 19)

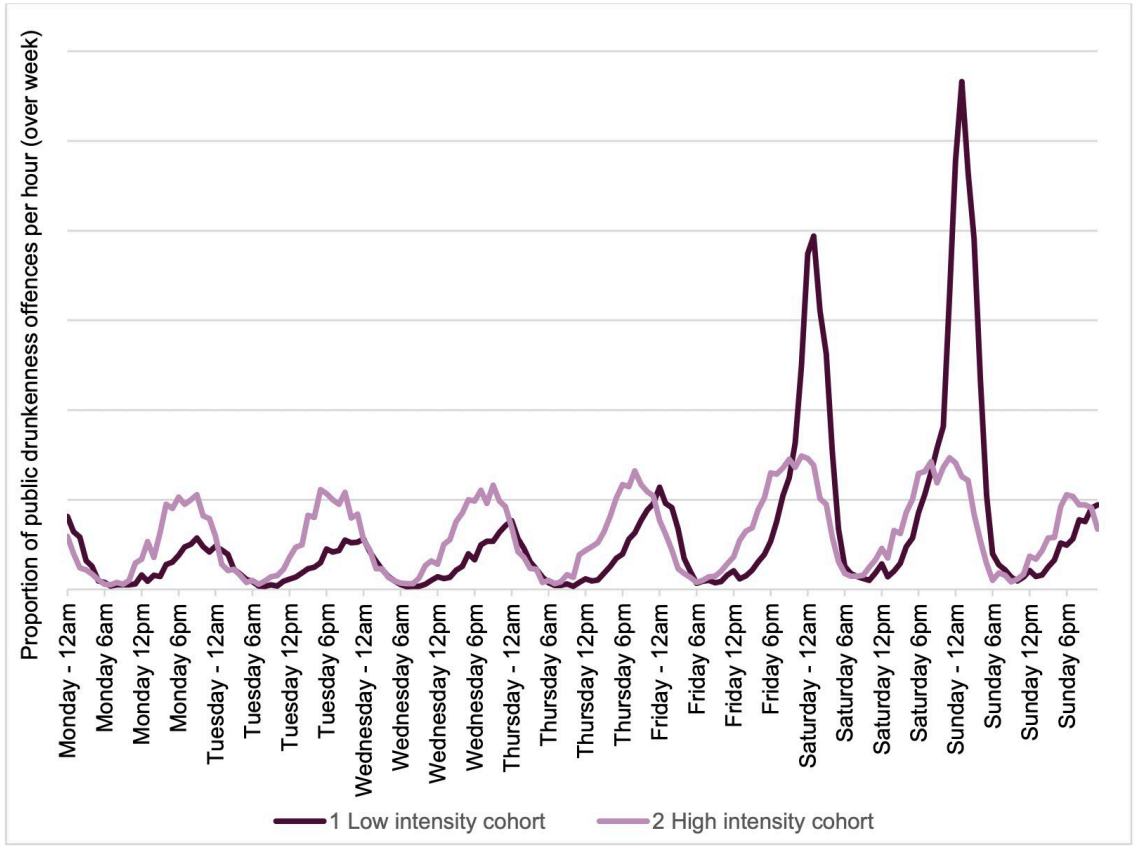
Low intensity cohort (LI)

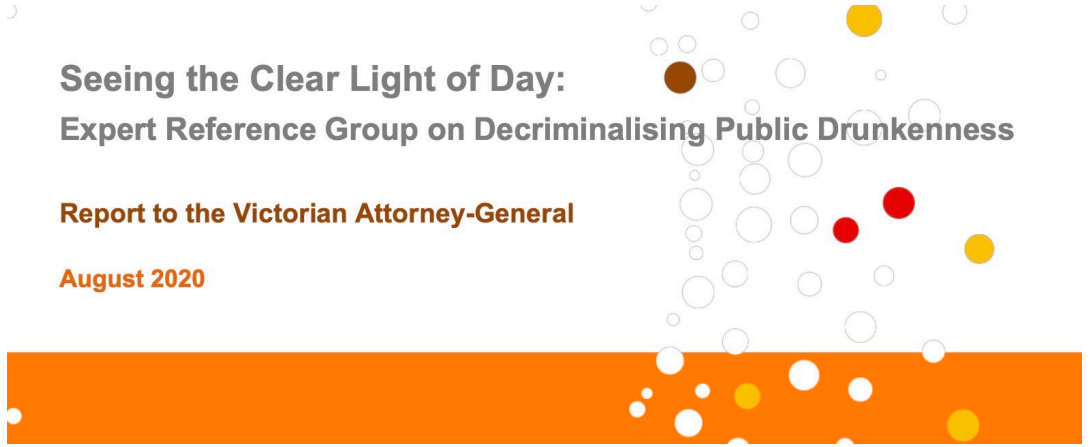
- 93.5% offenders, 74% offences. 84% one offence only
- 17% homelessness services, 12% AODTS, 39% ED presentations

High intensity cohort (HI)

- 6.5% offenders, 26% of all offences
- 46% used homelessness services, 30% AODTS, 72% ED presentations
- 70% of this cohort did NOT use AODTS (despite ~ 24/7 drinking)

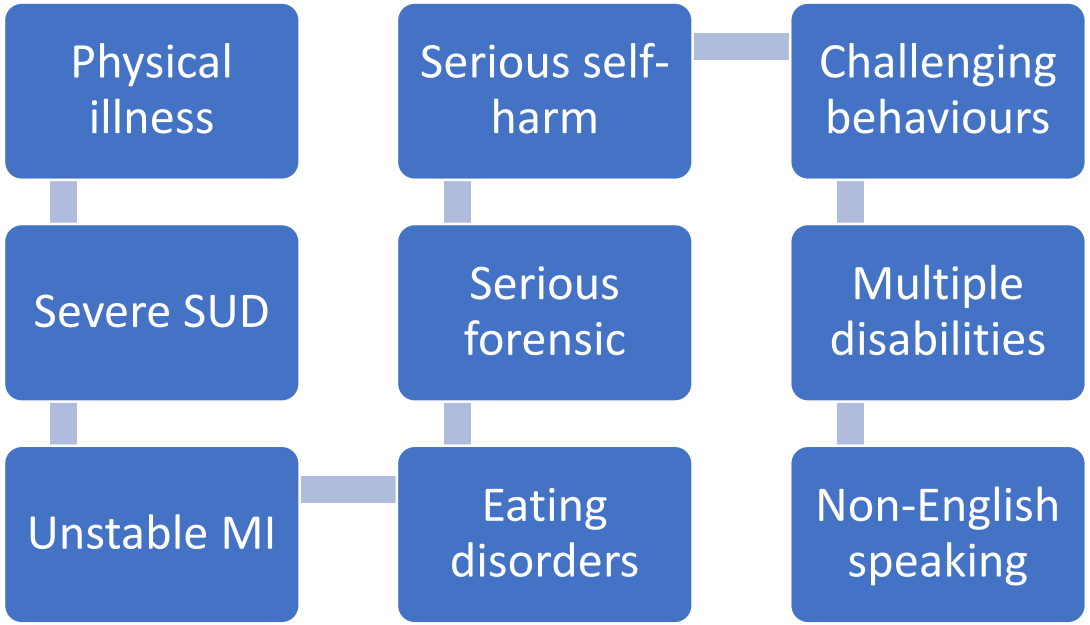
Figure 2: Hourly number of public drunkenness offences for each day of the week, by intensity cohort





3. Can’t get treatment

Can’t get into treatment



Can’t stay in treatment

Mutually reinforcing factors:

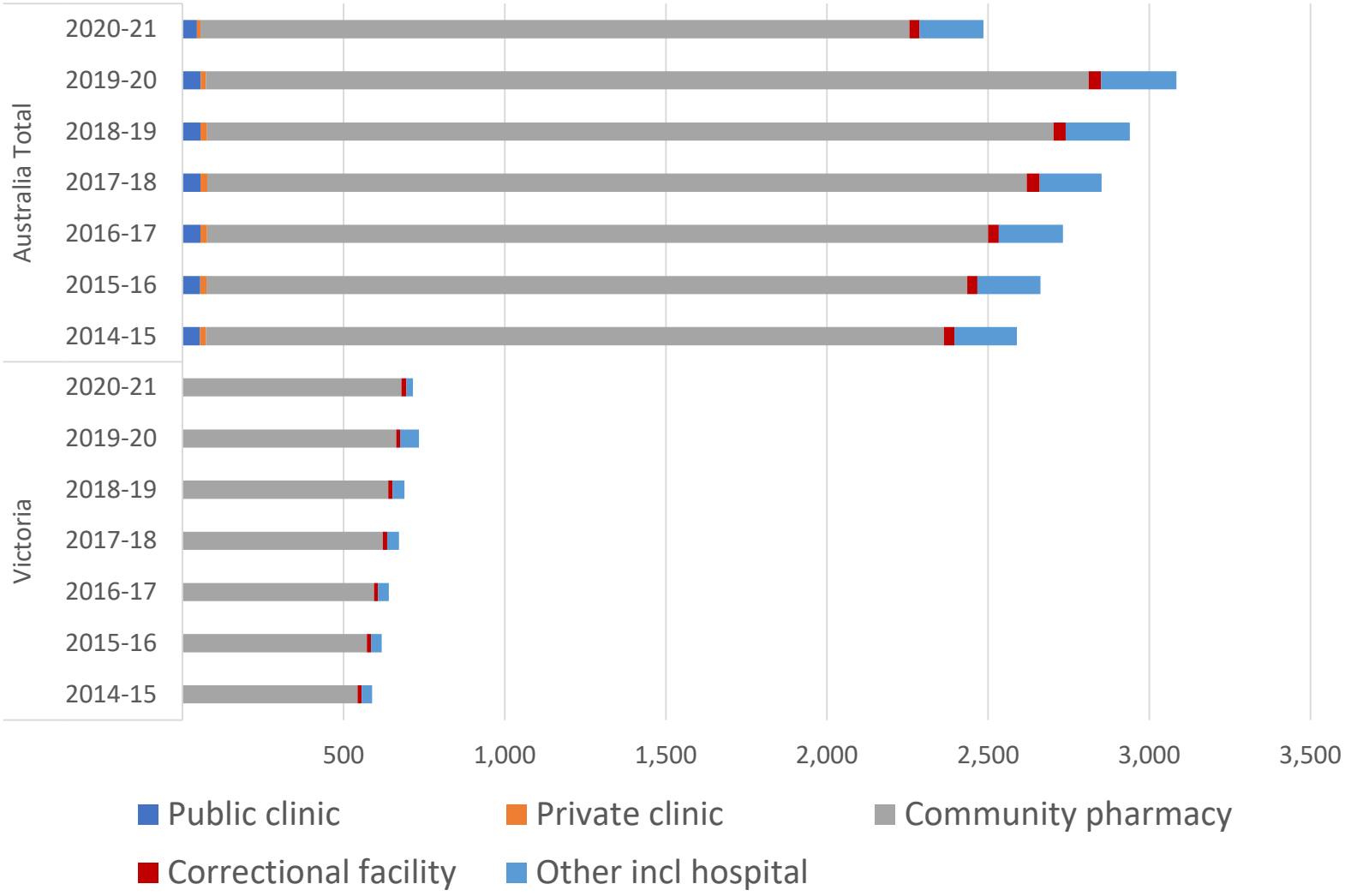
- Personality & affective style
- Life experiences
- Substance, pattern & duration of use
- Cognitive functioning
  - *Problem solving style*
  - *Impulse control*

Can’t get dosed

~ 93% dispensing in community pharmacies…

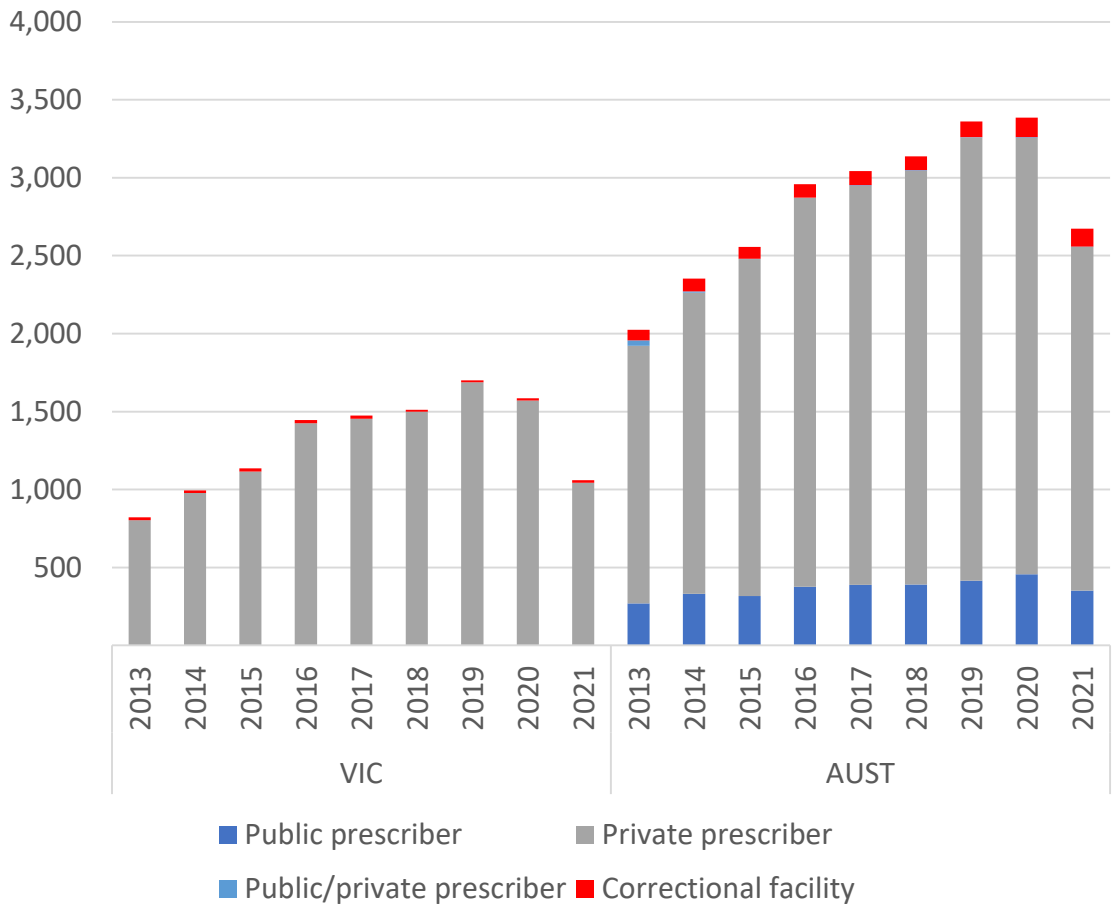
~ 7% in hospital or prison.

- Limited system capacity for HR focused prescribing
- Limited system capacity for managing challenging behaviours

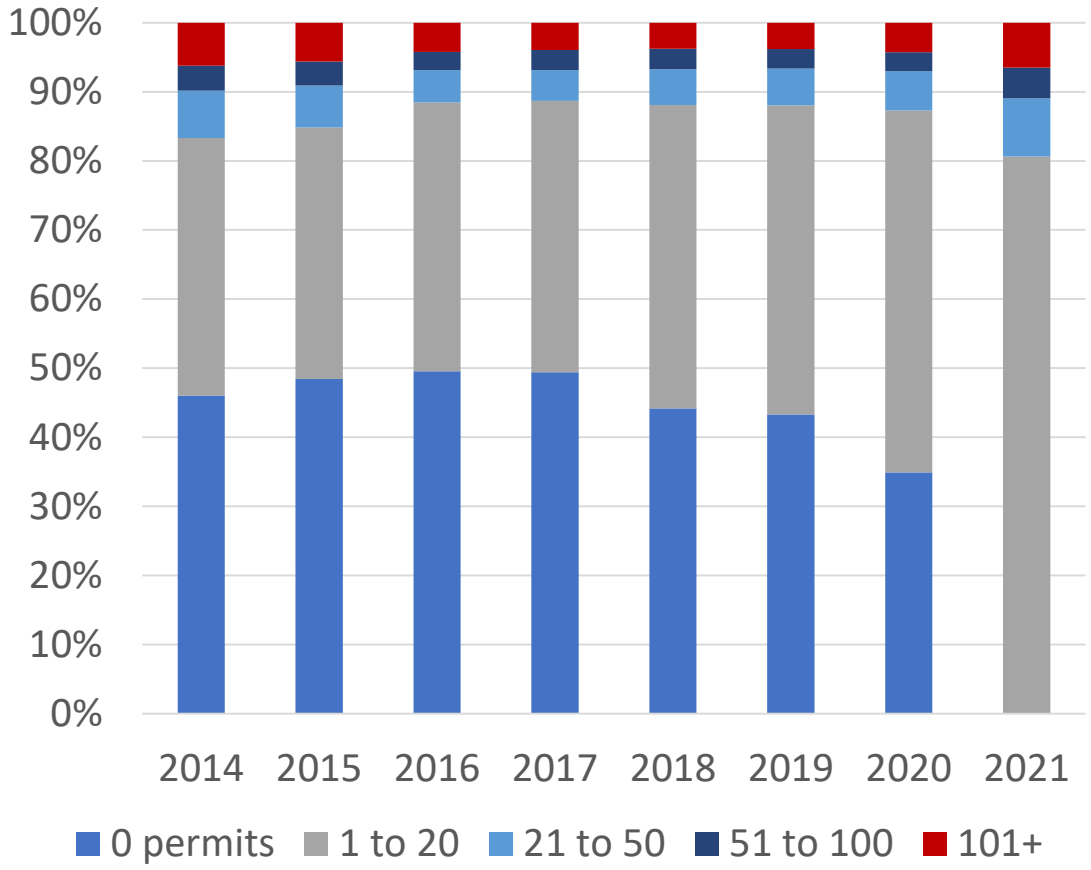


Adapted from NOPSAD 2021: Dosing point sites, states and territories, 2005–06 to 2020–21

AIHW NOPSAD 2021 (prescriber type, Vic, 2013-2021)



AIHW NOPSAD 2021: clients/prescriber, Vic



On the cusp of reform

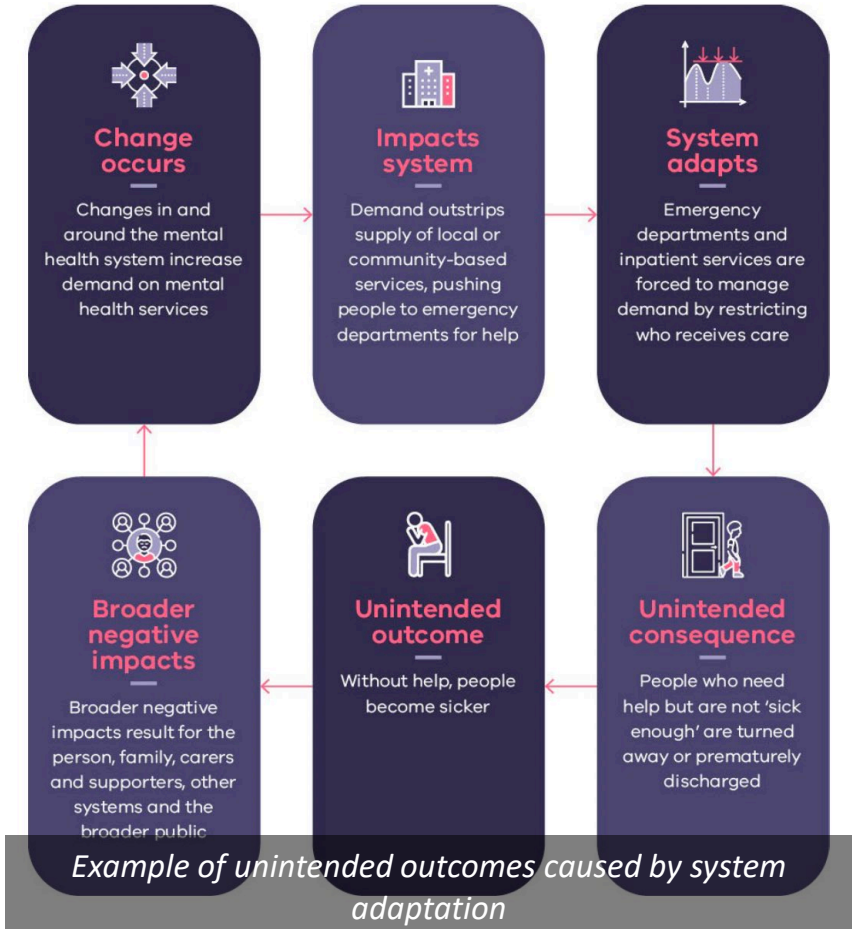
What we already know about reform…

- Resource intensive
- Reactive
- Destabilising
- Located in time…

Today's reform solves yesterday's problems, and

Today's reform creates tomorrow's problems

Implementation task v. mindset?



Example of unintended outcomes caused by system adaptation

RCVMHS Vol 1: complex systems

- MH (& AOD) is a complex system
- CS can self-organise, learn and evolve.
- CS can develop new emergent features, functions or purposes that can improve or erode it.
- Changes can produce unintended consequences
- Intervention disrupts system learning

Reform mindset

- A mind-set that allows creative, adaptive feedback loops and system learning
- It acknowledges the need for iteration and development
- And works to prevent the failures that necessitate reform.

Overcoming the “soft bigotry of low expectations”

- Purposeful data collection & reporting
  - Quantify service overlap…
    - AOD self-complete: *Have you been attended to by an ambulance or been in hospital?*
    - AOD comp: *Hospitalisations/ED presentations related to AOD use*
    - *# clients on CTOs*
  - Declined referral data
- Treatment optimisation & effectiveness research.
    - Data linkage: *AOD patient pathways ed. 2*
- Data driven service development
- Acknowledge treatment failure as system failure, not client failure

Thanks ☺

gabby.cohen@alfred.org.au

Evolution of AOD policy in Victoria

Major reform followed by incrementalism;

Each phase is a reaction to previous reforms;

Drivers for reform show little variation over time…

- Poor integration,
- Lack of connection with broader health and welfare services

(Ritter et al, 2016)

Table 1. *Summary of the policy reform documents*

Title	Year	Impetus for reform	Major changes
New Directions in Alcohol and Drug Services ('New directions')	1994	• Geographic isolation • Clinical isolation from mainstream health services • Need for cost cutting • Inequities of regional funding and poor regional planning • NGO system small and poorly co-ordinated • International research: outpatient, community-based as cost-effective	• Government no longer a treatment provider (purchaser–provider split) • Regional fund allocations based on planning formulae • New research, training and clinical centre
Victoria's Alcohol and Drug Treatment services: The framework for service delivery ('Framework 1')	1997	• Poor service system co-ordination • Fairer distribution of limited resources and value for money • Comprehensive, accessible and acceptable services • Priority populations: youth; women and children	• A framework for the provision of services with 20 service types (e.g. residential withdrawal, specialist pharmacotherapy services, counselling, outreach). • Standard set of key specifications to support consistent service provision across Victoria • Purchasing policy: funding on a unit cost basis, target groups, key service requirements • Statewide reporting system on client characteristics and treatments received ADIS
A new blueprint for alcohol and other drug treatment services 2009–2013 ('Blueprint')	2008	• 'Fragmentation' • Poor co-ordination between health sectors • Shifting patterns of harmful AOD use • Bureaucratic requirements • Improve quality	• 'Client-centred' • 'Service-focussed' • Simplification of the bureaucratic requirements arising from the 1997 Framework • Six priority areas: prevention, improving access, excellence and quality, clients, children and families and young people. Each area accompanied by detailed plans
New directions for alcohol and drug treatment services: A roadmap ('Roadmap')	2012	• 'Fragmentation' • Poor integration across health • Treatment episodic, limited continuity • Unknown quality of care • Lack of needs based planning • Services under-costed	• New principles for the service system: 'person centred, family inclusive and recovery oriented' • 'Choice' for consumers • Accessible, easy to navigate • Of a high-quality and based on evidence • Integrated early intervention • Responsive and sustainable • Capable and high quality workforce
New directions for alcohol and drug treatment services: A framework for reform ('Framework 2')	2013	• As above	• Detailed implementation plans from the 'Roadmap' • Plan for reform of adult community-based treatment services • Six core treatment types • Recommissioning services for joined up pathways and for quality • Future planning based on needs • New funding model (activity-based funding)

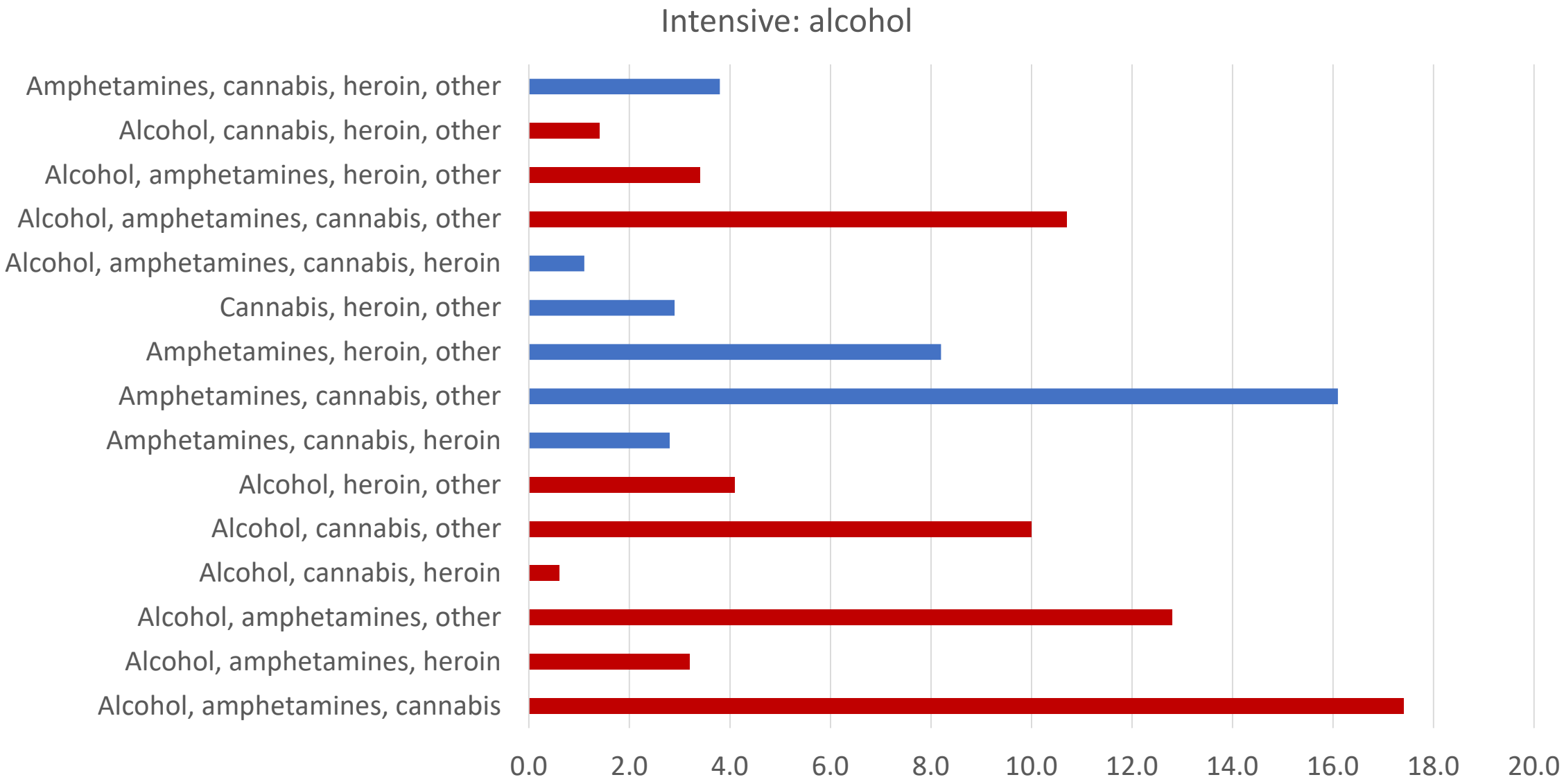
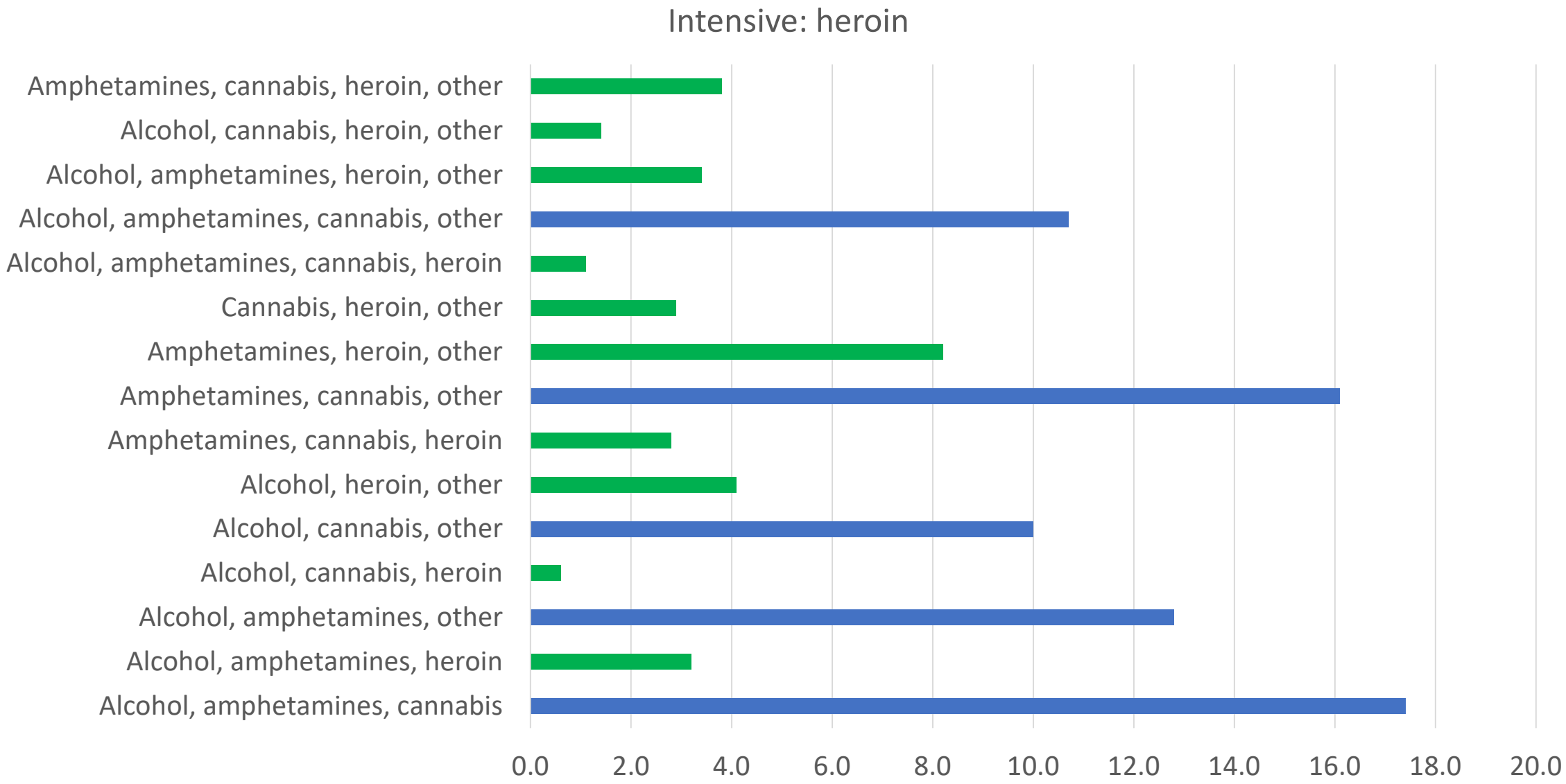


Table SC.9: Proportion of clients by number and type of principal drugs of concern, and treatment received, 2014–15 to 2018–19 (per cent)



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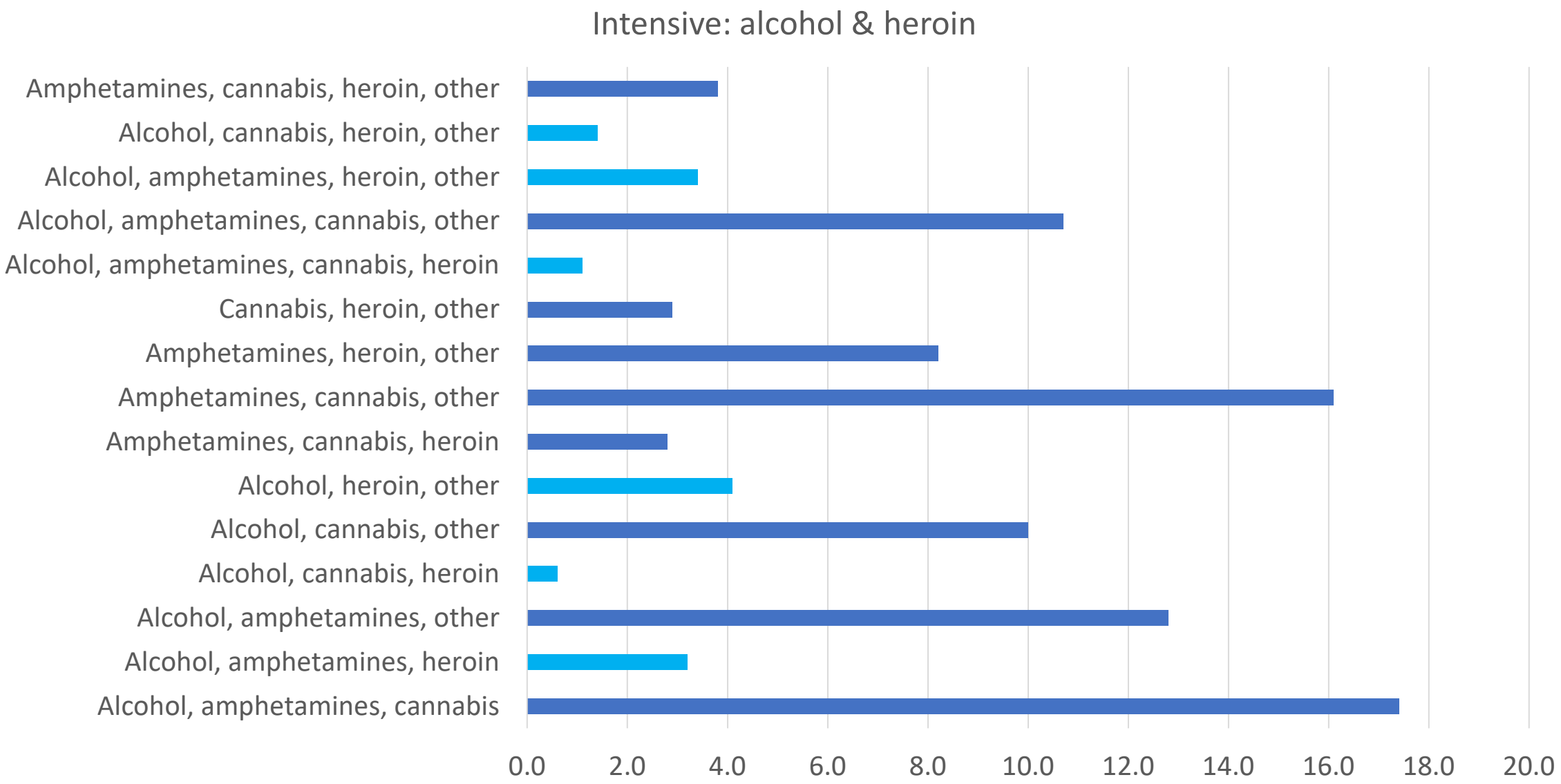

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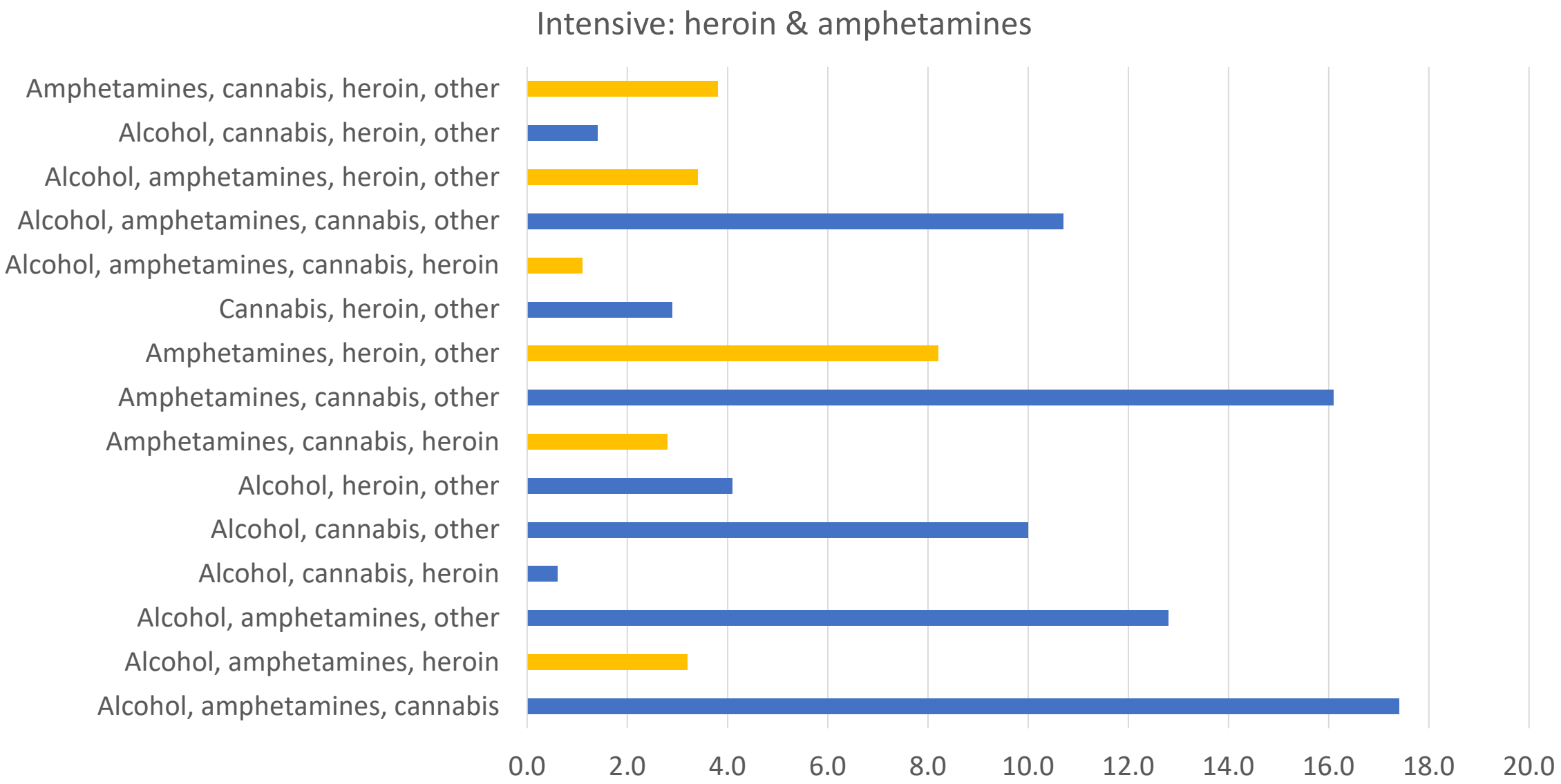

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