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Western Australian Network of Alcohol & other Drug Agencies

Western Australian Alcohol and Other Drug Service Sector: Impact of the Pandemic and Sector Response

September 2020

Acknowledgement

We acknowledge the traditional custodians of the land on which we live and work, and recognise their strength in connection to the land, sea and community. We pay our respect to their elders past and present.

We acknowledge the widespread and intergenerational effects of colonisation. The policy and actions of dispossession established long-lasting barriers between peoples, land and their culture. Furthermore, we acknowledge that this trauma has a systemic presence in Western Australian society, policy and the alcohol and other drug system. We acknowledge the need to address this issue by re-evaluating the systems in place which affect the cultural, social and economic matters of Aboriginal people.

WANADA is committed to advancing conciliation/reconciliation and fostering the valuable contributions that Aboriginal people make in the alcohol and other drug service sector, to deliver meaningful, lasting outcomes for Aboriginal people, families and communities.

About WANADA

The Western Australian Network of Alcohol and other Drug Agencies (WANADA) is the peak body for the alcohol and other drug education, prevention, treatment and support sector in Western Australia. WANADA is an independent, membership-driven not-for-profit association.

WANADA is driven by the passion and hard work of its member agencies, which include community alcohol and other drug counselling; therapeutic communities; residential rehabilitation; intoxication management and harm reduction services; peer based; prevention; and community development services.

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Executive Summary

The COVID-19 pandemic has had a significant and diverse impact on the Western Australian alcohol and other drug system.

Overall, the alcohol and other drug sector in Western Australia demonstrated a coordinated, sophisticated response to manage the risk of infection whilst maintaining, where possible, service continuity.

The impact of the pandemic, however, will have long-term implications. Some issues, such as the likelihood of increasing service demand, will become more apparent in future years. It is also important to note that this report is being developed in a period of significant uncertainty. While local transmissions have not occurred in Western Australia in some months, there remains the possibility of future outbreaks, as experienced in other jurisdictions. In this context, this report seeks to analyse the impact of the pandemic and the sector's response to date; and provide guidance to inform future planning. This includes consideration of:

- ongoing management of pandemic-related risk for the foreseeable future; and
- the need to learn from the experiences to inform an improved system.

Background

To support State Government recovery planning and system awareness, the Mental Health Commission requested sector data and information regarding the impact of the pandemic, and considerations for recovery.

In this report, WANADA has collated:

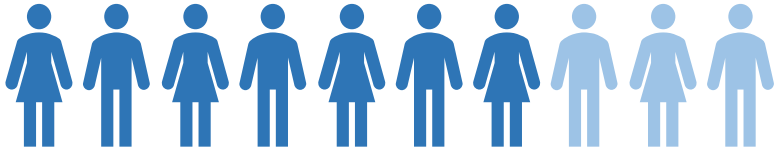
- the results of a WANADA-led alcohol and other drug service users' survey, with the intent to explore the impact of the pandemic, changes in service access and engagement for individuals and family members;
- sector survey results, along with a selection of service type case studies, to provide a more nuanced representation of the impact of the pandemic; and
- a range of system supports coordinated by WANADA during the pandemic.

Impact of the Pandemic on Alcohol and Other Drug Consumers and Family Members

The service user survey

Hard copy versions of the service user survey were made available to all WANADA member services between 3 August 2020 and 20 August 2020, to be disseminated to service users. WANADA received 87 service user survey responses.

Profile of respondents

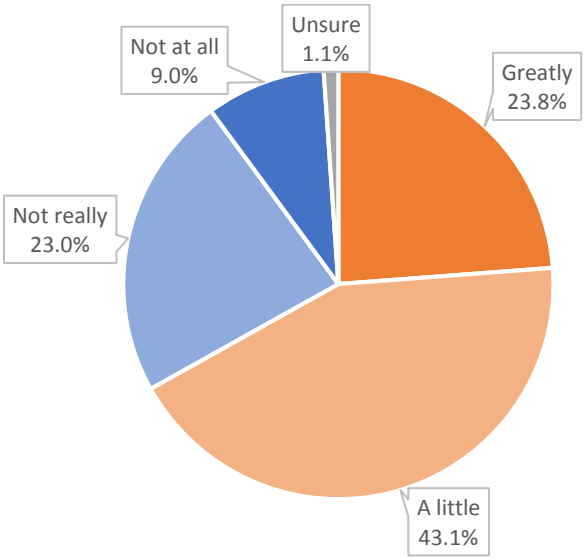


Most respondents (72.4%) identified as alcohol and other drug service users who were accessing the service for their own use.

- 21.8% service users who identified as current drug users
- 72.4% service users accessing service for own use
- 14.9% service users accessing service as a family member/significant other
- 1.1% (1 respondent) did not identify as any of the above

Note: Total does not add up to 100% because multiple options were accepted.

Impact of COVID-19



Comments indicate that negative impacts included:

- worsening mental health, especially anxiety, resulting from social isolation and uncertainty
- separation from family members, including children, due to restrictions
- job loss
- longer wait times for residential rehabilitation
- inability to access face-to-face support groups (i.e. AA/NA/SMART groups)

Impact of COVID-19 on help-seeking

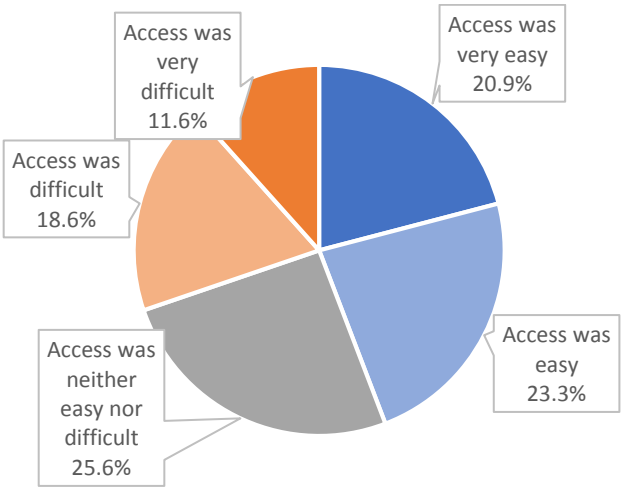
Most respondents (66%) stated that COVID-19 made no difference to their decision whether to seek treatment, with many indicating they were already engaged with treatment or planning to seek help anyway. Comments indicate those who were less inclined to seek help struggled with motivation, feeling isolated, and feeling fearful of leaving home.

Experience of accessing alcohol and other drug services

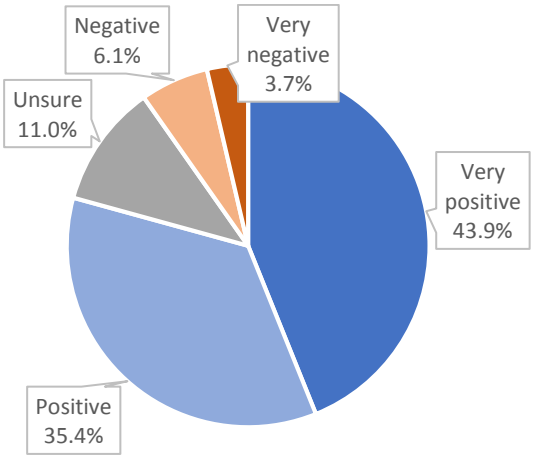
Most respondents (79.3%) indicated they had experience accessing alcohol and other drug services before COVID-19 and were therefore in a position to compare access experiences.

Almost three-quarters of the respondents (73.2%) have tried to access an alcohol and other drug service since March 2020. Of these:

- 44.2% found access was easy or very easy
- 30.2% found access was difficult or very difficult
- 25.6% found access was neither easy nor difficult



Comments indicate difficulties included longer waiting times for residential beds and the lack of face-to-face appointments either while waiting for an available bed in residential treatment or while accessing non-residential treatment.



Of those who have accessed alcohol and other drug services since March 2020:

- 79.3% of respondents indicated their experience was positive or very positive
- 9.8% of respondents indicated their experience was negative or very negative
- 10.9% of respondents were unsure how they would describe their experience.

Comments indicate appreciation for the services, while lamenting the reduction in face-to-face options for support.

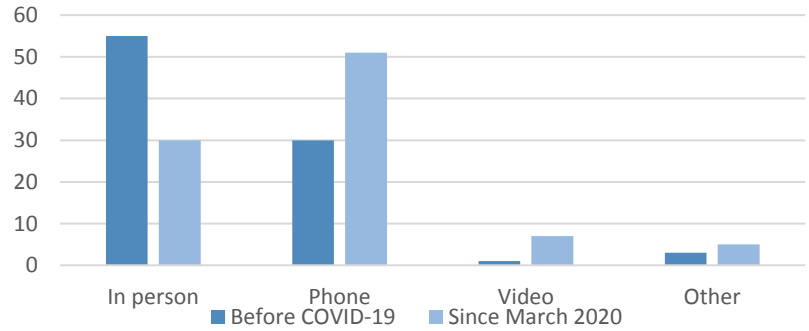
Experience of accessing other health or community services

Just over half of respondents (51.9%) have tried to access other health or community services since March 2020. Of these:

- 31% found access to other health and community services was easy or very easy
- 27.6% found access was either difficult or very difficult
- 41.4% found access was neither easy or difficult, and.

Comments indicate that it was difficult to access in-person medical appointments, and wait times were longer.

Mode of accessing alcohol and other drug services



Preferred option for accessing a non-residential alcohol and other drug service

- 62.6% of respondents indicated they would prefer in-person only.
- 18.1% of respondents indicated they would prefer a combination of in-person and other modes (phone or video).
- 19.3% of respondents indicated they would prefer phone only.

Comments include:

> *Video is handy but I feel not going in-person may keep people in active addiction longer.*
> *Having had one session face to face made it easier to do phone sessions during lockdown.*
> *Better when [we] are with the people.*
> *Face to face is better.*
> *I don't feel supported on the phone.*
> *Either is good.*
> *Phone is not as good as face to face.*
> *Being able to continue by phone was helpful during the lockdown.*

There is a clear expressed preference for face-to-face support, whether alone or in conjunction with telephone and video support. This is consistent with survey data from other international[1] and interstate jurisdictions[2]. Comments indicate many service users find face-to-face support more effective, which is demonstrated by recent research into the efficacy of videoconference psychotherapy that found the "working alliance" between a psychotherapist and a service user is superior in face-to-face counselling when compared with videoconference[3].

Suggestions to improve access to alcohol and other drug services:

Survey respondents were asked to give suggestions for how accessing alcohol and other drug services could have been improved. Identified themes include:

- a need to increase advertising/raise awareness of available alcohol and other drug treatment and support services. Comments include:

> *More advertising and spokespersons to go to schools and universities or workplaces.*
> *Better advertisement.*
> *More advertising.*
> *Awareness, word of mouth, advertising information.*

- increased service availability across all modes of service delivery. Comments include:

> *More AOD specialists.*
> *Safe ways to see service face to face.*
> *Rather than recorded messages & menu options, an actual "point of contact" human would be preferable.*
> *By not making people more isolated when in recovery!*
> *More online.*
> *A way to still have contact with community.*

[1] Barrett, Ashley K., and Melissa M. Murphy. 2020. "Feeling Supported in Addiction Recovery: Comparing Face-to-Face and Videoconferencing 12-Step Meetings." *Western Journal of Communication.* https://doi.org/10.1080/10570314.2020.1786598
[2] Association of Participating Service Users. 2020. *Victorian AOD Service Users' Needs and Experiences During the COVID-19 Crisis.* https://www.sharc.org.au/wp-content/uploads/2020/07/COVID-19ExperiencesReport.pdf
[3] Norwood, Carl, Nima G. Moghaddam, Sam Malins, and Rachel Sabin-Farrell. 2018. "Working Alliance and Outcome Effectiveness in Videoconferencing Psychotherapy: A Systematic Review and Noninferiority Meta-analysis" *Clinical Psychology and Psychotherapy* 25, No. 6 (November/December): 797-808.

- better communication of information to service users and between services (within and outside the alcohol and other drug sector). Comments include:

> *The link up with Centrelink regarding rent assistance. Follow up phone calls during assessment.*
>
> *By making sure all info is still handed out when enquiring.*
>
> *Better communication between the services and between these and my doctor.*

Many respondents expressed satisfaction and gratitude. Comments include:

> *Good as is.*
>
> *Satisfied how it is!*
>
> *Keep up the wicked work :)*
>
> *You can do it you just have to be motivated.*
>
> *In COVID19 the services were doing what they could under the circumstances.*

Western Australian Context: Impact of the Pandemic on Alcohol and Other Drug Treatment and Support Services

The State and Territory Alcohol and Other Drugs Peak Network (the Network), which comprises all state and territory alcohol and other drug service peak bodies, collaborated to better understand nationally the impact of the COVID-19 pandemic on alcohol and other drugs treatment and support services.

The survey was promoted by peak bodies across each state and territory. Each peak was responsible for promoting the survey in their jurisdiction. The survey opened on Thursday 21 May 2020 and closed on Friday 5 June 2020. Responses were received from 210 organisations. Western Australian organisations comprised over 11% (n=24) of respondents.

The figures on the following three pages summarise the WA survey findings in relation to impact on service delivery, impacts on service capacity and presentations and impacts on service demand. Where relevant, comparisons have made between the WA and national data.

> **The WA service survey data indicates the pandemic's impact varied throughout the alcohol and other drug sector.**

This is to be expected given organisations needed to tailor their responses to different service environments - including localised community issues, service models, infrastructure arrangements, workforce profiles and service user populations. To understand the diversity in the survey responses WANADA undertook service type case studies (presented below the survey summary).

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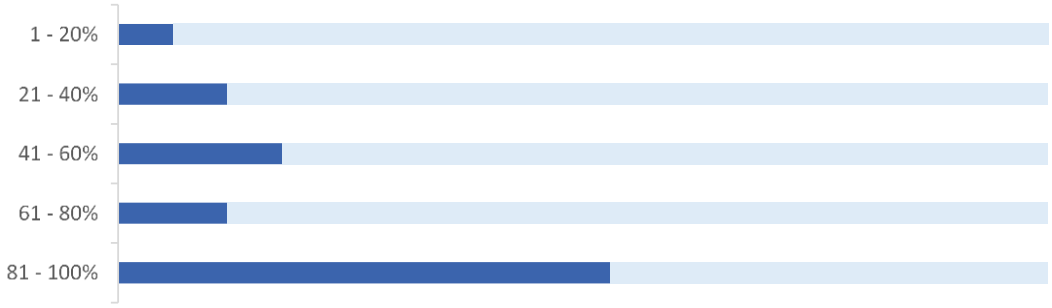
COVID-19 impact on service delivery

90% of WA survey respondents indicated they shifted non-residential service delivery from face-to-face to digital access (online and telephone) as a result of the COVID-19 pandemic.

52.9% WA respondents indicated that more than 80% of service delivery had shifted to digital access, compared with 6 in 10 respondents nationally.



Most WA respondents (88%) used more than one digital access platform, consistent with national responses (89%). Telephone was the most common platform (70%), followed by Zoom (65%), Microsoft Teams (24%), Health Direct (24%), and others.

66.7% of those who shifted to digital access indicated they would consider continuing to implement these changes following the pandemic, compared with 80% of respondents nationally.

Increased costs associated with changes to service delivery

- Accessing PPE 80% (compared with 66.4% nationally)
- Technology 70% (compared with 77.4% nationally)
- Additional cleaning fees 70% (compared with 55.4% nationally)
- Reduced income from client fees 35% (compared with 31.1% nationally)

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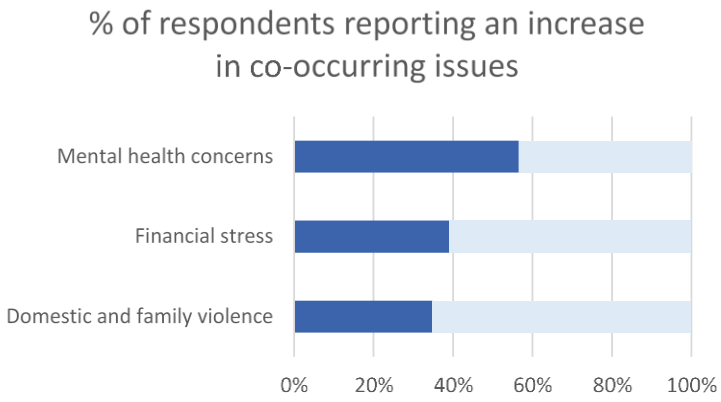
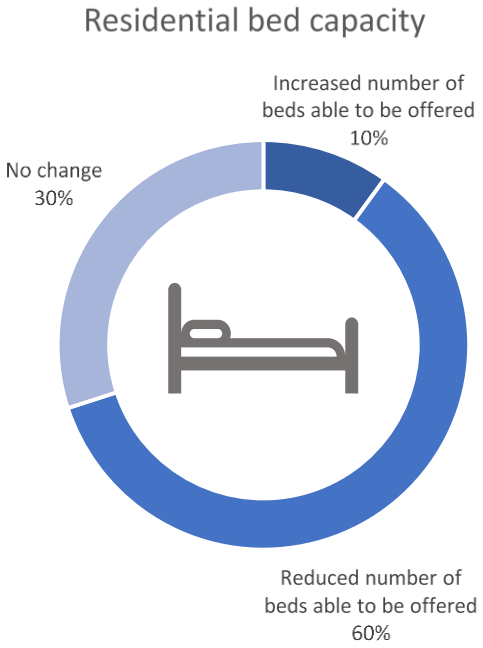
COVID-19 impact on service capacity and service user presentations

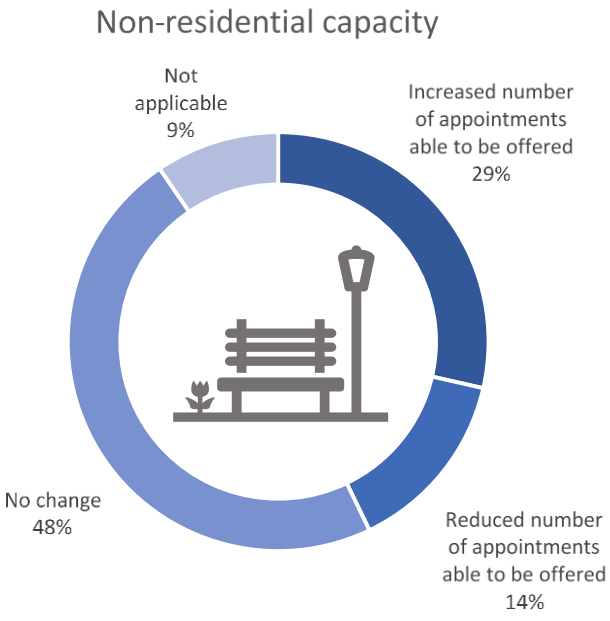
68.2% of WA respondents indicated they reduced residential service user numbers to support COVID-19 risk mitigation measures (e.g. physical distancing).





Respondents reported increases in co-occurring issues among service users, including increased mental health issues, financial stress, housing stress, and child protection issues.

Of the residential services who reported reduced capacity, 66.7% had to reduce their capacity by 21-60% due to COVID-19.



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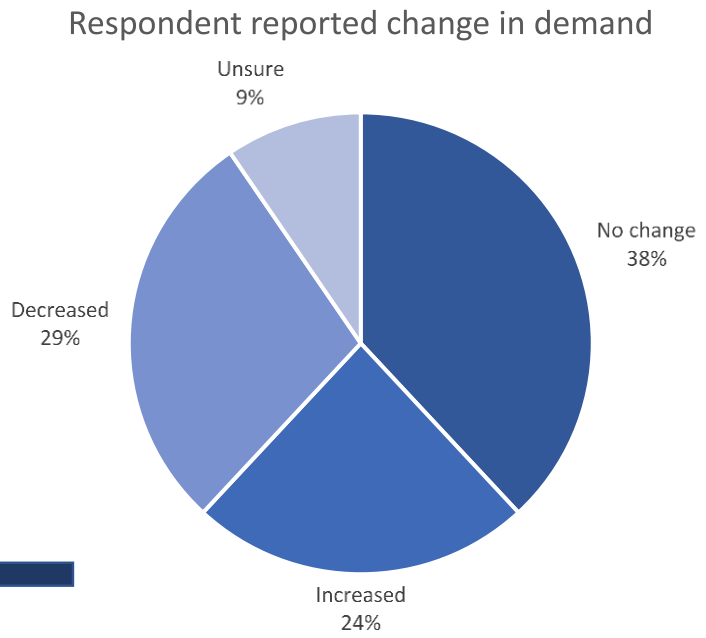
COVID-19 impact on demand March to June 2020

Demand across the sector remained reasonably stable, with some services identifying significant increase in demand while others identified significant reductions in demand, particularly in the earlier weeks of the pandemic.



Of those who said demand increased:

Increased by:	% respondents
1 – 20 %	20
21 – 40 %	40
41 – 60 %	40

Of those who said demand decreased:

Decreased by:	% respondents
1 – 20 %	33.3
21 – 40 %	16.7
41 – 60 %	33.3
61 – 80 %	16.7

Changes to levels of service user engagement

Slightly more respondents indicated reduced levels of service user engagement, reporting:

- More missed appointments (34.8%)
- Shorter engagement with the service (30.4%)
- Fewer enquiries (17.4%)

Those that indicated increased levels of service user engagement, reported:

- Fewer missed appointments (21.7%)
- More enquiries (21.7%)
- Longer retention in treatment (13%)

Case Studies: Western Australian Treatment and Support Services

WANADA collected several Western Australian alcohol and other drug service-type case studies to complement the service user and service provider surveys. These case studies allow for more in-depth consideration of the localised impact of the pandemic. They describe how services responded and considerations needed for recovery planning.

Case studies were gathered from residential and non-residential treatment services, as well as harm reduction, sobering-up and prevention services. The below brief focuses on residential and non-residential treatment services, which make up the bulk of the community alcohol and other drug service sector. Lessons from the diversity of services, represented in the case studies, however, provide an indication of the sophisticated purposeful pandemic response to support the service system.

Changes to organisations/services

Organisations demonstrated a sophisticated approach to implementing infection control and service continuity measures. In most cases, the changes introduced were extensions of existing infection control measures already being practiced. New changes were typically clinically informed, tailored to each organisation and service model, and well communicated to staff and service users.

Despite restrictions impacting service access and engagement, staff and consumers were both appreciative of the measures intended to keep everyone safe.

Technology (digital access)

The adoption of digital access differed across service types and was optimised to meet service-specific needs.

- Residential service examples saw digital access used to sustain: assessment and pre-residential engagement; residents' connection with family and significant others; service users' access to pandemic updates to contribute to their awareness of the gravity of the pandemic; partner services' care coordination engagement; and staff and management meetings and team building.
- Non-residential treatment services moved most one-to-one counselling sessions to telephone of video platforms. Similarly, digital access enabled remote staff and management meetings and team building. Service users were, in some cases, provided with phones and credit to support treatment and information access.
- Access to staff support through on-line/webinar sessions increased.

A number of barriers to digital access were highlighted:

- Connectivity is inconsistent across regions, impacting equitable service access. There was some indications of increased reliance on community resource centres/neighbourhood centres.
- Some service users had limited privacy to effectively engage.
- Group therapy and supports were less effective in maintaining engagement – and were more often than not reduced or suspended.

Changes in patterns of uptake/attendance

The survey results, undertaken early in the pandemic, indicated limited consistency across the sector in relation to demand and service uptake. Any analysis requires an understanding of the different operational and environmental contexts for the individual services. Case study analysis provides more depth to understanding service experiences.

- Most residential services that maintained service continuity implemented reduced capacity measures to ensure compliance with restrictions.
    - Retention rate increased, with residents feeling secure with their needs being met. This, however, resulted in increased wait times for pending residents.

    - It was also reported that there was an influx of people seeking residential services.
    - Conversely, the temporary increases in welfare payments and concerns with leaving family and significant others during the pandemic, impacted on motivation to access treatment.
- Non-residential service providers reported an increase in retention of existing service users and reduced “did-not-attends”.
    - This in turn, impacted on wait times for pending service users.
    - Consumers that had received pre-pandemic face-to-face counselling adjusted well, reporting positive experiences of, and gratitude for, the ongoing digital access services. Most, however, have indicated an ongoing preference for face-to-face sessions where possible.
    - It was reported that new service users, that had no pre-pandemic face-to-face engagement, required considerably more resources to establish rapport and necessary therapeutic relationships.
    - Engagement with consumers within remote communities was reported as more difficult to maintain.
    - The pandemic exacerbated resource and demand pressures, given there were already inadequate services to meet demand and staff numbers were already reducing due to ERO, limiting the capacity to meet any surge requirements.

Services were also impacted by community changes - affecting uptake, attendance, complexity and potentially long-term demand. Available evidence indicates that there will likely be increased harms and a delay in treatment/service engagement. Services contributing to the case studies described several environmental changes.

- Market changes e.g. cost/purity of illicit substances; increased online promotion, sales and delivery of alcohol.
- Changes to patterns of substance use, e.g. more consumption of alcohol at home, more poly-drug use, and individuals substituting primary drug based on availability.
- Increased community hardship, anxiety, and personal relationship issues.
- Services located in the metropolitan/town centres reported increased street-present people. This has resulted in some challenges in relationships between services and local businesses, often requiring negotiations and a developed appreciation of both health and economic concerns.
- Disruptions to usual supply of PPEs (e.g. sanitiser and gloves) and essential products such as toilet paper.
- Residential services had increased reliance on food/essential delivery and supply.

Case study data corresponds to the survey outcomes, where all services reported increases in co-occurring issues among service users, including increased mental health issues, financial stress, housing stress, domestic and family violence, child protection issues, etc. Case study comments indicated that the increases in complexity were not outside of the staff’s capacity, however did result in increased time and resources.

What can be carried forward / considerations for recovery

Organisations acknowledged that they would consider incorporating many changes, such as digital access options and increased infection control vigilance. Services, in general are confident in their preparations to respond to any localised outbreaks, and would be informed by expert guidance, such as health advice.

Many services raised concerns regarding resourcing. These included the need for increased capacity to meet community demand; access to PPE if there were to be a localised outbreak and considering the resilience of supply chains. Some services also raised concerns that existing systems issues have been exacerbated as a result of the pandemic and need to be addressed. These issues included addressing ambulance debt and alcohol availability and regulation.

In considering COVID recovery, and to respond effectively to the current complex environment, it is essential that planning and initiative implementation incorporate thorough sector consultation to ensure any initiatives are relevant to the local context.

Sector Coordination and Representation

During the pandemic, WANADA conducted a range of additional coordination, system support and representation activities. These activities were in delivered in addition to ongoing state and federal government policy, reform and capacity building initiatives that continued concurrently during this period.

WANADA's activities included the following.

- **Service-type specific practice sharing**. WANADA hosted several service-type specific meetings, including for residential, non-residential and sobering up centre services. The purpose of these meetings was to support the sharing of organisation practices for infection control and service continuity. WANADA collated service strategies and distributed these widely through our networks to inform service planning and responses.
- **Development of a service pandemic response capacity assessment tool**. This tool, developed with sector support, assisted organisations to conduct a self-assessment of their pandemic planning and identify opportunities for improvement. Many services provided copies of these assessments to WANADA, to support practice sharing, the identification of key support gaps, and to inform sector representation. The tool has been recently superseded by Department of Health resources.
- **Resource lists**. Informed by the issues and strategies raised by the sector, WANADA monitored health and associated websites to identify best practice resources that could inform the sector's response to the pandemic. This resource list, sometimes updated daily, included guidance on changes in restrictions, infection control resources and protocols, training, funding opportunities, PPE usage directions etc.
- **Representation of sector needs**. WANADA and the sector identified several system issues that impeded a fully effective response to alcohol and other drug related harms during the pandemic. These issues were collated and communicated to the State Government in four sector documents: Sector Needs Versions 1 & 2, Aboriginal Alcohol and Other Drug Worker Needs, and the WANADA Interim Recovery Plan for the Alcohol and Other Drug Sector.
- **Personal Protective Equipment (PPE) coordination.** For several months, PPE supply was limited and often unavailable, particularly for regional services. The lack of PPE was of significant concern, given the State Pandemic Plan identified alcohol and other drug dependent people as a vulnerable cohort. WANADA coordinated with the sector to identify available stocks in Perth, and to distribute it to regional services in need.
- **Naloxone and injecting equipment availability** – WANADA monitored the availability of harm reduction and equipment throughout the pandemic and Naloxone supply disruptions. When supply chains appeared to be impacted, WANADA conducted systemic advocacy with State and Federal stakeholders to highlight and seek a resolution.
- **Postal options.** WANADA worked with harm reduction services and the Department of Health to expand postal options for injecting equipment. This initiative supported consumer access to equipment while isolating, or where access options were reduced – e.g. hospital lock-downs.
- **Opioid Substitution Therapy Guideline Changes**. WANADA closely monitored national program guidance changes and advocated to Western Australian authorities for increased flexibility and consumer awareness of program options.
- **Access to asymptomatic testing**. WANADA strongly advocated for alcohol and other drug sector service users and workers to have access to asymptomatic testing. The sector had reported significant concern regarding both the vulnerability of the residential service user cohort, and the systems impact of necessary quarantine measures. WANADA engaged with the Department of Health, to raise awareness of the issue and to progress a solution. WANADA also hosted a forum with Prof. Chris Blythe, head of infection control within the Public Health Emergency Operations Centre. WANADA's efforts contributed to the alcohol and other drug sector being included in the DETECT program.
- **Business cases**. Since March 2020, WANADA has developed a range of business cases, recommending sector enhancements and systems initiatives aimed at maximising effective responses and reducing harm.

    - WANADA, in consultation with a range of service, cross-sector and consumer stakeholders, developed five business cases to address the needs of vulnerable cohorts.
    - WANADA developed a further four business cases to inform workforce planning and development – issues exacerbated by the pandemic and central to a sustainable recovery.
- **Taskforce and Stakeholder Coordination**. WANADA engaged in several working groups (e.g. Dept. of Finance and Dept. of Justice working groups on COVID-19 responses), taskforces (e.g. Vulnerable Cohorts Taskforce – Mental Health and Alcohol and Other Drug Use), roundtables and peak body coordination groups. In these groups, WANADA monitored emerging issues, identified collaboration opportunities, represented sector positions on urgent issues such as access to PPE, and provided feedback into the development of proposed service models (e.g. supported accommodation options for people isolating).
- **Residential and withdrawal service status summary.** WANADA consulted with the sector and determined the status of all residential and low medical withdrawal services. WANADA collated and shared this information with the sector, funding bodies and key stakeholders, to increase awareness and support referral practices during the pandemic.
- **Bed Management Tool.** WANADA continued collection and reporting of residential bed data, to inform system awareness of capacity and demand.

Pandemic Alcohol and other Drug Service Case Study
State-wide Prevention

Changes observed in the service user population/local community

Our organisation focuses on state-wide alcohol prevention. We also have significant engagement with policy makers and politicians.

As Western Australia began recording cases of COVID-19 we saw a change in the priorities of the State Government and individual Ministers. Many existing priorities were put on hold and resources were refocussed to respond to the impact of the pandemic. This was understandable, given the need for a strong focus on public health.

From a prevention and alcohol policy reform perspective, we saw some existing issues being brought to the fore:

- Home delivery of alcohol increased. There are continued concerns about these practices and access by young people.
- Alcohol advertising through social media increased substantially. These advertisements were highly targeted and relevant to the context, integrating lockdown experiences to take advantage of peoples' vulnerability.
- Changing trends were reinforced. We already knew people were drinking more at home. During the pandemic this increased.
- Industry influence was significant. These stakeholders argued strongly against the temporary state-wide liquor purchase limits and were public in their congratulations when the limits were lifted.

The pandemic had a major economic impact, particularly in the hospitality and tourism sectors. There has been sympathy from both government and the community to protect these businesses and their employees. This has possibly reduced willingness to address alcohol regulation.

Media interest has been consistent throughout the lockdown period. There was ongoing interest in alcohol, and lots of reporting on survey data.

As Western Australia began to lift restrictions, there were several pictures of Ministers drinking a beer, as a symbol of how well WA had done in managing the pandemic. From a prevention perspective, this was unhelpful, given concerns about increased drinking during isolation.

Organisation response to COVID-19

The pandemic has had a substantial impact on our organisation's fundraising events. My team is more secure, as we are funded through a government contract.

Our organisation supported staff to work from home between April and May 2020, followed by a gradual return with limits on staff numbers. We officially returned to normal workplace operations from September.

Our team responded to the pandemic by developing reports assessing the actions of industry regarding social media and commentary on alcohol policy.

The pandemic also impacted on our planned campaign timing. We needed to adapt and get relevant messages out quickly (e.g. messaging appropriate for the home-drinking context). We also needed to hold campaign messages that may have been lost given immediate health concerns.

Introduction of technology

Technology supported our team to continue with business as usual while working from home. We utilised remote access to our desktops, Microsoft Teams, Zoom and Whatsapp. We also engaged significantly through webinars.

The pandemic increased the uptake of what was already an emerging trend – we had already been using some online platforms, but our use of these platforms increased and became more seamless.

Changes to patterns of attendance/uptake

From a stakeholder perspective, the pandemic and the technology changes have encouraged broader engagement. Our webinars have a more national (and often international) audience. We now have more engagement than ever with our interstate partners. The pandemic forced people together and leadership encouraged fortnightly catchups and updates, which we have continued. We are also seeing more of a focus on online face-to-face options rather than email.

From a policy and communications perspective, the pandemic has required us to alter our approach. We recognise that many people are stressed and experiencing financial challenges. It is important we avoid being tone deaf in our communications and are considerate of the impact of the pandemic on the community and government.

What can be carried forward

I expect that we will retain some flexibility to work from home in the future. If there is another outbreak, we will pivot to working from home again. We will permanently keep our technology options. There are clear benefits to retaining these options, as long as they are not overused.

Considerations for the recovery phase

While we must be conscious of the impact of the pandemic, there is a risk that we will become too cautious and adverse to change. There is a need to ensure we don't move in the wrong direction on alcohol policy. There have been economic impacts, but we also need to consider the health and social impacts of alcohol consumption.

Many issues, such as advertising, have been exacerbated by the pandemic. What has occurred since March 2020 demonstrates what can happen in the absence of effective regulation.

The State Government responses to the pandemic have highlighted the benefit of focussing on public health priorities. It is important that this approach carries through, along with solutions to address existing alcohol policy concerns.

Pandemic Alcohol and other Drug Service Case Study
Sobering Up Centre Service

Changes observed in the service user population/local community

As WA began to record infections, we saw an increase in the anxiety experienced by our service user population. Many people possibly stayed away from services because of a concern about contracting the virus. Some service users did access hotel accommodation options for a time.

There were no changes in the needs of people accessing our service. They still needed access to a supportive, safe place and amenities without judgement and discrimination related to their substance use.

Organisation response to COVID-19

Our organisation's response to the pandemic was very professional. The organisation acted early, established a plan, introduced new procedures, identified at-risk staff, obtained supplies and communicated clearly with staff, service users and stakeholders.

To comply with physical distancing and infection control requirements, we reduced the bed capacity of our service.

Our cleaning processes increased significantly. We introduced regular deep cleaning, full cleaning after intake, disinfection of communal areas, and regular cleaning of contact surfaces such as door handles. We also introduced changes to our food handling processes.

The sobering up centre's staff were required to use personal protective equipment, such as masks and gloves. Everyone entering the centre received a temperature check and were asked screening questions. These practices sent a strong message that we were taking staff and service users' health seriously.

Our organisation provided clear guidance to staff. They were not to work if sick, and to get a COVID-19 test and medical certificate if they were symptomatic. Our organisation also supported staff to engage in the DETECT program to identify asymptomatic people with COVID-19.

Service users were very supportive and appreciative of all measures we introduced. They understood why we had introduced the changes and saw we were making an effort to keep them safe.

Introduction of technology

For the sobering up centre, the main technology introduced were forehead thermometers. Other technology such as digital access options were useful for other service types, however we could not implement these given the nature of our service.

Changes to patterns of attendance/uptake

We recorded a drop in the number of people accessing the sobering up centre, however the beds were regularly filled, and demand remained higher than our capacity. People began to present earlier so that they could access a bed. We also noticed the number of Aboriginal people accessing our service dropped. After July, the numbers appeared to have returned to pre-pandemic levels.

Some of our long-term regular service users accessed withdrawal and treatment services during the pandemic. Some service users also asked for letters of support to access long-term accommodation.

What can be carried forward

Our organisation and staff responded to the pandemic with integrity, and we are well prepared if there is a second wave.

We are maintaining our revised bed capacity, the increased cleaning routines, and the temperature checking of people accessing the service.

Considerations for the recovery phase

The pandemic highlighted some existing issues, particularly the debt many consumers have accrued because of ambulance call-out costs. Before, there had been the option of a group membership for our service users, but this is no longer available. This debt, and the actions of debt collectors, disincentivise our service users from using an ambulance in an emergency. This is a health and safety issue.

The pandemic will also have implications for infrastructure - if building and layout changes are required to comply with any long-term distancing or infection control requirements.

Pandemic Alcohol and other Drug Service Case Study
Harm Reduction

Changes observed in the service user population/local community

Our organisation focuses on injecting drug user communities in metro and the South West region of WA.

As WA started recording COVID-19 infections, and restrictions began to be implemented, we saw an increase in the number of street present people and police in the area around our services. Some local homeless services had increased their hours, which brought more people into the area. There are a range of community services in our area as well as local businesses. Business owners haven't been happy about the increased number of street present people. This has put pressure on the local government, in that they have had to manage competing interests.

Our service user demographic has not changed significantly since March 2020. We recorded slight increases in the number of Aboriginal people accessing our services, and a small increase in the number of performance and image enhancing users accessing our postal service.

Initially, individual occasions of service dropped, as did the number of new consumers accessing our services. However, equipment access per individual increased, resulting in minimal changes to our harm reduction efforts.

Organisation response to COVID-19

Our health professionals guided the implementation of our infection control measures. We introduced enhanced standard new hygiene measures a week before the first infections were recorded in WA. After the first infections were announced, we increased our response measures further.

We are always responsive to consumer needs and seek to meet their needs to the best of our ability. It was important that we supported consumers to stay safe while physical distancing. Our premises are too small to have all staff in at the one time and maintain compliance with physical distancing requirements. As a result we split our workforce into two separate teams. We also limited building access by service users. We had no choice but to quickly introduce measures, but workers embraced the change, even when the changes created an impost on them, such as working from home or requiring staff undertake additional cleaning and sanitising.

During the height of the restrictions, we had to stop group training, our clinic, and community development activities. Our mobile van had to stop for a period of time, as we had no control over physical distancing. We required staff to wear gloves at all times, introduced screening questions for service users and workers, and introduced routine cleaning and sanitising between each service user visit.

To support service continuity, we have re-focussed on outreach with physical distancing and offered a free postal service for people needing injecting equipment. We re-developed specific COVID-related harm reduction information for consumers, including educational YouTube clips playing on the TV in our waiting room.

Introduction of technology

We embraced technology more than we had done so in the past. Some of our services, like our training, have now been moved online. We have also arranged monthly sessions for the peer educators in the open where we could comply with distancing requirements.

We noticed additional challenges for the Culturally and Linguistically Diverse (CaLD) population that we support. Our CaLD consumer support has moved from face to face to over the phone. Staff reported that this was not ideal, as they were missing the physical cues needed when there are already language barriers. The COVID-19 information disseminated throughout the community was confusing to our CaLD service users and our service remit expanded to support improved COVID awareness.

Changes to patterns of attendance/uptake

Consumers were very understanding about why we implemented all the changes to our services.

Overall, our occasions of service slightly decreased between March and July 2020, with a slight increase in the number of Aboriginal people accessing our Perth site. Our regional site recorded no changes in service user demographics or needs. These changes were not outside what we expected.

Prior to the pandemic, it was easier to have conversations and provide brief interventions to service users. However, since March, people have been required to wait outside before accessing the service, and the opportunity to engage in conversation/brief intervention has diminished somewhat.

Our equipment return rates slightly dropped, but this was expected. During the height of the restrictions we supplied additional equipment per service user, encouraging consumers to reduce their access to our service where possible, and dispose of equipment in a safe way. After a month, with restrictions easing, we went back to consumers only accessing the equipment they more immediately needed.

From July, we have been back to pre-pandemic service trends. Consumers are now familiar with the changes introduced.

What can be carried forward

We will maintain our current infection control and distancing practices until the State Government changes the restrictions. We have a thorough risk management plan for outbreaks, and logs of all the changes we have made to date. We discuss these changes weekly and explore contingencies for any events.

We are looking at adapting our training to make it more accessible in the future. We don't currently have the resources, however we are looking to implement interactive technology and social media to support our cohort with information, such as hepatitis C treatment options. All of these measures will enable us to better meet consumer needs.

We will keep some of the changes introduced due to the pandemic. For example, we have always had sanitiser on the front bench, but we have installed a dispenser and now ask everyone to use it before they use the door. It is a simple measure to support better hygiene and will contribute to reduced rates of influenza amongst our consumers.

Considerations for the recovery phase

We have the human resources to appropriately respond if there were to be a localised outbreak, however:

- access to PPE has, and is likely to be, a problem. Appropriate PPE must be made more readily available for services supporting at-risk people. The process to access PPE needs to be improved.
- improved government communication and consultation with sector services should form part of any rapid response to ensure effective, practical and targeted initiatives.
- local service, business and residents' consultation and communication will need to be improved and prioritised for increased awareness of community needs.

Contact with contract managers initiated by us has been more difficult than usual since March. However, requests/demands for organisation planning, strategies and information from contract managers has been high. This indicates to us that there is a lack of: appreciation for what we deliver, trust in our ability to implement health requirements, and confidence in us effectively managing organisational change.

For some of our workers, the new ways of working have presented challenges, but in general these have been embraced. We have actively worked to maintain staff well-being. As per the rest of the community, our staff are feeling a sense of weariness that is generally impacting morale.

Pandemic Alcohol and other Drug Service Case Study
Regional Non-Residential

Changes observed in the service user population/local community

We received anecdotal reports about some changes in our local communities:

- The illicit drug market for methamphetamine was significantly impacted. Availability/purity reduced and cost increased.
- People were drinking more alcohol at home, when compared to pre-pandemic levels
- Community hardship increased. Many people engaged in JobKeeper and JobSeeker. As the rates for these measures reduce shortly, this will have a cumulative impact.

One notable change that we recorded was an increase in people experiencing personal relationship issues. As people were isolating, they were unable to access their normal support structures.

These anecdotal changes have not translated into our service data yet. This is to be expected – there is clear evidence regarding the delay between problems and harms occurring and people seeking treatment services. The impact on alcohol and other drug treatment services will be long term.

Organisation response to COVID-19

As WA began to record COVID-19 infections, we immediately began to plan and implement a remote service model. This approach was based on the need to: keep service users and staff safe; minimise the impact on our service users; and ensure service continuity in light of increasing restrictions.

In the first phase, which operated for 2-3 weeks, we structured our workforce into two teams. There were strict controls to avoid contact between each team – one team would work in the office, while the other team would work remotely from home. The teams worked off a one-week roster, with deep cleaning of the office each weekend as the teams transitioned. For those working remotely, we established a working from home policy that required each staff member have a closed, confidential space to work. In the office, all staff and visitors were temperature-checked, external meetings were cancelled, and we managed entry into the building using a video-enabled doorbell.

As restrictions were strengthened, we introduced our second phase and transitioned the service to fully remote. We maintained one administration staff member and a counsellor on site (but in separate parts of the building). One staff member could not work from home, and the administration officer ensured continuity of access and updates to hardcopy files.

During the second phase of our plan, all service programs were provided remotely, with the exception of our program within the local prison. The Department of Justice required us to work face-to-face or risk breaching our contract. Unfortunately, communications with the prison, and the procedures being implemented to manage the risk of infection, were not clear. This approach made it harder to look for alternative ways to deliver the service and increased the stress of our staff.

Our staff had an encouraging sense of comradery during the most stringent restrictions. There was also a clear understanding that we had vulnerable service users that relied on us for support. The organisation had an open approach to make sure that staff had the tools and support to effectively work from home. This included the opportunity to take office equipment home, and providing regular online check-ins.

As restrictions began to ease, we transitioned staff back into the office while maintaining physical distancing and infection control requirements. We did note some staff experienced a delayed response to the stress of the pandemic when they began to return to the office, impacting their wellbeing.

Introduction of technology

We utilised a range of technology options to assist our operations.

- Our services were provided both over the phone and via video platforms.
- Staff were provided with laptops/tablets that would allow them to work remotely.
- Where needed we provided existing service users with phones and credit to support their service access when isolated.
- We utilised social media platforms to support continued engagement and discussion on some broader wellbeing topics, such as culture and safety.
- Meetings were conducted remotely using Teams or Zoom.

Regional connectivity was good (if using Telstra) in towns. In-between towns, however, signal coverage was less optimal.

Changes to patterns of attendance/uptake

Existing service users responded to our changes positively. They had a sense we were all experiencing this situation together and trying to make it work.

After transitioning to remote service delivery, we noted an increase in engagement and a decrease in "did-not-attends" among our existing service users. Many service users had found the changes helpful – they could engage with a counsellor in the safety of their own home and not have to go out and be impacted by their social anxieties. As counselling sessions didn't need to focus as much on working through these increased anxieties, there was more time and opportunity to work more deeply on their dependence. Many service users reported improved session quality and engagement with change.

For people on our waitlist, they had not had the opportunity of coming into our service and engage face-to-face with our staff before we transitioned to remote delivery. As we began to engage with these people remotely during the pandemic, we noted that it was more resource intensive to engage, develop rapport, and establish a therapeutic relationship.

We noted some existing issues were exacerbated by the pandemic. For example, there was an increased impact on remote Aboriginal communities. Sustaining service engagement with these communities was more difficult during the pandemic. Many people were informal clients, who had engaged with us through other programs. Access to phones/reliable connection was limited in some cases. Many people weren't comfortable in using the technology options to access the service. Some people were living in overcrowded houses, where finding a quiet or private space to talk over the phone was difficult.

As restrictions began to lift, we provided service users the option of maintaining remote sessions or returning to face-to-face. Existing service users were enthusiastic about re-commencing face-to-face sessions – even those who had reported positive experiences using remote options. A small number of people continued to use remote options.

In the last few months, we have recorded an increase in the number of people seeking treatment at our service. Our service's capacity to meet this increased demand has reduced, however, as a result of increased costs related to the Equal Remuneration Order, which have not been addressed in our funding agreement. As a result, we have had to reduce FTE. This reduction in capacity has also contributed to increasing wait times.

What can be carried forward

We are maintaining our vigilance and have a blueprint that ensures we are prepared to act rapidly if there are localised outbreaks.

Our service is maintaining the infection control measures introduced during the pandemic – we are continuing our cleaning practices, temperature checking and physical distancing until directed otherwise by health officials.

We continue to support remote options: service users have the choice of face-to-face or remote sessions. Staff have increased access to work from home options, where appropriate, and we have retained a preference for meetings being remote rather than face-to-face.

Our IT Strategy has been amended. Going forward we will primarily purchase laptops and tablets. This will allow staff to use docking workstations in the office, and also support staff to work remotely.

Considerations for the recovery phase

We recognise that there is the potential for localised outbreaks in this ‘’new normal’ environment. Looking at Victoria, however, the second wave is more demoralising. There will need to be a stronger focus on supporting staff and service user welfare and wellbeing.

Increasing sector capacity to better meet community demand is essential. This must also include service funding that addresses the impact of the Equal Remuneration Order. Following restrictions, and moving into the ‘recovery’ phase, staffing and resources are our biggest challenge. This will particularly be the case if we enter another stage of severe restrictions.

- We do not have sufficient capacity to meet current – let alone projected – local demand. In addition, the evidence indicates the likelihood of delayed impact on service demand because of the pandemic.
- If there were future lockdowns, we will have more new service users engaging remotely – this will have a larger staffing and resource impact than during the restrictions in early 2020. Our waitlist is much larger than it was in March/April.
- Staff are more aware of, and stringent about, not being in the office if they have minor cold symptoms. It is positive that they are more vigilant about infection control, but it also has a larger impact on service capacity.

Pandemic Alcohol and other Drug Service Case Study
State-wide Residential/Therapeutic Community

Changes observed in the service user population/local community

Our residential services apply a therapeutic community model. Before the pandemic, the majority of consumers were presenting with methamphetamine as their principal drug of concern, followed by alcohol. Anecdotally methamphetamine was harder to access, and new consumers were presenting with higher polydrug use. Addressing polydrug use is within the service's capacity.

Our residential services already worked with people with complex needs in terms of mental health, physical health and other social well-being. There were no significant increases, beyond staff's capacity as such, in this complexity in the presentations of residents due to COVID.

Our service user demographics did not noticeably change.

Like everyone, access to bulk toilet paper, cleaning products, hand sanitiser and gloves (which were routinely used before COVID) were more difficult to acquire initially. However, we were able to see through this initial period and have ensured a stockpile.

Organisation response to COVID-19

Nursing staff associated with the services, and the organisation's executive, provided us with great guidance at the start of the pandemic. Nursing staff provided residential staff with information on the use of PPE and contributed to a COVID-19 outbreak response plan. The organisation's executive group provided ongoing communications. Staff were well informed about the response plans and strategies, including approaches to meeting the required restrictions.

Staff at the residentials implemented increased physical distancing, were temperature tested at the start of every shift, and more consciously applied hygiene and hand sanitiser practices and cleaning routines. Staff with any cold or flu symptoms were more strictly required to stay at home, get COVID tested and isolate until the testing results came through as negative. Implementing physical distancing practices were overwhelming for some to start with, however all staff maintained a solution focused approach to implementing the changes, and it has become routine practice now.

The residential services already had an established casual work pool to cover day and night staff absences due to illness. Staff morale has remained high, with many feeling grateful to be able to continue working and delivering the critical service for the service participants.

Service consumers were supported to increase physical distancing, were temperature tested on arrival and as needed. They were also supported to be more conscious about hygiene and hand sanitiser practices that were already promoted and encouraged pre-pandemic. They were provided with information and education on a daily basis, including having access to daily news reports to contribute to their awareness of the gravity of the pandemic.

Bed capacity of the services was reduced due the needed infection control measures. Residents were required to isolate pre-admission into the residential services (e.g. at the low medical detox service - low medical detox was extended to 2 weeks to maximise the identification of any infection and reduce the risk of introducing the infection into the residential community). This slowed down admissions. Some of the beds were set aside for possible emergency isolation support, and one-person-per-room requirements were introduced as needed.

Plan "B" options, if there was a need to close the residential services, were discussed with each service user. Plans were established for consumers who had a place or residence to return to, and coordinated exit plans were put in place for those consumers who were otherwise homeless. This initially resulted in some increased anxiety among the residents, however this was well managed through staff support.

Changes to patterns of attendance/uptake

The retention rate of residents was very high, as they felt safe at the service, with security assured in relation to food and other needs. This impacted on the waiting times for new residents.

There was also an influx of people looking for residential service provision. The reasons for this are unclear – possibly as a result of reduced supply of consumers' principle drug of concern, or recognition that the residential setting would offer increased safety and security. This influx was, however, despite some consumers choosing not to engage (possibly as a result of increased welfare payments reducing people's motivation to change).

Digital access was introduced to support admission groups and pre-residential engagement sessions.

Family and significant other visits with residents were stopped; however, residents were supported with increased digital connection with their loved ones – via zoom, skype or facetime.

Sessional services by partnership organisations, to meet residents' holistic needs, were offered through digital access.

There was increased reliance on **food and supply delivery services**, which were at times previously supplemented by staff and resident shopping activities. This resulted in some items not always being guaranteed, however adequate supply of essentials and needs was never an issue. There was considerable appreciation and tolerance by service users of any anomalies in access to non-essential goods.

What can be carried forward

Many of the practices that comply with the pandemic infection control requirements were already in place, however they were reinforced, increased or more consciously applied. For example, hygiene practices, use of gloves, cleaning practices and staff not attending if unwell. Colds, flu and other ailments experienced by residents are unavoidable, and practices to reduce any contagions were also in place if less stringent. The stricter application of these practices is likely to continue.

Consumers and service staff have always been supported to access flu shots in the winter period. The relevance of this during the pandemic was reinforced, with awareness that the service users are health compromised due to their substance use.

Physical distancing practices, including family and significant other visits and sessional support by external services, can be maintained while required, and staff are confident they can be easily reintroduced at any time if necessary.

Temperature testing, introduced since the pandemic, is likely to continue as usual practice.

While exit plans are a normal part of the service delivered, the staff are confident they can be easily geared up to include contingencies if there is a need for emergency exits or service closure.

Considerations for local outbreak and the recovery phase

The service is prepared, with a ready strategy for any local outbreak.

A stockpile of PPE has been established and will be maintained. This stockpile includes pre-pandemic PPE requirements, and now includes masks, shields and body suits.

Products likely impacted by supply disruption, such as toilet paper, have also been stockpiled.