Stigma and discrimination among the NSW Health and NGO workforce towards people experiencing harm from use of alcohol or other drugs

Report of mixed-methods research conducted on behalf of the NSW Ministry of Health

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Report legend

Key point: Highlighting important points or messages in this research.

Bookmarks/Links: Linking to relevant information and enhancing report navigation.

Appendix: Further information provided in an appendix.

Terminology

Terms used frequently in this report are explained in the table below. The terms chosen reflect person-centred and non-stigmatising language as recommended in guides such *Language Matters,* published by the Network of Alcohol and other Drugs Agencies (NADA) and the NSW Users and AIDS Association (NUAA).

Term	How the term is used in this report
Alcohol or other drugs (AOD)	'Other drugs' refers to non-prescribed drugs or prescribed drugs used to harmful levels
Person or people experiencing harm from use of alcohol or other drugs	Refers to people currently or historically experiencing harm to their physical, psychological or socio-economic wellbeing due to their current or past use of alcohol or other drug. (Also used in the shortened form: 'person with experience of harm from AOD use')
Client(s) or patient(s) experiencing harm from use of alcohol or other drugs	Refers to a person in the context of seeking or receiving treatment or support from healthcare and other support services.
NSW Health	Refers to the NSW Government agency that administers and provides publicly funded healthcare in NSW. NSW Health also employs the staff providing these services.
Local Health District (LHD)	A part of NSW Health that administers and provides publicly funded health services (such as hospitals and community health centres) to residents of a specified geographic area.
Non-government organisation (NGO)	Refers to an organisation that provides treatment and support services (such as residential rehabilitation) to people experiencing harm from AOD use. NGOs are not-for-profit charitable organisations that usually receive some funding from government and some from other sources such as fundraising initiatives.
NSW Health and NGO workforce	In this report, this term specifically refers to people who are employed by NSW Health or by non-government organisations, and who work in one of four settings - specialist AOD services, mental health services, maternity services or Emergency Departments.
Specialist AOD services	Services within NSW Health or an NGO which provide specialist treatment and support to people who experience harm from AOD use. 'Public sector AOD services' and 'NGO AOD services' are also referred to separately when required.
Mental health services Maternity services Emergency departments	In this report, these terms refer to types of publicly- funded services that are part of NSW Health. Emergency departments are based in public hospitals, while mental health and maternity services include both hospital-based and community-based services.
Outpatient/community workforce	This term is only used in this report to refer to survey participants who, when asked to nominate their principal place of work, nominated an outpatient department of a hospital (e.g. 'fracture clinic') or a general community or primary care setting (e.g. 'community health centre') that were not mental health, AOD or maternity services.

Acronyms and abbreviations

ACI	NSW Agency for Clinical Innovation
AOD	Alcohol and other drugs
CAOD	Centre for Alcohol and Other Drugs, NSW Ministry of Health
COM-B	Capability, Opportunity, Motivation and Behaviour framework
ED	Emergency departments
LHD	Local Health Districts
MDT	Multidisciplinary team
MH	Mental health
MoH or 'the Ministry'	NSW Ministry of Health
NADA	Network of Alcohol and other Drugs Agencies
NGO	Non-government organisation
NSW	New South Wales
RRR	Regional, rural and remote areas of NSW
TDF	Theoretical Domains Framework

Executive summary

People who experience harm from the use of alcohol or other drugs (AOD) are known to encounter negative attitudes and sub-optimal outcomes when they seek treatment and support from services. The research described in this report sought to understand the attitudes, beliefs and behaviours among some parts of the workforce towards people who are at risk from their alcohol and other drug use. This understanding was developed using the concepts of stigma and discrimination.

Stigma and discrimination in health and support services

Stigma is the process of stereotyping and marking out as different based on a person's perceived characteristics and can be felt or enacted by an individual towards self or others. Discrimination is the action or practice of treating a person with a certain ascribed or perceived characteristic differently and in an inferior way to other people without the characteristic. Stigmatising beliefs and attitudes can lead to people consciously or unconsciously behaving in a discriminatory way. In the context of healthcare and other support services:

- professionals themselves can hold stigmatising attitudes and act differently towards different client groups
- stigma and discrimination can be 'built in' to the systems, environments and processes within which the professionals work
- public norms and attitudes within broader society can be reproduced within the context of service provision.

Consequences of stigma and discrimination

Experiences of stigma and discrimination are distressing and can result in people who are already dealing with complex circumstances feeling shame, anger, rejection and a sense of worthlessness and hopelessness. In turn, a vicious cycle can be created – a person can become reluctant to seek treatment and support, only seek services when their physical and psychological needs are acute, and then experience repeated stigma and discrimination and poor health outcomes. They can also have a compounding negative effect on peoples' social, psychological and emotional wellbeing, hinder their ability to reconnect with the community, and limit access to other services.

Research objectives and methods

This research sought to understand the attitudes, beliefs and behaviours and determinants of stigma and discrimination among people employed in NSW Health and non-government organisations (NGO). Several service types were chosen to focus recruitment and participation on those most likely to encounter people experiencing harm from alcohol and other drug (AOD) use. These service types were emergency departments, mental health services, maternity services and drug and alcohol services in the public sector, as well as drug and alcohol services within NGOs. A total of 367 people participated in a focus group, key informant interview, or an online survey.

Using a mixed-methods approach underpinned by theories of behaviour change, the research team conducted thematic analysis of qualitative data and segmentation analysis of quantitative data.

Findings from thematic analysis of qualitative research

Focus group discussions and interviews were structured to ask participants about their experiences, observations and views about four topics: awareness of stigma and discrimination; the optimal treatment and support of people experiencing harm from AOD use, free from stigma and discrimination; perceived barriers to achieving this ideal situation; and suggested strategies to overcome barriers to the ideal situation.

Participants exhibited different levels of awareness of the problem of stigma and discrimination towards people experiencing harm from use of AOD. Most participants were aware that stigma and discrimination occurs in the NSW context towards this client group, and that stigma and discrimination was more pronounced within particular services and towards certain groups.

Second, participants were reasonably consistent in their descriptions of the ideal situation in supporting people experiencing harm from AOD use – including principles of person-centred, trauma-informed holistic approaches to care and treatment, provided by experienced and empathetic professionals. In an ideal world, these professionals would be able to coordinate support and treatment with other services, with the support of their organisation.

Third, participants often pointed out perceived barriers to achieving the ideal situation, including a lack of skills and training, observed negative behaviours among other staff, time pressures, unsupportive organisational cultures, and policies and processes that act as barriers to providing optimal care. Finally, participants suggested interventions and strategies that would help overcome these barriers, including access to and time for education and training, support for staff health and wellbeing, and reviewing policies, processes and models of care to better support those experiencing harm from AOD use.

When discussions were analysed according to service type and workplace of the participants, there were several notable differences in overall attitudes and beliefs about people experiencing harm from AOD use, and about the capability, opportunity and motivation barriers and enablers to behaviour change and stigma reduction.

Findings from segmentation analysis

Psychographic segmentation analysis of quantitative survey data resulted in the development of six distinct groups or segments, based on patterns of survey responses among more than 300 participants. Each participant was assigned, through the analysis, to one segment. Profiles were then developed of a ‘typical’ member of the segment, on the basis of which recommendations for targeted behaviour change interventions and messages were made. The members of each segment tended to have similar demographic and attitudinal profiles.

Segment name	Demographic patterns
Optimistic specialist	**Services**: Public and NGO AOD services **Professions**: Allied Health, AOD workers **Age**: 40-49 **Gender**: More likely female
Unruffled specialist	**Services**: Public AOD services **Professions:** AOD workers, Managers, Doctors **Age**: 50-59
Worried community generalist	**Services:** Outpatient and community **Professions:** Managers; Peer workers; AHWs

Segment name	Demographic patterns
	Age: Over 50
Pressured hospitalist	**Services**: Emergency, mental health **Professions**: Nurses/midwives **Age**: 30-39 **Gender**: More likely male
Fearful generalist	**Services**: Outpatient and community, mental health **Professions**: Nurses/midwives **Age**: 20-29 **Gender**: More likely female
Detached specialist	**Services:** Public AOD services in LHDs **Professions:** Allied health, Doctors **Age**: 60 +

Recommendations

Each psychographic segment was found to have a particular set of strengths, barriers and enablers in relation to their capabilities, opportunities and motivation to promote and take part in stigma reduction. This formed a COM-B based diagnosis, to which strategies and interventions from the Behaviour Change Wheel and its associated behaviour technique taxonomy could be matched.

The most noticeable pattern in the psychographic segments' COM-B-based diagnosis was a clear divide between the Generalist segments (Pressured Hospitalists, Worried Community Generalists, and Fearful Generalists) and the Specialist segments (Optimistic, Unruffled and Detached Specialists), such that:

- the Generalist segments faced the greatest challenges to stigma reduction because of their more stigmatising beliefs and attitudes and perceived barriers either in their own knowledge and skills or the environment in which they worked; and
- the Specialist segments each had particular strengths and weaknesses that could be supported by the recommendations, but on the whole were well placed to act as stigma reduction champions and mentors to others in non-specialist services.

Recommendations were developed for each of the six psychographic segments in the form of:

- targeted messaging to be used in communications and other stigma reduction activities aimed at the segment
- overarching strategic approach to support the segment in playing its part in stigma reduction
- suggested mechanisms to action the strategic approach, with example behaviour change techniques and enablers of change.

Overarching strategic approaches recommended for the segments were:

- enablement (Optimist Specialists, Unruffled Specialists, Detached Specialists)
- persuasion (Unruffled Specialists)
- education and training (Worried Community Specialists, Pressurised Hospitalists, Fearful Generalists)

- modelling (Worried Community Specialists, Pressurised Hospitalists, Fearful Generalists)
- environmental structuring (Pressurised Hospitalists)

1. Introduction

Background

Through this research project and related work, the NSW Ministry of Health (the Ministry) and its research partners aim to reduce the stigma and discrimination that can create a barrier to accessing health services, including AOD treatment and support services.

The Ministry's Centre for Alcohol and Other Drugs (CAOD) commissioned this research, and worked in partnership with the NSW Agency for Clinical Innovation (ACI) and the Network of Alcohol and other Drugs Agencies (NADA). The goal of the research is to identify the nature, extent, and factors contributing to stigmatising and discriminating treatment towards people experiencing harm related to AOD use expressed by selected segments of NSW Health and non-government organisation (NGO) workforce. The selected workforce segments or service types, include alcohol and other drugs services, mental health, maternity and emergency departments within Local Health Districts (LHDs), and specialised NGO alcohol and other drugs services.

Overall project aims

In response to the research findings, the project seeks to identify mechanisms likely to be effective in raising awareness of and reducing stigmatising and discriminatory attitudes, beliefs and behaviour in the selected service types by:

- Developing a segmentation framework to understand common attitude, belief and behaviour patterns among sub-groups of the participating sample
- Using this framework to identify barriers and enablers of behaviour change and stigma reduction for each segment, and to recommend the most appropriate evidence-based messaging and strategies for stigma reduction activities for each segment.

Findings and recommendations will inform the future planning and development of service models, workforce, education, training and other activities to reduce the stigma and discrimination that create barriers to accessing AOD treatment and support services.

Alignment with NSW Health policy

This research aligns with the *NSW State Health Plan*'s three overarching directions: 1) keeping people healthy, 2) providing world-class clinical care and 3) delivering truly integrated care. The research is also particularly pertinent to the Plan's strategy to support and develop the workforce (NSW Health, 2014).

The NSW Health workforce are required to uphold the CORE values of collaboration, openness, respect and empowerment. Any form of stigma and discrimination towards consumers or colleagues contradicts these CORE values and undermines the access to and quality of care provided by NSW Health and partner NGOs.

Elevating the Human Experience: Our Guide to Action, a state-wide strategy developed by NSW Health, describes what the NSW health system can do to deliver human-centred care and subsequently an excellent family, carer, patient and staff experience of care, every time (NSW Health, 2020). This research project is

aligned to and will help deliver this strategy; reducing the stigma and discrimination experienced by people that suffer harm from use of AOD will improve their experience of healthcare (as well as the experience of staff), as it will improve quality of treatment and the respect that people receive.

Evidence review

Current understanding of stigma and discrimination

DEFINITIONS OF STIGMA AND DISCRIMINATION

Stigma and discrimination are often described as existing when four separate components interact:

1. A label is applied to a perceived human difference (e.g. age, mental illness)
2. These labelled differences are linked to characteristics perceived by the labeller to be undesirable, which form a negative stereotype (e.g. people with mental health illness being linked to being dangerous)
3. Those who are labelled and stereotyped are seen as distinct, different and separate
4. Stigmatised groups experience discrimination and disadvantage in a range of areas such as healthcare, jobs and housing, leading to poorer health and social outcomes (Link, 2001) (Stuart, 2016).

Discrimination can exist at an individual level in interactions, or at a structural or societal level (for example, when accumulated in an institution creating inequities). Both stigma and discrimination are contingent on access to social and economic power, which is what enables groups to devalue and marginalise others (Stuart, 2016).

TYPES OF STIGMA

Types of stigma can be categorised in different ways in the literature. A common distinction made between different types of stigma is as follows:

- Structural stigma, which is where stigma accumulates within an institute or organisation and some people are excluded, disadvantaged or discriminated against as a result, which leads to inequities. For example, in healthcare, stigma may present itself by organisations not providing particular individuals with timely access to care (Hatzenbuehler, 2016).
- Public stigma, which refers to the negative and harmful views that members of the public have of people with a specific condition (Corrigan & Watson, 2002).
- Self-stigma, which is where people see themselves as less deserving, blameworthy and powerless (Hatzenbuehler, 2016). Stigma can be 'felt', describing the expectation of negative judgement (real or imagined), and 'enacted', which is the direct experience of negative judgement (Gray, 2002).

Nature and impact of AOD stigma and discrimination in health settings

There has been an increasing amount of research examining stigma and discrimination within health settings towards people who experience harm from AOD use in the last decade, globally.

Stigma and discrimination can create barriers to people seeking and receiving help to address AOD use. It can also hinder their ability to reconnect with the community, as well as limit opportunities to access other services or employment. This limited access can lead to exclusion, marginalisation, and social isolation, which can further negatively impact the person's mental and physical health as well as their families and friends (Lancaster, Seear, & Ritter, 2018).

INTERNATIONAL EVIDENCE

The stigma towards people with harmful AOD use in health settings ranges from outright denial of care, provision of sub-standard care, and physical and verbal abuse, to more subtle behaviours such as making people wait longer for treatment, or delegating their care to more junior colleagues. There are several factors known to perpetuate stigma towards people experiencing harm from AOD use among health professionals. These include negative attitudes, fear, and a lack of awareness about both the complexity of AOD-related harm, and about the nature of stigma itself. There may also be a perceived inability to manage the condition clinically, and institutionalised procedures or practices that create barriers to access and provision of high quality treatment and care. (Nyblade, et al., 2019).

A systematic review of international evidence evaluating health professionals' attitudes towards patients with substance use disorders (and the consequences of these attitudes), found that generally, attitudes towards patients with AOD issues were of a negative nature, and that these attitudes contributed to sub-optimal care. One known reason for this is that healthcare professionals' attitudes and behaviours can reduce the likelihood of people with AOD issues seeking help (for any health problem) and diminish patients' feelings of empowerment, which leads to poorer outcomes and experience. Health professionals' perceived violence, manipulation, and a lack of motivation from patients with harmful AOD use have been identified as factors impeding optimal healthcare delivery for these patients. Health professionals also lacked adequate education, training and support structures to work with this patient group. Health professionals were found to have a task-oriented approach to delivering healthcare, resulting in less personal engagement and diminished empathy (van Boekel, Brouwers, van Weeghel, & Garretsen, 2013).

AUSTRALIAN EVIDENCE

An Australian report by the Queensland Mental Health Commission (2018) concluded that experiences of stigma and discrimination are common in the everyday lives of people who experience harm from AOD use, and are pervasive in healthcare and public health settings. These experiences are distressing and can result in people feeling shame, anger, rejection and a sense of worthlessness and hopelessness, which can, in turn, trigger other alcohol and other drug use (Queensland Mental Health Commission, 2018).

For Aboriginal and Torres Strait Islander people experiencing harm from AOD use, the term 'racism' has been used to describe experiences of stigma and discrimination. Stigma and discrimination towards Aboriginal and Torres Strait Islander people has been shown to impact social and emotional wellbeing, as well as access to services. Other barriers for Aboriginal and Torres Strait Islander people in accessing AOD services included remoteness and marginalisation within geographic and social contexts, not feeling safe, and desiring more culturally appropriate service environments (Queensland Mental Health Commission, 2020). To help address

stigma and discrimination in Aboriginal and Torres Strait Islander communities, the Mental Health Commission (2020) recommended consultation with these communities (including local Elders and mentors) in identifying solutions, a system-wide approach to addressing racism, a holistic approach to health, a workforce who are culturally trained and aware, and a more trauma-informed approach within mainstream service providers.

Previous work on stigmatising attitudes and discriminatory behaviour in the context of health services in NSW found discrimination reported by those with Hepatitis C (many of whom inject drugs) (Hopwood, Treloar, & Bryant, 2006). Research to understand the experiences of people accessing South Western Sydney LHD Drug Health Services indicated that hospitals and also GP practices are not always welcoming environments for these people, and quality of care is not experienced consistently. In addressing stigmatising and discriminatory behaviour, the research suggested healthcare workers use targeted strategies that build trust with clients (Farrugia, Fraser, Edwards, Madden, & Hocking, 2019).

Evidence on interventions to reduce stigma and discrimination

A MULTI-FACETED APPROACH

Anti-stigma interventions can be universal (addressing an entire population) or targeted and delivered in a particular setting (Buechter, Pieper, Ueffing, & Zschorlich, 2013). A 2019 systematic review of interventions demonstrated several key strategies to reduce stigma in healthcare. Nearly all of the interventions took multi-faceted approaches (Nyblade, et al., 2019), with the most frequently used methods being:

- Contact with the stigmatised group, which involves utilising members of the stigmatised group in the delivery of the interventions. This helps to develop empathy within the audience by humanising the stigmatised individual and thus breaking down stereotypes.
- Provision of information, which involves teaching participants about the condition itself or stigma, what stigmatising behaviours might look like, and their effects on health
- Participatory learning, which involves participants actively engaging in the intervention.

An evaluation of several interventions designed to reduce stigma related to substance use disorders found that contact-based interventions alone and contact-based educational programs have the most robust evidence base for reducing stigma (Livingston, Milne, Fang, & Amari, 2011). Effect sizes for contact-based interventions are about twice the size of education alone (Corrigan, Morris, Michaels, Rafacz, & Rusch, 2012).

Overall, the research demonstrates that health professionals' anti-stigma programs should include **both a contact component and an education component.**

KEY FEATURES OF CONTACT-BASED EDUCATION INTERVENTIONS

Evidence from a Canadian study (Knaak, Modgill, & Patten, 2014) shows that effective contact-based education associated with a positive attitude change included several critical features as follows:

- social contact in the form of personal testimony from a trained speaker who has lived experience
- multiple formats or points of social communication. For example, the combination of a presentation from a live speaker, a video presentation, multiple first-voice speakers, and various points of social contact between program participants, and people with lived experience
- focus on behaviour change by teaching skills that help healthcare providers know what to say and do

- an enthusiastic facilitator or instructor who models a person-centred approach (as opposed to a pathology-first approach) to set the tone and drive messaging
- emphasise and demonstrate recovery as a critical part of the messaging.

EFFECTIVENESS OF COMMUNICATION STRATEGIES

Several features of effective communications programs that can inform the work of organisations implementing anti-stigma and anti-discrimination initiatives include (The National Academy of Sciences, 2016):

- identifying specific target groups and particular goals appropriate to each group
- making strong appeals that are relevant and personally consequential to particular audiences
- understanding how specific audiences orient to messages and what kinds of cues and styles hold their attention so that the message is absorbed and remembered
- knowing what matters most to each target group.

Other key factors that benefit communication-focused strategies among different workforce groups include a passionate champion, building partnerships, and involving people with lived experience from the beginning (Knaak & Patten, 2016).

Communication campaigns can help reduce stigma and discrimination but require **well-defined goals** and objectives, and should reach the **targeted audience** in a sustained or adequately frequent manner.

Rationale for this research

Research with frontline health staff about their experiences in responding to and supporting people who experience harm from AOD use has previously been conducted in NSW. For example, research has been undertaken to explore the impact of shame on counselling clients in AOD settings (Gray R. , 2010). Another study sought to understand the impact of online training within healthcare providers to reduce discriminatory attitudes towards people who inject drugs and increase the workforce's confidence in working with this client group (Brener, Cama, Hull, & Treloar, 2017). The current project was conceived to act as foundational and comprehensive primary evidence on which to build a state-wide stigma and discrimination reduction initiatives.

The research is underpinned by tried and tested behavioural theoretical frameworks which (a) provide a detailed taxonomy of potential barriers and enablers of behaviour change and (b) link these barriers and enablers to practical behaviour change techniques, options for policy and strategy review, and provide a systematic approach to identifying factors at an individual, organisational, and structural level that influence stigma and stigma reduction. Furthermore, the frameworks will help inform the identification of effective interventions to reduce stigma and discrimination.

Objectives

This research has **three primary objectives**:

1. Understand the types and drivers of stigma and discrimination in the NSW Health and NGO workforce's attitudes and behaviours towards people who experience harm from AOD use.
2. Identify segments of the healthcare and NGO workforce whose members exhibit similar patterns of beliefs, motivations, and behaviours related to people's care and treatment of harm from their AOD use.
3. Recommend appropriate, evidence-based messaging and associated communications delivery mechanisms targeted to each of these segments to support increased awareness of stigma and discrimination and reduce its occurrence across the NSW workforce.

2. Methodology

This section provides an overview of the research methodology including the guiding theoretical frameworks, ethical considerations, selection and recruitment of participants, data collection, and analysis methods.

Research phases

There were five phases of the research methodology, each of which built on the previous phase.

1. **Phase 1: formative research and research design**
    a. Small group discussions and phone interviews with consumers, service providers and policy staff to confirm approach
    b. Rapid desktop review to understand the current international and Australian evidence base and best practice approaches
    c. Theoretical basis for project developed, based on COM-B framework, to support understanding of barriers and enablers to behavior change and stigma reduction.
2. **Phase 2: data collection tools, recruitment strategy and ethics**
    a. Design of data collection tools (key informant interview guide, focus group guide, and online survey questions) based on formative research findings
    b. Design of participant recruitment strategy, participant information, and consent materials
    c. Ethics applications and approvals including approvals from every Local Health District.
3. **Phase 3: data collection from NSW Health and NGO workforce**
    a. Targeted recruitment via existing professional networks, from specialist AOD services (both public sector and NGO), mental health services, maternity services and emergency departments.
    b. Five key informant interviews, 13 focus groups and an online survey conducted.
4. **Phase 4: data analysis**
    a. Organisation and analysis of quantitative and qualitative data using SPSS and NVivo
    b. Coding of qualitative information using a hybrid deductive-inductive approach where:
        i. Pre-defined categories (based on the major topics targeted during the focus groups and interviews) were used deductively to provide an initial structure to the focus group and interview data
        ii. Within these categories, descriptive themes were inductively developed to identify patterns of responses among participants
        iii. Descriptive themes were considered alongside COM-B categories to assess the capability, opportunity and motivation barriers and enablers of stigma reduction in the context of NSW Health and NGO services.

c. Quantitative analysis of fixed choice responses from online survey:
    i. Data cleaning and descriptive statistics to characterise the participant sample
    ii. Factor analysis to identify patterns of responses to more than 40 attitude questions from the online survey
    iii. K-means cluster analysis to identify mutually-exclusive segments whose members (survey participants) exhibited similar demographic and psychographic characteristics.
d. Discussion of emerging findings for face validity in a stakeholder workshop.

5. **Phase 5: segment profiling and write-up**
    a. Development of six segment profiles and associated messaging and recommendations to support targeted reduction of stigma and discrimination in NSW.
    b. Write-up of report to inform the Ministry's approach to reducing stigma and discrimination in the health workforce towards people who experience harm from use of AOD.

Phase 1 - Formative research and research design

This study employed multiple qualitative and quantitative data collection and analysis methods. This mixed methods approach was chosen to support development of a comprehensive and nuanced understanding of the research problem, incorporating diverse and complementary perspectives (Creswell & Plano Clark, 2017). An associated benefit of using several data collection methods (interviews, focus groups and an online survey) was to maximise the opportunities for participation by healthcare and NGO-based professionals.

Formative research

A formative research phase was conducted to support contextual understanding among the research team and to inform the design of the data collection tools. There were two stages to this formative research, namely:

- Two small group discussions - the first with four consumer representatives including from the NSW Users and AIDS Association (NUAA), and the second with two service providers and two Ministry of Health policy staff
- A rapid desktop review to understand best practice approaches to addressing health workforce stigma and discrimination, including implementation enablers and barriers.

Guiding theoretical frameworks

The assumptions behind the research design come from behaviour change theories and frameworks. These frameworks are based on a body of evidence about factors influencing the likelihood that some new attitude, behaviour or cultural norm will be taken up and maintained among a particular group of people (the 'targets' for behaviour change). Behaviour change frameworks provide a structured taxonomy of the factors that can act as barriers and enablers to change, at individual, organisational or social levels.

Much research using these frameworks has been conducted in the field of public health in terms of changing health behaviours (e.g. influencing people to stop smoking) and in the field of marketing in terms of understanding how to influence different groups of people to buy or use a product or service.

Attempting to reduce stigma and discrimination is a similar task in that it requires an understanding of what gets in the way of changes to attitudes and behaviours, and requires identifying how stigma and discrimination are embedded in peoples' ways of thinking as well as in the organisations and systems within which they live and work.

COM-B AND TDF FRAMEWORKS

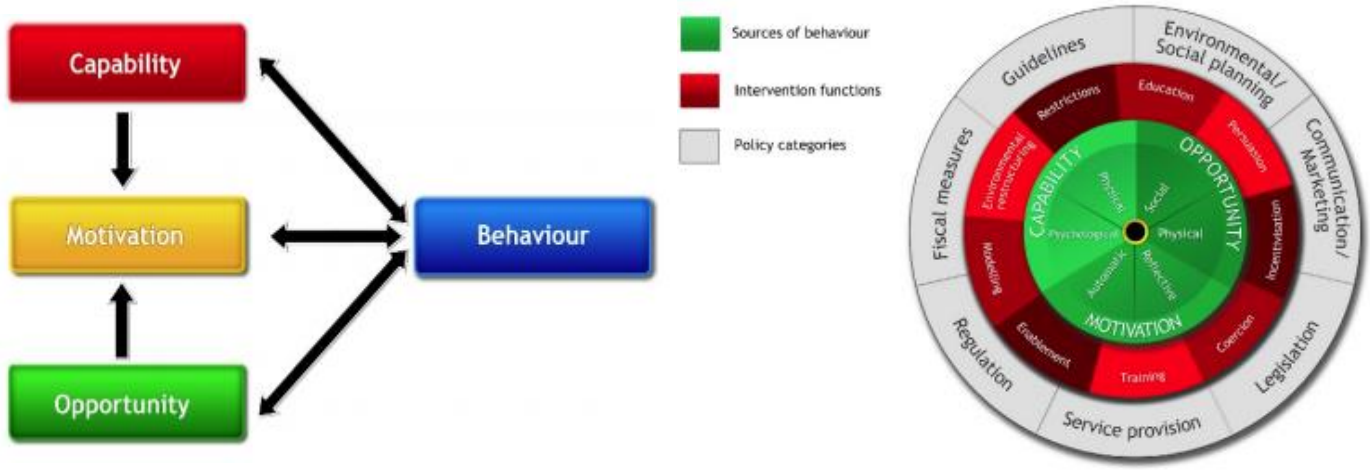
The Capability, Opportunity, Motivation and Behaviour (**COM-B**) system and Theoretical Domains Framework (**TDF**) informed the data collection and analysis.

The COM-B and TDF were chosen to guide this research because they help to identify (diagnose) the barriers and enablers to reducing stigma and discrimination in particular groups of health and support professionals. As well as supporting this behavioural 'diagnosis', the frameworks have also been so frequently used by researchers that evidence-based strategies and interventions to address particular 'diagnoses' have also been developed (in the form of the Behaviour Change Wheel, for example). The COM-B/TDF framework allows for systematic and robust exploration and analysis of the range of factors that are known to potentially influence behaviour. There is a well-established evidence base for the utility, appropriateness and effectiveness of these frameworks (used together and separately) in understanding how to intervene to influence specific behaviours in particular contexts (Atkins, et al., 2017).

THE CAPABILITY, OPPORTUNITY, MOTIVATION AND BEHAVIOUR (COM-B) SYSTEM

The COM-B system (Figure 1, left) provides a framework for understanding behaviour through exploring the factors related to capability, opportunity and motivation. These conditions are viewed within the context of a 'behavioural ecosystem', where all three must be present for any behaviour to occur. Interactions between these components can influence behaviour and vice versa. By systematically exploring the factors underpinning the target audience's capability, opportunity and motivation to enact a particular behaviour, it is possible to determine how to intervene to most effectively influence this behaviour.

Figure 1: The COM-B system (left) and the Behaviour Change Wheel (right)



The Behavioural Change Wheel (see Figure 2, right) illustrates nine intervention functions to address deficits in one or more of the three conditions. Around this are seven policy categories that could enable those interventions to occur (Mitchie, van Stralen, & West, 2011).

Visit http://www.behaviourchangewheel.com/ for further information on and to access an interactive demonstration of the Behavioural Change Wheel

THEORETICAL DOMAINS FRAMEWORK (TDF)

The TDF is an integrated and validated theoretical framework synthesising 128 theoretical constructs from 33 leading behavioural theories into 14 key domains. These domains map onto the COM-B categories of capability, opportunity and motivation and can be used to identify specific avenues for behavioural intervention, shown in Figure 2 below (Cane, O'Connor, & Michie, 2012).

Figure 2: Mapping of the COM-B system (green) to the Theoretical Domains Framework (yellow)

Using segmentation to complement the COM-B

AUDIENCE SEGMENTATION IN PUBLIC HEALTH

Audience segmentation has its roots in social marketing. For more than 20 years, public health researchers have endorsed social marketing principles in designing and implementing public health education interventions to improve their effectiveness (Lefebvre & Flora, 1988). These principles include:

- the segmentation of a target audience into homogenous groups
- an examination of knowledge, beliefs, social norms, and behaviours about the outcome or behaviour targeted for change
- the identification of communication channels relevant to each audience segment

- the development and targeting of messages and interventions appropriate to the particular cluster of knowledge, beliefs, social norms, and behaviours in each audience segment
- piloting material or programs with each audience segment confirming its applicability (Slater & Flora, 1991).

Segmentation methods were chosen for this research to complement the use of the COM-B and TDF behaviour change frameworks, as they can support the increased effectiveness of behaviour change interventions. When the motivations, beliefs and attitudes of a sub-group are understood, it is possible to design interventions that are more likely to feel relevant and persuasive.

Segmentation provides a better understanding of each segment's contextual challenges and facilitates effective content for key messaging and delivery mechanisms (Boslaugh, Kreuter, Nicholson, & Naleid, 2005).

DEMOGRAPHIC SEGMENTATION

Public health professionals have long recognised intragroup differences within populations but typically use demographic variables (age, gender, education, occupation, etc.), to describe or predict health behaviours. However, health attitudes and behaviours are not always clearly related to demographics (Lau, Hartman, & Ware, 1986). Demographic breakdowns on their own also rarely provide an understanding of the various personal and social contexts in which behaviours take place (Grier & Bryant, 2005), which is why psychographic segmentation methods were developed.

PSYCHOGRAPHIC SEGMENTATION

Psychographic segmentation is the grouping of a population into sub-groups based on clusters of attitudes, beliefs, and behaviours that each sub-group share. Psychographic segmentation seeks to identify and understand sub-groups sharing similar social norms and values, attitudes, beliefs, behaviours, and interests and uncover needs and motives. Psychographic segments are valuable because although two individuals may appear to be similar in terms of demographics and experience, they may hold very different attitudes, beliefs, and behaviours.

Developing effective interventions to facilitate behaviour change in health contexts requires a detailed understanding of the demographic, psychological, and ecological factors associated with the behaviour. Health behaviour change interventions could be more effective if tailored to groups of individuals based on key factors likely to moderate the effectiveness of interventions such as motives, preferences, and needs. Improving the effectiveness of interventions for unmotivated individuals should begin with analysing the underlying reasons for lacking motivation and support needs regarding behaviours and how these may be specifically targeted in interventions (Hardcastle & Hager, 2016).

Phase 2 – Data collection tools, recruitment strategy and ethics

Data collection tools

QUESTIONS COVERAGE

The COM-B framework informed the development of the data collection tool to elicit responses mapped to the dimensions of capability, opportunity and motivation. Questions to participants were categorised broadly into four overarching thematic categories:

- **Awareness of stigma and discrimination** (including their observations and direct experiences) in health settings towards people who experience harm from AOD use.
- **Perception of the ideal situation** for people who experience harm from AOD use and how close or distant the current situation was to this ideal.
- **Key barriers** (capability, opportunity, and motivation) to the ideal situation
- **Suggested strategies** to reduce stigma and discrimination to help overcome these barriers, including their actions, others in their service, and other parts of the health system.

Questions also addressed participants':

- prior experience and interaction with people who experience harm from AOD use
- attitudes and use of language about people who experience harm from AOD use, and attributed different attitudes to other service types
- levels of willingness or ability to change based on where they located the main driver of the problem.

Further information on the data collection tools is provided in **Appendix B.**

Recruitment strategy

PURPOSIVE RECRUITMENT

Participants were health professionals and other staff employed by NSW Health or non-government organisations providing services to people experiencing harm from alcohol and other drugs in New South Wales.

Participants were recruited on a purposive basis using the ethics approved inclusion criteria, which relate to the Ministry of Health, ACI and NADA's aim to understand stigma and discrimination among those staff members who commonly encounter these people during their work.

Further information on the study's inclusion criteria is included in **Appendix A**.

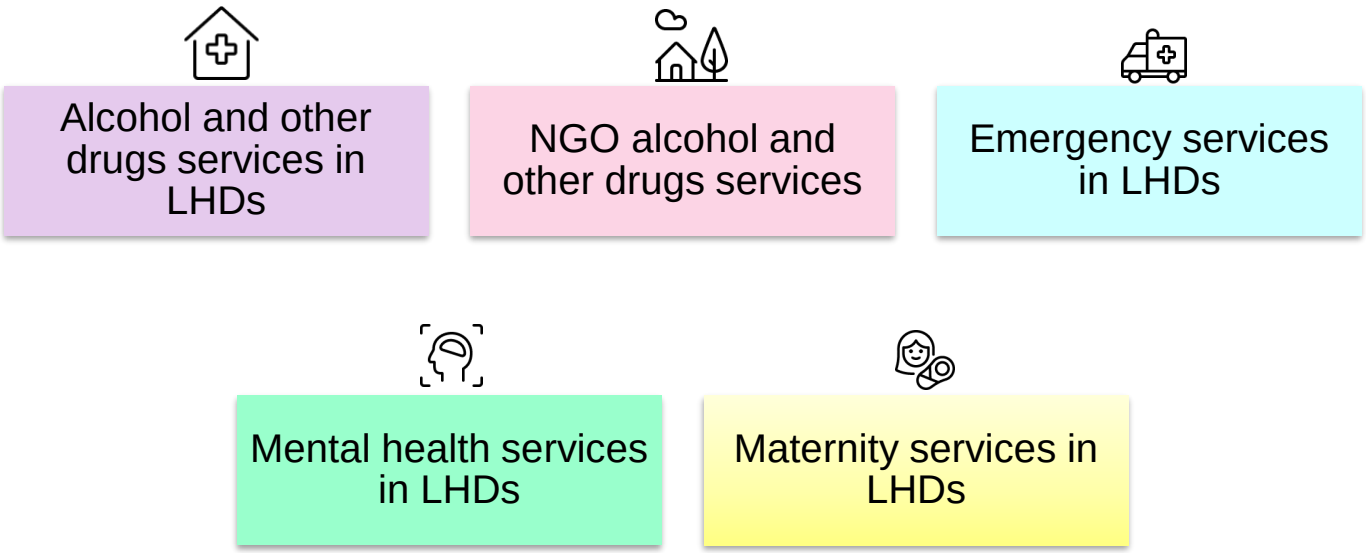
Purposive sampling was chosen given the exploratory nature of this study, the need to sample people who are available during the data collection period, and the need for participants to have sufficient professional experience relevant to the research questions. This means that the findings are indicative of overall patterns of attitudes and behaviours but, in common with all studies using purposive sampling, cannot be considered generalisable across the entire health workforce.

TARGET PARTICIPANTS

This study targeted the NSW health workforce within selected service types (see Figure 3, below).

The Project Steering Committee decided that these services had a frequent intersection with AOD clients where stigma and discrimination exist and who may be positively impacted by any subsequent intervention. The targeting of these services aligns with the Ministry's approach to tackling stigma and discrimination across the NSW health workforce.

Figure 3: The selected service types targeted for this study



RECRUITMENT CHANNELS

The research team purposively recruited key informants from peak bodies based on their prior knowledge of key opinion leaders in the AOD sector (NGOs and LHDs/SHNs) in NSW. Focus group and survey participants were also purposively recruited using standardised invitations to all members of selected email networks managed by the ACI, NADA and the Ministry. The use of these email networks helped ensure that the recruitment process efficiently targeted professionals with the required knowledge and experience to provide informed perspectives on the subject matter.

- The ACI brings together clinicians, managers and consumers to support NSW health service improvement and innovation. The specific networks used for recruitment to this study were Drug and Alcohol, Mental Health, Emergency Care Institute, Maternity and Neonatal, and Paediatric.
- NADA is the peak body in NSW for non-government organisations providing treatment, care and support to people experiencing harm related to their use of alcohol or other drugs. The specific networks run by NADA used for recruitment for this study included: Women's, Youth, NADA Practice Leadership Group (NPLG), and Aboriginal Drug and Alcohol Residential Rehabilitation Network (ADARRN).

- The Ministry also promoted the research using internal networks to increase the focus groups' uptake due to initial low interest/engagement. These networks included: LHD Mental Health, NGO Drug and Alcohol, and Nursing and Midwifery Office/Child and Family and Midwifery Leaders.

Ethics

Hunter New England Human Research Ethics Committee (HREC) 2019/ETH12823 approved the research and it was conducted following the *National Statement on the Ethical Conduct of Human Research 2018.* All participants in this research provided written informed consent. The research team obtained site authorisations for all participating Local Health Districts (LHDs) in NSW, which involved approvals from relevant Heads of Department and local Research Governance offices. The research team also obtained support from the Community Mental Health Drug and Alcohol Research Network (CMHDARN) Research Ethics Consultation Committee (RECC) to promote NGO participation in the research.

Phase 3 – Data collection from NSW Health and NGO Workforce

Key informant interviews and focus groups

Key informant interviews explored attitudes, beliefs and values at an organisational level and focus groups explored attitudes, beliefs and values on an individual level.

Five key informant interviews (each 30 minutes duration) were conducted with representatives from state-level peak organisations in the NGO AOD sector and from public sector Local Health Districts (LHDs) and Specialty Health Networks (SHNs). In addition, 13 one-hour focus group discussions were held with frontline professionals from service delivery organisations in the public and NGO sectors. Detailed notes were taken during consultations and cross-checked against the recordings for accuracy, where required.

All interviews and focus group discussions were held by telephone or by teleconference. This methodology supported participants' attendance from diverse geographical locations in the context of evolving COVID-19 restrictions. Virtual discussion also gave the participants the option of anonymity.

Online survey

Use of the anonymous online survey aimed to accommodate healthcare professionals' schedules and reduce participation barriers.

The online survey was brief and designed to be completed in approximately 15 minutes to maximise response rates and reduce participation barriers. The survey was programmed using *Qualtrics* and was open for four weeks to maximise the opportunity to participate. The survey questions included multiple-choice, binary choice and open-ended questions. Most multiple-choice questions were 5-point scales assessing agreement with

statements reflecting attitudes, beliefs and behaviours known from the literature to be indicators of potential stigma or discrimination. Open-ended questions encouraged respondents to reflect on their own experiences and observations at work. Demographic data collected was limited to age, gender, sector of employment (NGO vs LHD), primary place of practice (e.g. Maternity services, AOD services), and role type (e.g. doctor, nurse). The online survey was sent to individuals working in frontline service delivery positions within the relevant services in NSW LHDs and specialist NGOs providing AOD services.

Phase 4 – Data analysis

Qualitative analysis

Qualitative data was generated by the key informant interviews, focus groups, and the open-ended free-text elements of the survey. This data was analysed using framework analysis principles in *NVivo 10*. Initial descriptive coding of interview and focus group data inductively identified themes from within the data. We mapped these themes against the COM-B meta-categories of capability, opportunity and motivation using categorisations from the TDF theoretical domain constructs (see Figure 5, below). Therefore, the resulting coding framework was a hybrid inductive-deductive scheme informed by established conceptual frameworks with emphasis placed on the participants' issues.

The coding framework was applied to the qualitative data with iterative refinement to reflect emerging themes which fell outside of the COM-B/TDF framework.

This segmentation involved grouping by service type both the qualitative data collected from the key informant interviews and focus groups, and the data from the survey relating to demographics. This first step in segmentation is essential in highlighting the varying context in which each workforce segment operates, its interaction with AOD, the shared attitudes, beliefs and behaviours, and examples of stigma and discrimination.

Quantitative analysis

Quantitative data were generated through fixed choice responses from the online survey. The first step was to conduct descriptive statistics on the demographic information from the survey using *Microsoft Excel*. Secondly, factor analysis was conducted in SPSS followed by k-means cluster analysis to identify existence of patterns in attitudes, beliefs and behaviours amongst responses.

DESCRIPTIVE STATISTICS

Frequencies were determined for demographic variables. These variables were:

- Age group
- Gender
- Profession
- Service type.

These demographic variables were used during subsequent stages of psychographic segmentation to create demographic profiles of the final segments.

SEGMENTATION ANALYSIS

The purpose of segmentation analysis within this research is to understand patterns in attitudes, beliefs and behaviours among the survey participants. These patterns were identified using a combination of factor analysis and k-means cluster analysis.

Section 5: Findings by Service Type includes the key findings from the segmentation analysis.

Factor analysis (psychographic segmentation part I)

Factor analysis was conducted using SPSS using responses from 300 survey participants to approximately 40 different attitude questions in the survey. These questions asked the respondents to (a) indicate their level of agreement with a statement on a 5-point scale, or (b) indicate the frequency with which they had particular internal experiences (e.g. worries, concerns) and external experiences (e.g. experience of working with a client to follow through on a care plan).

Further information about the factor analysis method, correlations between factors, and interpretation of box plots can be found in **Appendix D.**

The five-factor solution for the survey questions explained 40% of the variance in data. The groupings are helpful only as a starting point for further analysis and helped us understand relationships between the different attitude statements and patterns of attitudes and behaviours across other parts of the workforce.

Table 1: Five factor solution

Factor name	Example component attitudes (from survey questions)
Positive and negative judgements toward clients themselves	Positive = endorse clients' right to decide their lifestyle and not to be judged for it Negative = endorse belief in clients' weak character, low employability and drug-seeking motivations
Sympathy for clients	Endorse non-personal factors for creating client circumstances, including adverse life events and using substances as a method of coping with difficulties.
The belief that clients are dangerous	Endorse feeling or experiencing of unpredictability, abuse, or violence from clients.
Negative emotional experience	Endorse experience of fear, anger, frustration, anxiety and stress when encountering clients.
Positive emotional experience	Endorse experiences of hope, empathy and concern for clients.

K-means cluster analysis (psychographic segmentation part II)

The five factors were insufficient to create mutually exclusive sub-groups of the survey respondent population. However, the factor analysis did identify patterns of attitudes, beliefs and experiences. Each participant had received five 'factor scores' during the factor analysis process, showing how strongly their responses aligned

positively or negatively with each factor. These five scores could be used as inputs to a cluster analysis process to assign each participant to a single sub-group of the overall cohort.

Cluster analysis is a statistical process of segmentation that assigns each survey participant to a sub-group based on minimising the 'distances' (differences) between their 'scores' on each of the five factors and the average score for the sub-group on each factor. The pattern of each person's scores across all five factors is also considered when assigning members to sub-groups.

For this analysis, the factor scores were entered into a published open-source model developed at the School of Marketing at the University of Sydney for cluster analysis, using the k-means method. Interpretation of the outputs showed that a six-segment solution was the most meaningful. Each participant was assigned to one psychographic segment as part of this output.

Phase 5 – Segment profiling and write-up

Psychographic profiling

Descriptive statistics were analysed for each psychographic segment to determine patterns in participants' characteristics assigned to that segment. The characteristics (variables) examined are listed below. Segments were also analysed for other similar traits such as demographic variables (e.g. age group, gender, service type, profession).

Table 2: Psychographic variables

Psychographic variable groups	Variables
Exposure to AOD	Work exposure frequency, personal life exposure
Strength of stigmatising beliefs and behaviours	Likelihood to avoid clients, attitude to compulsory treatment programs, advice to a friend on disclosing AOD issue
Prior experience with clients	Physical violence, verbal abuse
Emotional experience	Anger, fear, hope
Individual opportunity barriers	Self-perceived confidence, knowledge, skills, time
Contextual opportunity barriers	Training, resources, policies, time
Belief in the need for change	Clients deserve equal care, not treated equally in the health system
Motivation to change	Overall attitude, self-reflection, optimistic can reduce

Section 6: Findings by Psychographic Segment shows the findings from the segmentation analysis.

Validation workshop

The research team facilitated a validation workshop to present preliminary research findings on 4 March 2021 to engage relevant stakeholders who were involved with the inception of the research or were part of the consultation process, including:

- the Advisory Committee, including CAOD, LHD, NGO and consumer representatives
- ACI representatives from the relevant networks of NSW health professionals (mental health, drug and alcohol, emergency care and maternity/paediatric)
- NADA Practice Leadership Group representatives from various NGO organisations
- those involved in the consultation process, e.g. key informant interview participants.

The workshop's purpose was to seek input and advice from key stakeholders to:

- discuss and test the face validity of the research team's key findings
- consider the segmentation approach used in the research, identifying any challenges and any opportunities for improvement/refinement
- contribute to the development and prioritisation of key messaging tailored for workforce segments, including consideration of message content and delivery that would be feasible, realistic and palatable to the service type

The workshop's outputs helped inform the development of recommendations in this final report.

WORKSHOP ATTENDEES' REFLECTIONS ON KEY FINDINGS

There was a consensus from the workshop attendees that the health system required more work to reduce stigma and discrimination within the NSW health context and improve health outcomes for people experiencing harm from AOD use. Participants highlighted the importance of structural and policy changes as enablers for interventions (such as education programs) and the AOD peer workforce's value in improving the workforce's understanding of the complexity of AOD, and in shaping messaging.

CONSIDERATIONS FOR KEY MESSAGING

Workshop attendees noted that messaging needs to be positive and inclusive, with inclusion of personal stories to ensure messages real and tangible. Participants suggested developing an overarching message which targets the entire NSW and NGO workforce, whilst also developing some supporting messages which target minority groups.

Acknowledging and addressing the context and environment where services operate is also important to consider when developing messages. For example, the difficulties of managing clients in an often busy and stimulating ED environment. Participants also suggested that messages should aim to increase health workers' understanding of why they might develop particular attitudes and beliefs. It was felt that this would increase

empathy among the workforce, and help to explain the interplay between values, attitudes, behaviour, and the environment.

POTENTIAL DELIVERY MECHANISMS

Workshop attendees suggested that it would be important to adopt a range of approaches and make use of multiple channels. Channels for targeted messaging may include healthcare settings, with the inclusion of peer workers (relevant to the staff group) to create or deliver the messaging.

3. Participant demographics

This section summarises the demographic characteristics of participants across all methods of data collection. This includes the total number of participants for each method, and the breakdown of participants by age, gender, service type, profession and geographic location of work.

Overall: 53% of participants were aged 50 years and over, 73% were female, 84% worked in the public sector, 54% worked as a nurse/midwife, 23% worked in mental health services and 22% in drug and alcohol services.

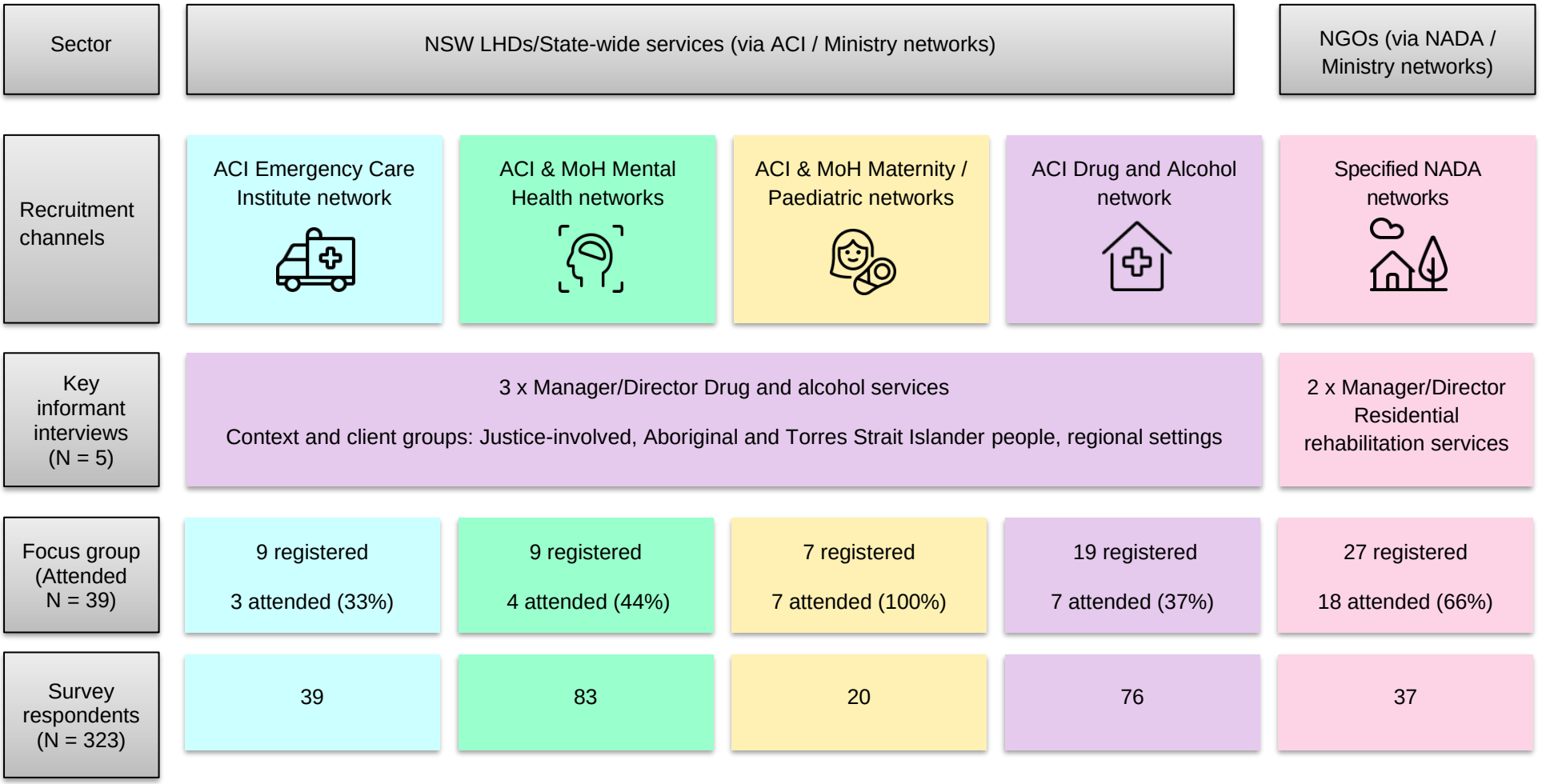
Overall participation by method

The study received a total of 367 responses across the three data collection methods (key informant interviews, focus groups, and the online survey). Figure 4 provides a breakdown of participants and Figure 5 provides more detail about participation.

Figure 4: Number of participants across each of the three data collection methods

5	39	323
Key informant interview participants	Participants across 13 focus groups	Survey participants

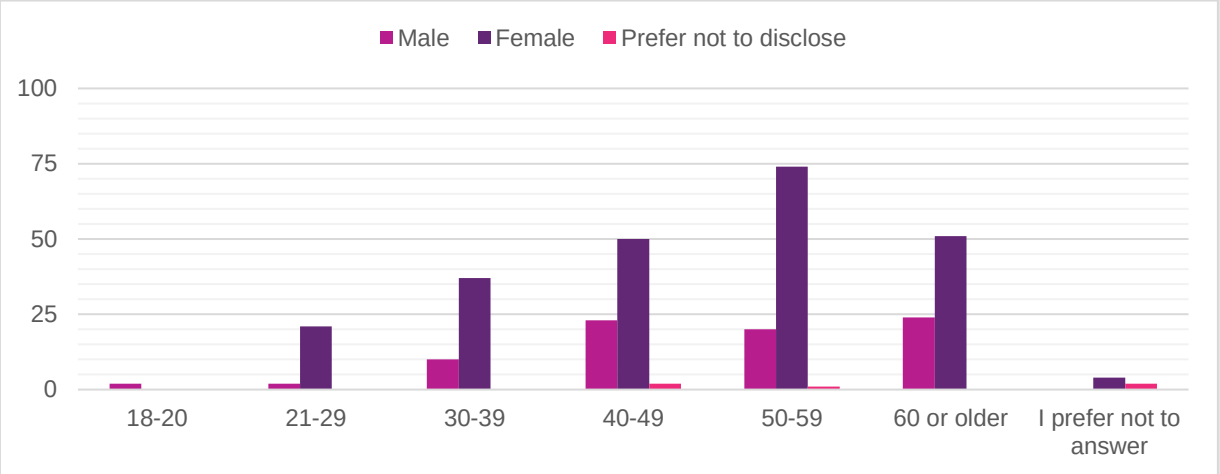
Figure 5: Overview of the total sample by service network and by data collection method



Age and gender

The survey captured information on participants' age and gender (see Figure 6 below). 53% of the total survey sample were 50 years and over. The 50-59 age group represented the largest proportion overall, and nearly three quarters (73%) of the total survey sample identified as female.

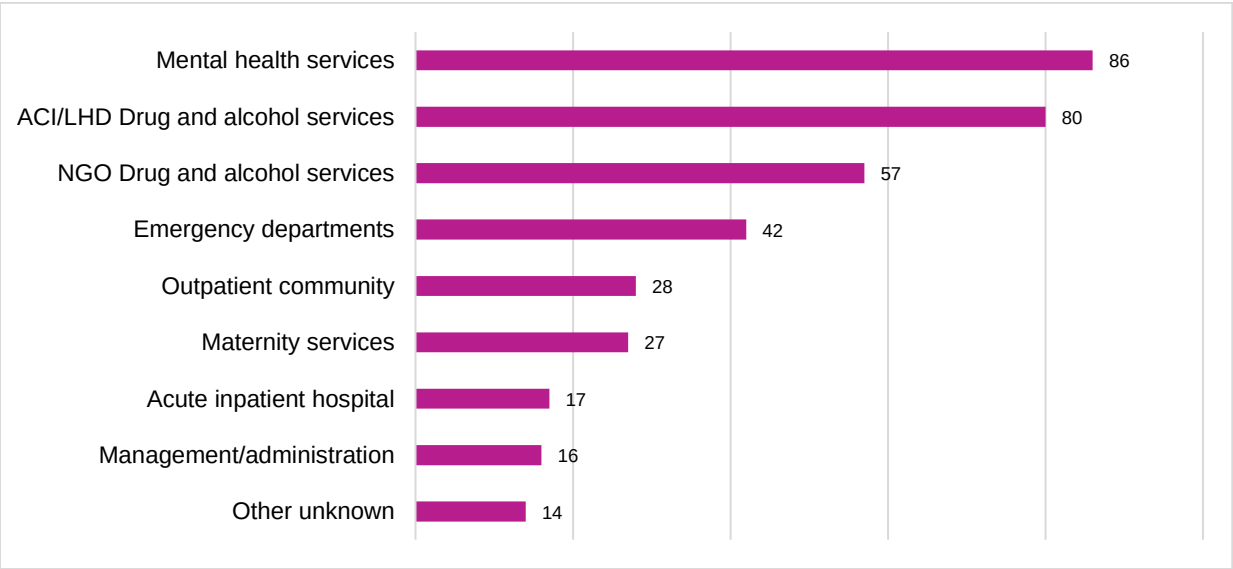
Figure 6: Reported age and gender (survey only, n=323)



Work setting and profession

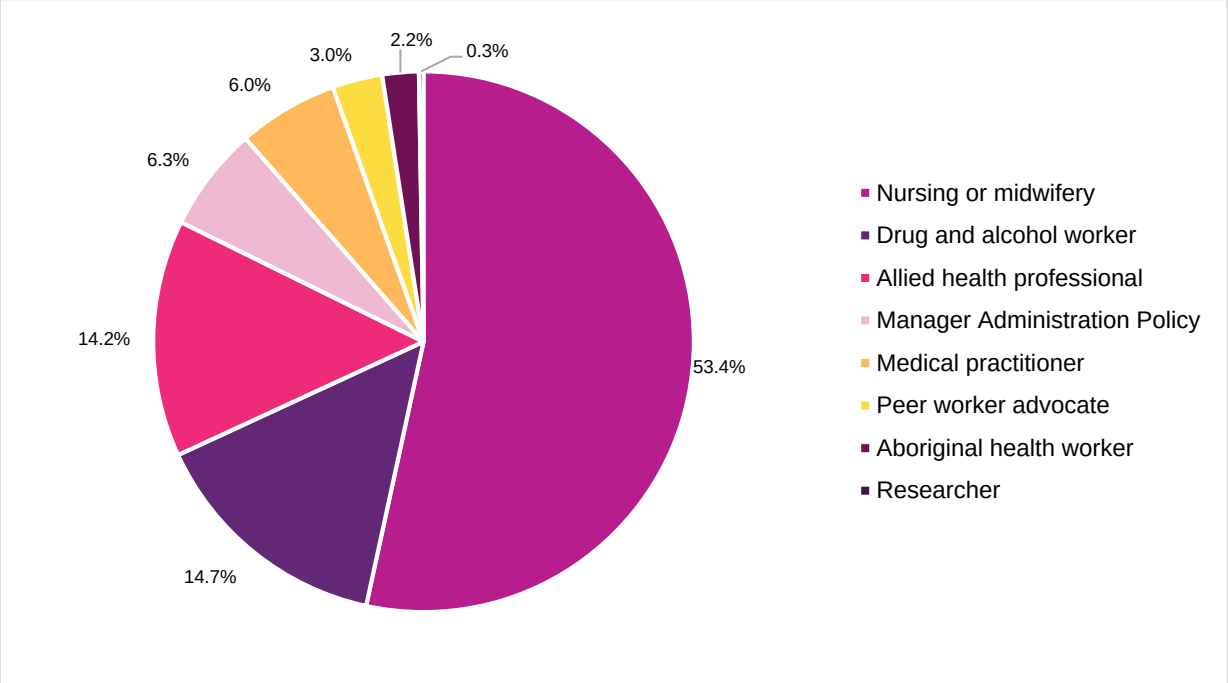
The majority of participants (84%) worked in public sector services, with the remaining 16% working in non-government organisations (NGOs) (16%). In terms of service type, largest proportion of participants worked in mental health services (23%), followed by public sector drug and alcohol services (22%), and NGO drug and alcohol services (15%).

Figure 7: Number of participants by self-reported service type (all participants, N=367)



Participants working in nursing or midwifery made up the largest proportion of participants (54%), followed by drug and alcohol workers (15%) and allied health professionals (14%).

Figure 8: Reported profession (proportion of all participants, n=367)



Location of work (survey participants only)

Forty per cent of participants working in NSW Health Local Health Districts (LHDs) were based in metropolitan areas, while 45% were based in regional, rural and remote areas. A smaller proportion reported working in NGOs or in state-wide services (SHN/other) which include the Children's Health Network, Justice Health Network. Of the NSW Health participants in the survey, by far the greatest number worked in Sydney LHD (n=57) or Southern NSW LHD (n=50), followed by Western NSW (n=35) and Western Sydney (n=27). All other LHDs had 20 or fewer participants.

Figure 9: Location of survey participants (n=323)

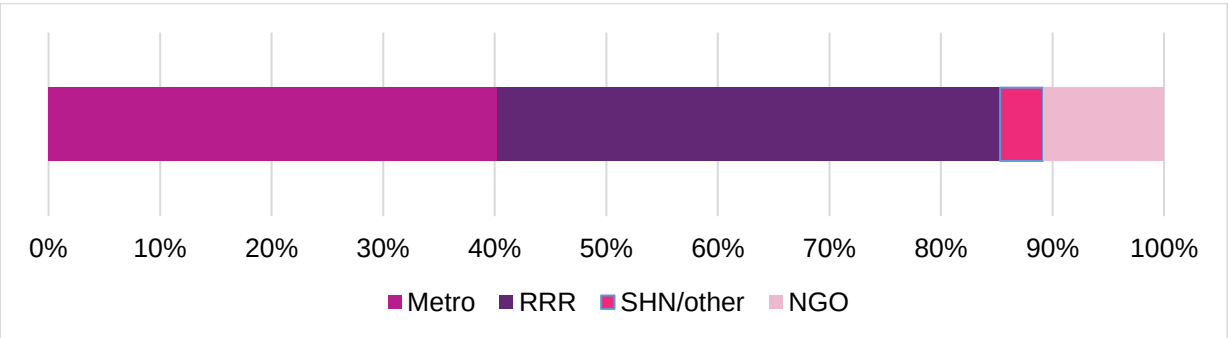
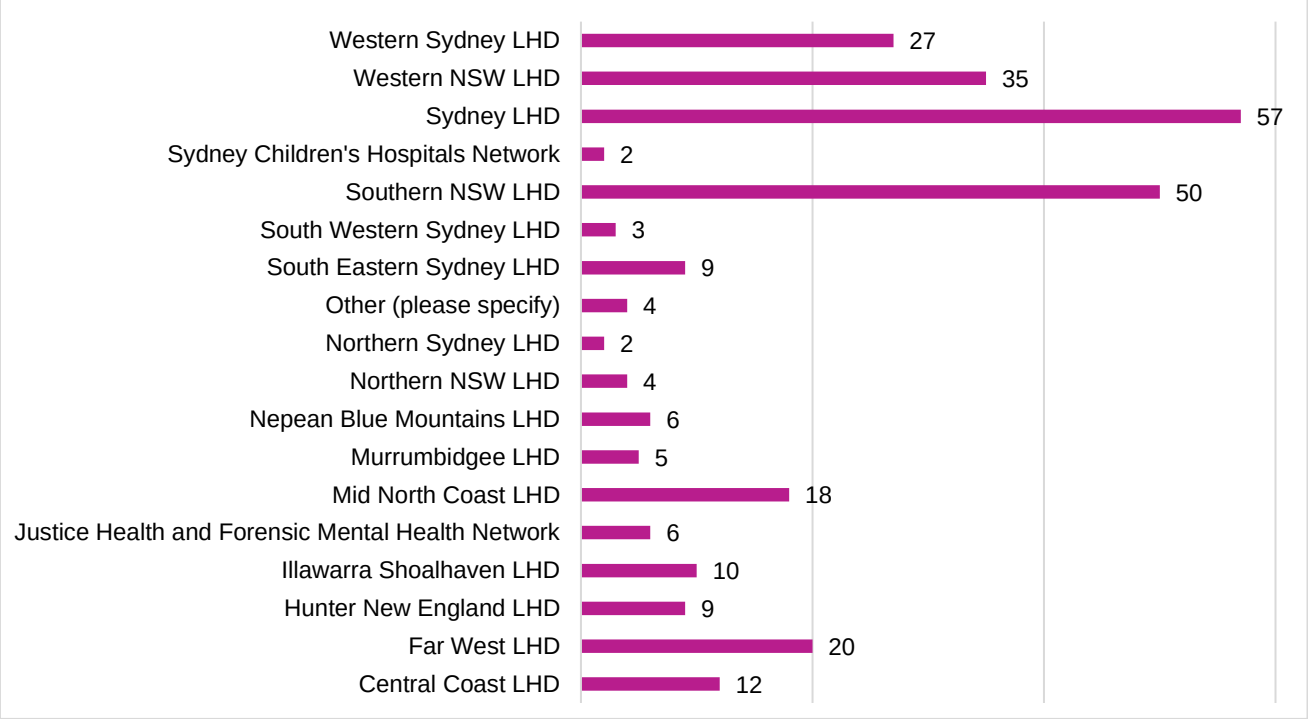


Figure 10: Number of survey participants from each NSW Health organisation



4. Findings by theme

Introduction to thematic findings

This chapter and the next chapter present themes that emerged from analysis of key informant interviews and focus group discussions. This chapter looks at overarching patterns of themes across the participant group, while the following chapter breaks these patterns down by the type of service in which participants worked.

The question guides for the qualitative research were structured to ask participants to reflect on their experiences and observations, and give their thoughts and perspectives, on four broad topics.

1. Participants' awareness of the existence and types of stigma and discrimination among the workforce (see section 4.1 below).
2. Views about the features of optimal care and support that is free from stigma and discrimination ('espoused ideals') (see section 4.2).
3. Experiences, observations and views about barriers to providing optimal care that is free from stigma and discrimination ('barriers to ideals') (see section 4.3).
4. Suggested strategies for overcoming the barriers to optimal care and support ('overcoming barriers to ideals') (see section 4.4).

These four broad topics were used during thematic analysis as an initial organising framework for the qualitative data. Themes were then inductively developed within each of these four broad categories.

USE OF THE COM-B FRAMEWORK

The COM-B and TDF frameworks guided the development of the four major topics of interest described above. The questions asked of participants gave them the opportunity to reflect on various factors related to capability, opportunity and motivation and that are known to influence behaviour change. The patterns of responses given by participants have been linked in this and the following chapter to elements of Capability, Opportunity and Motivation.

This chapter explores themes related to capability, opportunity and motivation that appeared to be common across multiple service types within NSW Health and NGO services, while the **following chapter** breaks down patterns of themes emerging among participants from each targeted service type.

CAPABILITY, OPPORTUNITY AND MOTIVATION FOR BEHAVIOUR CHANGE

The following list summarises aspects of capability, opportunity and motivation that will be discussed as part of this chapter and the next.

- **Capability barriers and enablers**
    - **knowledge** of harms related to AOD use, and awareness of stigma and discrimination in the workforce context
    - **knowledge** about what optimal treatment and support would look like in an ideal world
    - **skills, knowledge** and capacity at work.
- **Opportunity barriers and enablers relate to:**

  - **environmental factors** in the workplace such as time, resources, environmental stressors, policies, procedures
  - **social and cultural factors** within and beyond the workplace, such as group and organisational norms and beliefs, leadership and modelling, professional identity

- **Motivation barriers and enablers** relate to:
  - internal experience of interactions with people experiencing harm (emotions of fear, anxiety, hope, concern) and personal impact of one's work (burnout, stress)
  - level of belief in need to change, belief in own ability to change, belief in impact of own change, and overall readiness to change
  - types of beliefs about own level of capability – confidence, self- efficacy and feelings of empowerment
  - optimism.

Capability-related themes

Awareness of stigma and discrimination

Overall, most participants were aware that people who experienced harm from AOD use were subject to stigma and discrimination when accessing healthcare in NSW, and described that the extent of stigma and discrimination was more pronounced in particular services and groups.

TYPES OF STIGMA IDENTIFIED

Consistent with the evidence available on the existence of different types of stigma, participants observed and described various kinds of stigma towards people experiencing harm from AOD when accessing healthcare in NSW, including interpersonal stigma, structural stigma and self-stigma.

GROUPS PERCEIVED TO BE MOST AT RISK OF STIGMA AND DISCRIMINATION

Participants noted that stigmatising and discriminatory treatment were more pronounced for particularly vulnerable groups of people who experience harm from AOD use. These groups included:

- **People who use illegal drugs including** those with past drug use (even if unrelated to the presenting problem).
- **Aboriginal and Torres Strait Islander people** and other marginalised communities, whose experiences of stigma and discrimination intersect with racism and prejudice.
- **People who frequently relapse** due to their AOD use (particularly those presenting in ED). These people can be denied access to services, misdiagnosed, placed in the 'too difficult' group by staff, or not adequately given the support they need.
- **Parents, expecting parents and families** who experience harm from AOD use, for example in maternity services. Participants did however note that this has improved in the last decade.

- **People with co-occurring alcohol, other drugs and mental health issues**, particularly those trying to access mental health services.

AWARENESS OF OWN AND OTHERS' DISCRIMINATORY PRACTICE

While participants were conscious of types of stigma and discrimination, they often described the phenomenon in terms of what they had observed among other staff.

Participant examples of stigmatising language

Participants provided examples of stigmatising language that they heard used by other health workers in relation to people who experience harm from AOD use. This language includes "addict", "druggo", "frequent flyer", "your girls", and "the doozy patient".

There were also some examples of participants displaying stigmatising attitudes or discriminatory assumptions and behaviours in remarks made as part of focus group discussions. This was sometimes attributed to pragmatic considerations, such as rapid sedation of an acutely intoxicated person in an ED rather than because of lack of time.

Stigmatising attitudes and discriminatory practices were sometimes based on beliefs that people with specific types of needs were less suitable or worthy to receive a certain service. This occurred in different ways in different types of services. For example:

- 'Cherry picking' clients for mental health services who do not have harm related to AOD use as well as a mental health need (as this is perceived to be the remit of AOD services)

"You're too complicated. Let's give you this diagnosis".

Mental health focus group participant

- In ED, treating some types of intoxication as less 'acceptable' than others – particularly illicit drug intoxication or alcoholism. Some harms may be seen as more understandable – for example, in veterans or in students on a night out.
- Seeing clients with harm from AOD as taking resources and time away from other patients.

"Lots of people in ED dealing with this person – taking away from people who are acutely unwell".

ED focus group participant

- One participant described clients receiving legally mandated treatment as 'contaminating' their AOD NGO service, because staff experience of these clients can increase their judgement of other clients who are receiving treatment by choice.

A few participants described people experiencing harm from AOD use as 'bothersome' or 'challenging', displaying this by talking down to clients and, during acute periods of intoxication, using swift sedation rather than de-escalation (in ED) because of time or resource constraints.

One participant described their feelings about a situation where an Aboriginal client sought treatment in a location by the river closer to country:

"I feel clients sometimes have a sense of entitlement wanting to choose the location of their rehab".

Public alcohol and other drugs focus group participant

Knowledge and awareness of good practice and optimal support

Focus group participants were asked to reflect on what they believed to be the ideal situation or context in terms of staff and system interaction with people who experience harm from AOD use.

Participants' perception of the ideal situation in supporting people with AOD issues is a patient-centred, trauma-informed, holistic approach provided by an experienced and empathetic health worker. Participants' noted that the health worker should be able to effectively coordinate support and treatment with other health services, and also be adequately supported by their organisation.

POSITIVE AND THERAPEUTIC RELATIONSHIPS WITH CLIENTS

Participants perceived that a positive, encouraging and strengths-based approach from health services when interacting with clients, was of key importance. An example of a strengths-based approach provided by participants was a focus from the health service during interactions with clients on the positives of not using substances rather than the negatives of using substances.

Health services and their staff should furthermore engage with clients in a non-judgemental and non-threatening way and utilise empathy and compassion, to create a safe space for clients and a relationship based on, compassion and respect. For example, during handover conversations, clients should exercise discretion and not mention any history of intoxication that a client has, if it is not relevant. If relevant and therefore mentioned, this should not lead to staff treating clients negatively.

Some participants noted the benefits of taking an informal approach when holding sensitive conversations with clients (such as their level of alcohol consumption), finding that such an approach can help to build clients' confidence in interacting with health services. Central to building to trust and respect is the use of language which is free from stigma and discrimination. The example of clients' initial assessment in ED was given as a common context for use of stigmatising and discriminating language.

Finally, participants highlighted the importance of a holistic approach to care that is centred around the patient, one that considers the complexity of clients' lives and the competing priorities that often exist for clients as part of that (for example, housing concerns, financial pressures, relationships). Part of this approach was felt to be empowering clients to be actively involved in their care.

"…more positive and encouraging approach with clients, empowering them and involving them in care".

Maternity focus group participant

AN ADEQUATELY SKILLED AND EXPERIENCED WORKFORCE

Participants (across key informant interviews and focus groups) consistently placed importance on health services having a workforce that is suitably trained to meet the needs of people who experience harm from AOD use. Ideally, workers would have previous exposure and experience working with this client group. Examples of the skills and experience required include motivational interviewing, basic knowledge in pharmacology, and particularly in the context of ED and security staff, the ability to de-escalate a difficult situation verbally (rather than default to restraint or sedation as an initial approach).

"Lack of education resulting in judgement…[experiences can be] negative when dealing with other health professionals who don't understand drug and alcohol".

Key informant interview participant

The importance of clients having access to a well-resourced multi-disciplinary team was also highlighted, with adequate capacity built in that allows for proactive follow-up by staff where required.

COLLABORATIVE WORKING BETWEEN SERVICES

As many of these clients will require access to multiple services, participants highlighted that in order to achieve an effective coordinated and holistic approach, collaboration between services involved in a client's care is critical. Without this, clients are often pushed between services, or fall through gaps. Participants provided the example of the importance of community AOD services working collaboratively with inpatient psychiatric services. An example of a collaborative approach in practice is one service providing a warm referral to another service for a client.

Several participants noted that the busy and populated ED environment is often not conducive to the therapeutic nature of care and support that clients need when situations escalate (unless necessary from a clinical perspective). Diverting clients to alternative more calm environments (such as a AOD detoxification and mental health unit) leads to more timely and effective de-escalation of a situation, and thus minimises the damage or distress for clients, staff, and other ED clients.

SUPPORTIVE AND ENABLING LEADERSHIP AND ORGANISATIONAL CULTURE

The achievement of positive and therapeutic relationships with clients, an adequately skilled and experienced workforce, and collaborative working between services were reported to be contingent on a leadership team and an organisational culture that enables and supports these. For example, the leadership team need to role model the avoidance of using any stigmatising and discriminating language. Where staff do use inappropriate language, it should be challenged and addressed with the relevant staff member, Participants provided another example of organisations putting systems and processes in place which support staff to work with people who experience harm from AOD use. These include clinical and professional supervision, opportunities to de-brief and engage in reflective practice, and access to health and wellbeing resources.

Perceived barriers to optimal support

Participants reflected on the barriers to achieving the espoused ideals, particularly the factors that are perceived to drive the development and maintenance of stigmatising attitudes and discriminatory behaviour. The key themes that emerged are listed below, grouped using the COM-B behaviour system (see Figure 2 pg. 11 for information on COM-B).

Participants described several key barriers to achievement of the ideal situation, including a lack of skills and training among the workforce, observed negative behaviours from the workforce, time pressures, unsupportive organisational cultures, and policies and processes that act as barriers to providing optimal care.

Capability barriers

LACK OF ADEQUATE SKILLS, TRAINING OR EXPERIENCE IN AOD

A lack of understanding and empathy among certain staff was seen by participants as a critical barrier to achieving the espoused ideals. This was put forward most strongly by AOD services (including NGOs), in relation to ED staff. This lack of understanding and empathy was thought to be driven particularly by a lack of knowledge of the relationship between trauma and substance use, the complex nature of AOD presentation which can include comorbidities and psychosocial determinants, how language can be stigmatising, and the impact of stigma and discrimination on clients.

Some participants commented that they themselves felt they lacked the skills (and sometimes confidence) to appropriately respond to people who experience harm from AOD use, which resulted in a reluctance or discomfort to address certain issues with clients. One example provided was that mental health nurses are trained to work with people with chronic mental health conditions, and are not trained to manage issues associated with a client's substance use. Additionally, GPs may not be adequately equipped as they may not be aware of the support services that they could refer to, or they may be aware but not have adequate knowledge or confidence. Participants reported observing stigmatising behaviour from the Department of Communities and Justice (DCJ) child protection caseworkers towards clients and their families. This was perceived to be due to a lack of knowledge and skills in AOD.

The online survey found that staff working in public and NGO drug and alcohol services are least likely to worry 'always' or 'often' about a lack of knowledge or skills. Maternity service, ED and outpatient and community staff are most likely to worry 'always' or 'often' about a lack of knowledge or skills (see Figure 11). In terms of profession, the online survey found that doctors are least likely to worry about a lack of knowledge or skills whilst managers and administrators are most likely to worry 'always or often' (see Figure 12).

Figure 11: Responses by service type to "*I experience worry that I do not have the appropriate skills or knowledge to support the person*". Agreement expressed as a per cent of respondents per service type (N = 323).

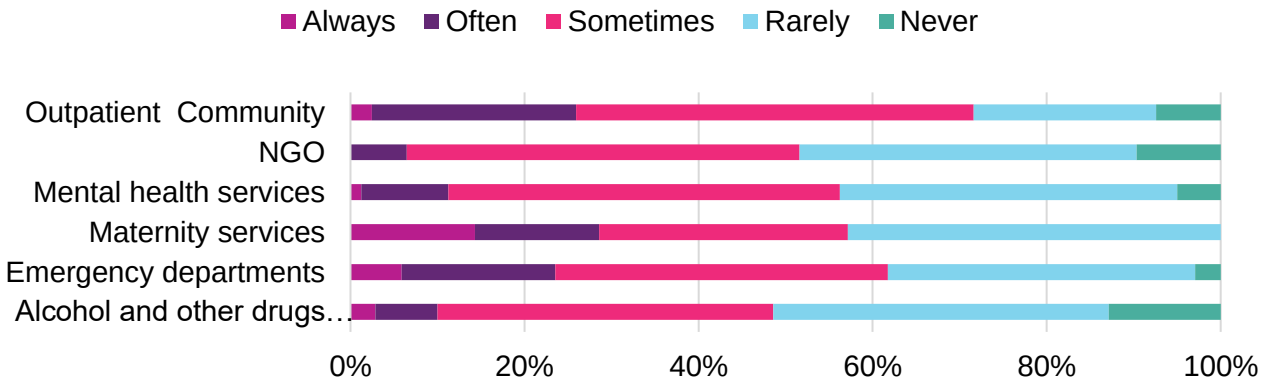
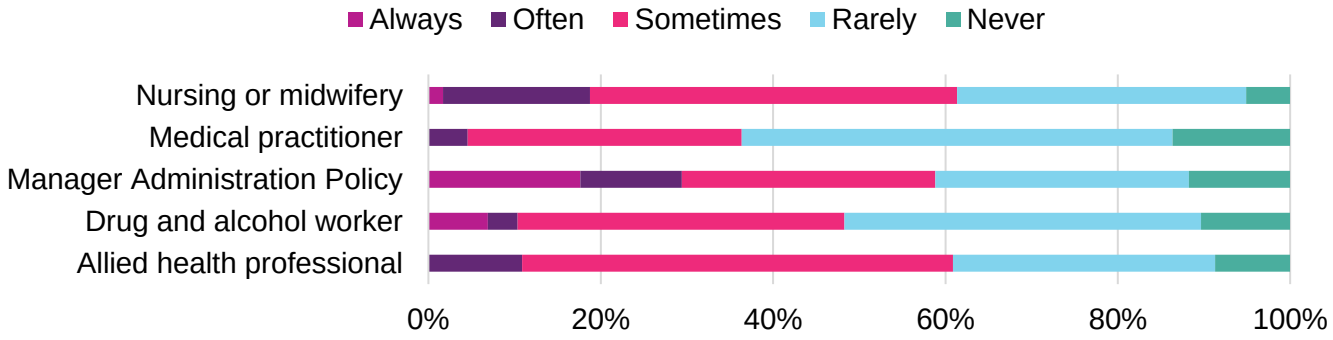


Figure 12: Responses by profession to *"I experience worry that I do not have the appropriate skills or knowledge to support the person presenting to my service"* Agreement expressed as a per cent of respondents per profession (N = 323).



Opportunity barriers

TIME PRESSURES, LIMITED CAPACITY AND BURNOUT

Across all types of consultations, it was common for participants to report time pressures, a lack of capacity, and sometimes burnout, as a barrier to providing optimal care to people who experience harm from AOD use. Participants provided the example of ED nurses, who they reported often experience burnout as a result of working with challenging clients throughout long shifts (~12hrs), and often multiple presentations in one shift. Some participants reported that they themselves have experienced "compassion fatigue" and feelings of frustration that clients are "not trying harder" and a belief that "they would be back tomorrow".

As an additional barrier, participants reported that these clients commonly present out of hours, when health workers with the adequate training and skills to work with these clients may not be available. This can compound the stigma and discrimination experienced by clients.

UNHELPFUL ORGANISATIONAL CULTURES, POLICIES AND PROCESSES

Participants reported that the culture, policies and processes established and implemented by their organisations can sometimes present barriers to providing optimal care to people who experience harm from AOD use.

For example, participants highlighted that some assessment tools were not conducive to providing a personalised experience for the client, and instead were structured in a way that supported efficiency, leading to a "box-ticking" experience from the client's perspective. Additionally, relevant policies may also fail to take into consideration the complexities of AOD related issues and comorbidities, which may further marginalise clients. Participants also highlighted that it is less common in ED than in AOD services to routinely conduct psychosocial needs assessments, and staff are less likely to be trained in trauma-informed care.

Participants observed the culture of an organisation as a barrier to providing optimal care for clients. It was reported that in some services such as mental health and ED, there can be entrenched beliefs that AOD "is not [their] business". Additionally in some organisations it was put forward that there is a culture of focusing disproportionately on clients' past "issues" which feature in their medical history, which did not lend itself to providing optimal care in the present.

Participants reported that models of care that are focused on achieving abstinence as opposed to harm minimisation are not conducive to providing optimal care to people who experience harm from AOD use, as they can be over simplistic and not fully account for the complexities of the situation.

Participants also highlighted a lack of integration and collaboration between the services involved in providing care for people who experience harm from AOD use, particularly between mental health and AOD services. Referral between services was highlighted as one of the most prominent barriers for clients, including long waiting times (for example a six week waiting period for some rehabilitation services) and strict eligibility criteria which can often lead to “closed doors”.

"We work hard to help clients access services … feel a bit helpless sometimes with so many brick walls".

NGO focus group participant

SOME CLIENTS LACK FINANCIAL MEANS LEADING TO ACCESS INEQUITY

Participants commented that clients’ financial situation can negatively impact their ability to access optimal care. Some clients are not able to access telehealth, which is more commonly offered since COVID-19 pandemic emerged, as they do not have the technology required (phone/laptop). Some clients are also unable to access services where an out of pocket payment is required, for example private clinics or access to psychologists.

ADVERSE EFFECTS OF LEGISLATION, THE MEDIA AND CULTURAL NORMS ON INDIVIDUALS’ ATTITUDES

Participants across most focus groups commented on the effect of the criminalisation and regulation of illicit drug use on societal attitudes towards people who experience harm from AOD use. The media may also influence public misconceptions with inaccurate and sensationalist portrayals of people experiencing harm from AOD use, creating attitudes of fear; for example by airing TV campaigns on illicit drugs.

Broader societal and cultural norms were also seen to impact individuals’ attitudes, including misconceptions about people who experience harm from AOD use. For example, a number of participants highlighted the view held by many that addiction is a choice. As another example, societal and cultural norms in Australia view certain scenarios of intoxication as socially acceptable, and other scenarios as not socially acceptable. For example, the scenario a young person who presents at ED intoxicated after a night out can be considered more socially acceptable than a person with a history of AOD use presenting at ED intoxicated. These norms also mean that certain drugs are considered “dirty”, such as crystal methamphetamine (‘ice’). These norms can compound stigmatising attitudes and behaviours. Participants also noted racist and discriminatory attitudes, particularly towards Indigenous clients, which amplifies the experience of stigma.

REDUCED SERVICE PROVISION IN REGIONAL, RURAL AND REMOTE AREAS

There was a perception among participants that there is a lack of services and resources available for clients who experience harm from AOD use in regional, rural and remote areas. It was believed that this is partially driven by a lack of funding in the NGO sector, and the challenges that sometimes occur in recruiting and retaining staff outside of metropolitan areas. It was reported that these retention issues can negatively impact continuity of care for these clients.

Motivation barriers

OBSERVED AND EXPERIENCED NEGATIVE BEHAVIOURS FROM SOME HEALTH WORKERS

Participants reported that health workers, particularly those working in ED, are often subject to abusive or threatening behaviour from people who experience harm from AOD use. It was thought that this may reduce the level of empathy and understanding that some health workers have towards these clients. Health workers' experience of abusive behaviour may also reinforce existing negative attitudes they may hold about clients, and reinforce the use of stigmatising language by staff, which can further perpetuate the stigma. Examples of stigmatising language that were put forward were phrases such as "drug addict" or "alcoholic".

Participants also suggested that in some scenarios where staff are motivated to either change their own stigmatising attitudes, or to intervene when they observe such behaviours in other staff, they may not feel empowered to take action if the same behaviours are enacted by their leadership team. Furthermore, participants noted that where leadership teams exhibit these negative behaviours, it may then be modelled by colleagues and also clients, further perpetuating the behaviours.

Maternity and ED services are most likely to think that clients are lying to them and don't want help when they present to their service. Public and NGO AOD services are least likely to think this See Figure 13). In terms of professions, nurses are most likely to 'often' or ‘sometimes’ worry that clients are lying to them and don’t want help when they present (see Figure 14).

Figure 13: Responses by service type to "I experience worry the person presenting my service is lying to me and doesn't want help". Agreement expressed as a per cent of respondents per service type (N = 323).

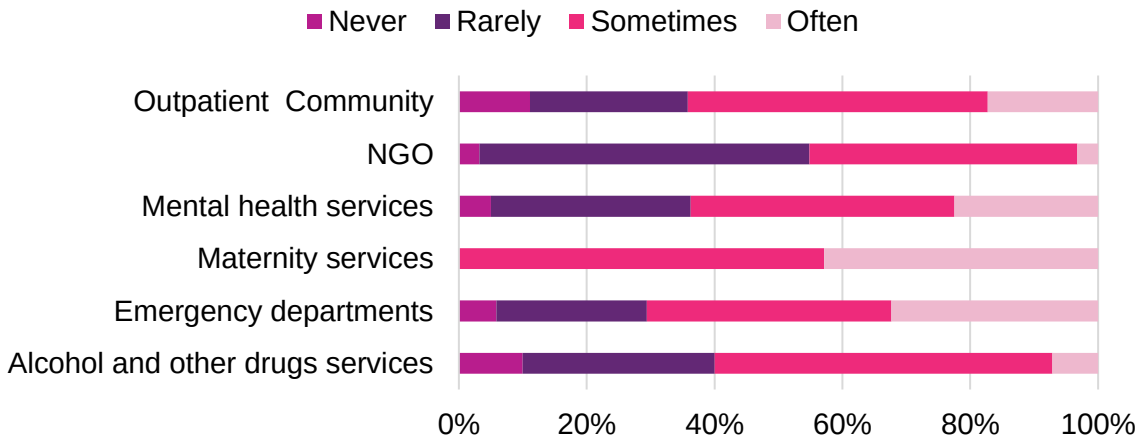
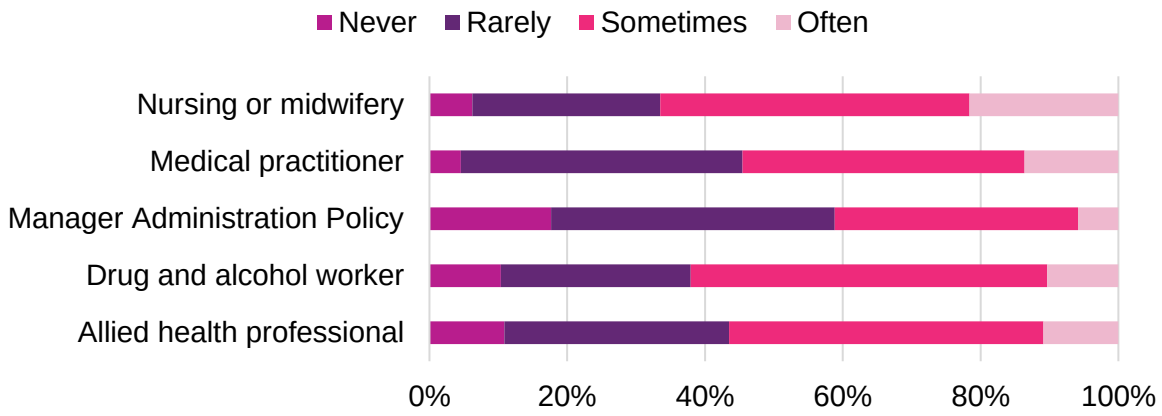


Figure 14: Responses by profession to "I experience worry the person presenting my service is lying to me and doesn't want help". Agreement as a per cent of respondents per profession (N = 323).



NEGATIVE BEHAVIOURS FROM NON-HEALTH SERVICES INTERSECTING WITH HEALTH

Participants reported observing clients being stigmatised and discriminated against by workers from non-health services. Participants gave the example of NSW Police physically handling clients more aggressively than they perceived necessary when clients were brought into ED involuntarily under a Mental Health Act Schedule. Some participants also commented that if observed by health workers, the behaviour of police may have a negative influence on the attitudes that health workers have toward clients, negatively impacting how they treat clients.

Another barrier to optimal care as reported by some participants is that AOD is not always seen by primary care (most notably GPs) as their core business, and as a result the sector does not always have the knowledge and skills to manage clients with AOD issues effectively. Participants also noted General Practitioners as being sensitive to the perceptions of other clients in their practices, which may negatively impact their attitudes and behaviours towards clients who experience harm from AOD. Participants also believed that a lack of exposure to AOD issues can perpetuate the feelings of fear in the general public towards people who experience harm from AOD use, which can amplify stigma.

Perceived enablers of optimal care and support

As part of the focus group discussions, participants reflected on what changes at different levels of the health system might help to reduce the stigma and discrimination experienced by clients, to optimise their care. These factors have been grouped into sub-themes and mapped to the COM-B domains of Motivation, Opportunity and Capability.

Participants highlighted several enablers to achieving optimal care, including providing further education and training for the NSW and NGO workforce, supporting staff wellbeing, implementing a person-centred holistic approach to care, and reviewing policies, processes and models of care to better support those experiencing harm from AOD use.

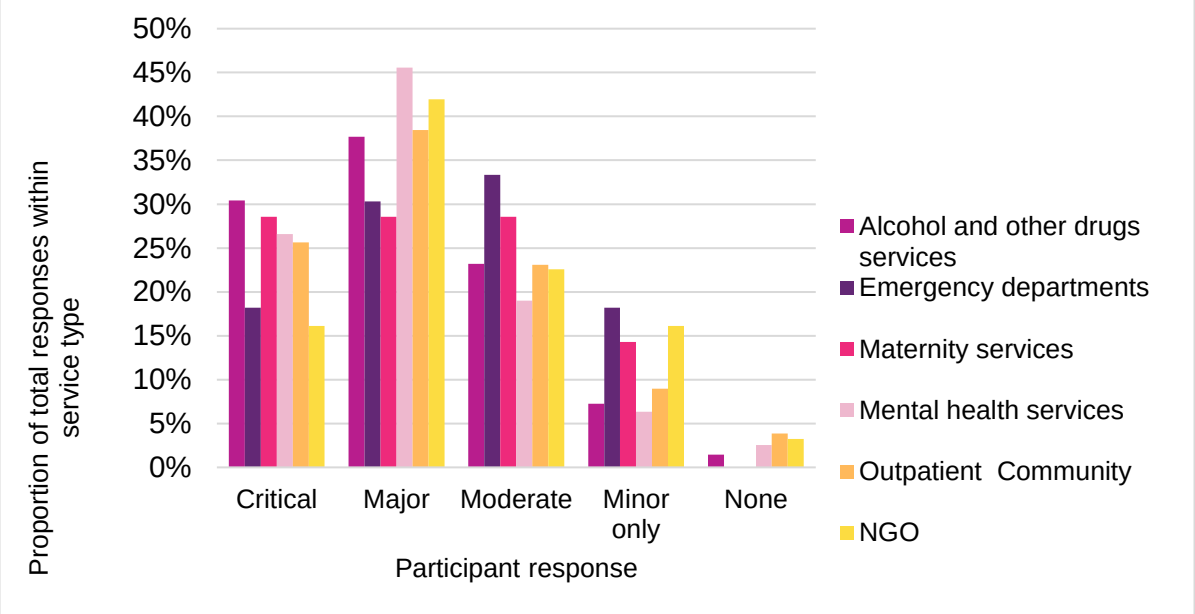
Capability enablers

PROVIDE FURTHER EDUCATION AND TRAINING TO THE NSW AND NGO WORKFORCE IN AOD

The need to further educate and train the workforce in AOD was highlighted as important by a number of participants, to improve their awareness and understanding of AOD issues. Some AOD service participants believed that this training should ideally be delivered by AOD peer workers (i.e. those with lived experience), and with the inclusion of positive recovery stories. It was felt that the training should cover skills such as trauma-informed care, pharmacology, and motivational interviewing. Some participants suggested that this training should be mandatory, for example as part of HETI training. GPs were noted as a group whose training in this area would be particularly beneficial, as they are often the first point of contact for clients.

The majority of survey respondents considered changes to knowledge and training to be of 'critical' or 'major' importance for reducing stigma and discrimination in their service/organisation, except for ED services, of which just under half of participants considered changes to knowledge and training to be of 'critical' or 'major' importance (see Figure 15).

Figure 15: Response by service type to survey question: "How much impact could more opportunities to improve confidence, knowledge and skills have in helping you, your team and your organisation promote and display positive attitudes and behaviours towards people who experience harm from AOD use".



IMPLEMENT A PERSON-CENTRED HOLISTIC APPROACH TO CARE

Participants suggested that services seek to implement a person-centred holistic approach to care that is trauma informed. Participants provided examples for how this can be achieved including the use of people-first language and communication by the workforce, a focus on building trust with clients and creating a safe environment, and respecting cultural differences. Other ways to implement this approach include showing empathy and avoiding and challenging stigmatising language. Staff can also reduce clients' self-stigma by educating clients that AOD use is often a coping to manage with stress and trauma.

"[Clients should] feel seen, heard and understood, without judgement".

NGO focus group participant

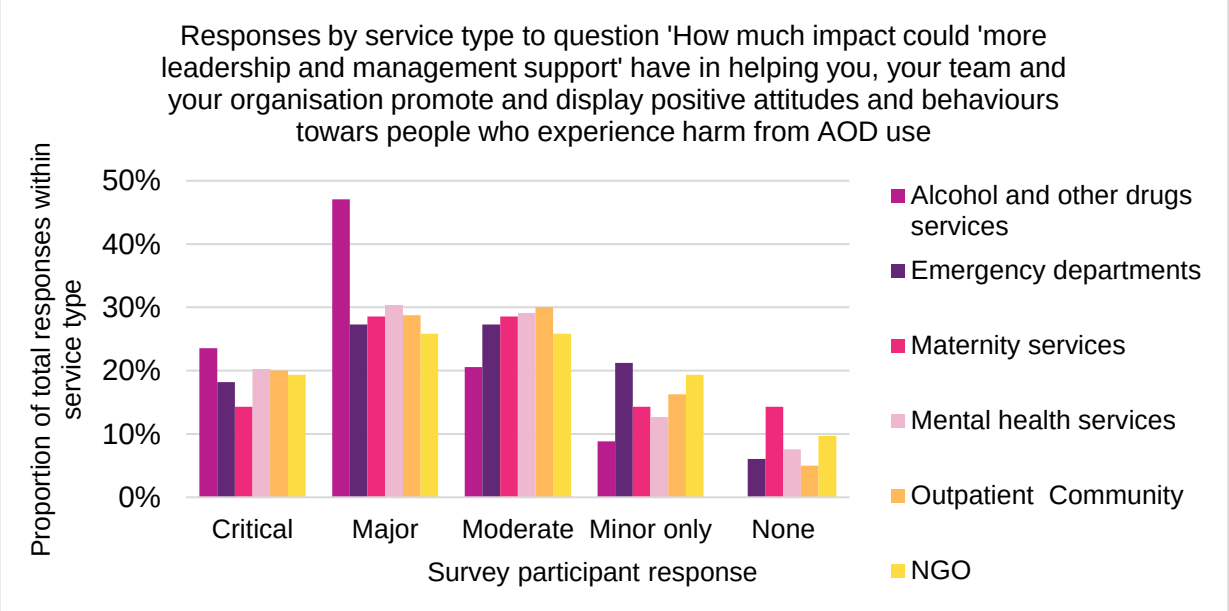
Opportunity enablers

FURTHER SUPPORT OF STAFF WELLBEING AND EMBEDDING A POSITIVE CULTURE FROM LEADERSHIP

Participants suggested that in order to prevent staff burnout, organisations should offer and encourage staff to engage in clinical/professional supervision, reflective practice, and self-care, as well as providing relevant resources. The provision of spaces and forums for staff to be able to de-brief after working in high pressured and difficult environments, and talk through the management of complex cases, is also important. This is even more critical for staff who may experience assault and trauma in the workplace.

The majority of survey participants in each of the service types indicated that "more leadership and management support' would have 'critical,' 'major' or 'moderate' impact on helping them, their team, and their organisation to promote and display positive attitudes and behaviours towards people who experience harm related to their AOD use" (see Figure 16).

Figure 16: Responses by service type to question "How much impact could 'more leadership and management support' have in helping you, your team and your organisation promote and display positive attitudes and behaviours towards people who experience harm from AOD use"



REVIEW AND ENHANCE POLICIES, PROCESSES AND FRAMEWORKS

Participants suggested services review current policies, processes and frameworks to ensure they enable (rather than act as a barrier to) the delivery of optimal care for people who experience harm from AOD use. This requires a consideration of the complexity of care often required.

Participants suggested improving the coordination and integration of care between public services, and also sectors, to prevent clients from "falling through gaps". For example, between ED, AOD, maternity and mental health services, but also more broadly between the LHD AOD sector, and the NGO sector. The relationship

between mental health and AOD services was mentioned as having particular importance, to achieve a “no wrong door” system. Participants suggested focusing on a review of referral pathways and eligibility criteria, with increased coordination and integration in mind.

Several participants suggested a review of patient pathways within the system with a view to diverting clients away from the ED environment as much as possible, unless necessary from a clinical perspective. Participants provided the examples of diverting clients to an AOD detoxification or mental health unit, instead of ED, where possible, with appropriate assessment on arrival.

For those clients that do present at ED, participants noted the importance of increasing access to staff with experience of AOD out of hours in ED, and those staff having the capacity to provide any necessary follow up. They also noted that consideration of the 4-hour ED target in the context of these clients would be helpful, as the target is not always conducive to providing optimal care to clients.

"We're sobering them up for 4 hours and then sending them out to get drunk again".

ED focus group participant

Ensuring models of care are trauma-informed (as opposed to purely medically focused), particularly in ED and mental health services, was also highlighted as important.

COLLABORATE EFFECTIVELY WITH OTHER SECTORS AND DEPARTMENTS

Participants suggested that NSW Health work more closely with other public sector departments, including:

- The Department of Education, to raise awareness and educate children and young people about AOD issues at schools through the use of a peer worker to reinforce positive stories and humanise the topic.
- NSW Police, to collaborate and identify strategies to reduce stigma and discrimination towards clients. For example, if the police are escorting a client to ED, by phoning ahead the ED can look to prepare a safe space for the client and identify experienced staff that can work with the client.
- The Department of Communities and Justice (DCJ), to raise awareness of the complexity of AOD issues among child protection caseworkers, and to identify opportunities to reduce stigma and discrimination towards clients and improve outcomes, particularly those clients moving from DCJ into NGO drug and alcohol rehabilitation centres.

REVIEW FUNDING AND LEGISLATION TO IMPROVE ACCESS AND OUTCOMES

Participants provided some suggestions on funding and legislation to reduce AOD stigma and discrimination, including:

- Additional funding for AOD (particularly NGO) services, to improve access for clients.
- Review of existing legislation to further consider the limitations (for example, access and treatment) of and opportunities to reduce stigma and discrimination for clients. For example, the *Intoxicated People (Care and Protection) Act 1994*, authorised by the ACT Parliamentary Counsel.
- Consider approaches to achieve drug law reforms and shift societal attitudes on AOD. For example, on the point of the criminalisation and regulation of illicit drug use.

MESSAGING FOR THE GENERAL PUBLIC

Participants suggested several messages for the general public to improve their perception of and attitudes towards people who experience harm from AOD use. These messages include:

- Everyone has a role in reducing stigma and discrimination
- Strive to reflect on own stigmatising attitudes and beliefs
- Challenge stigmatising language and discriminatory behaviour in everyday discussions.

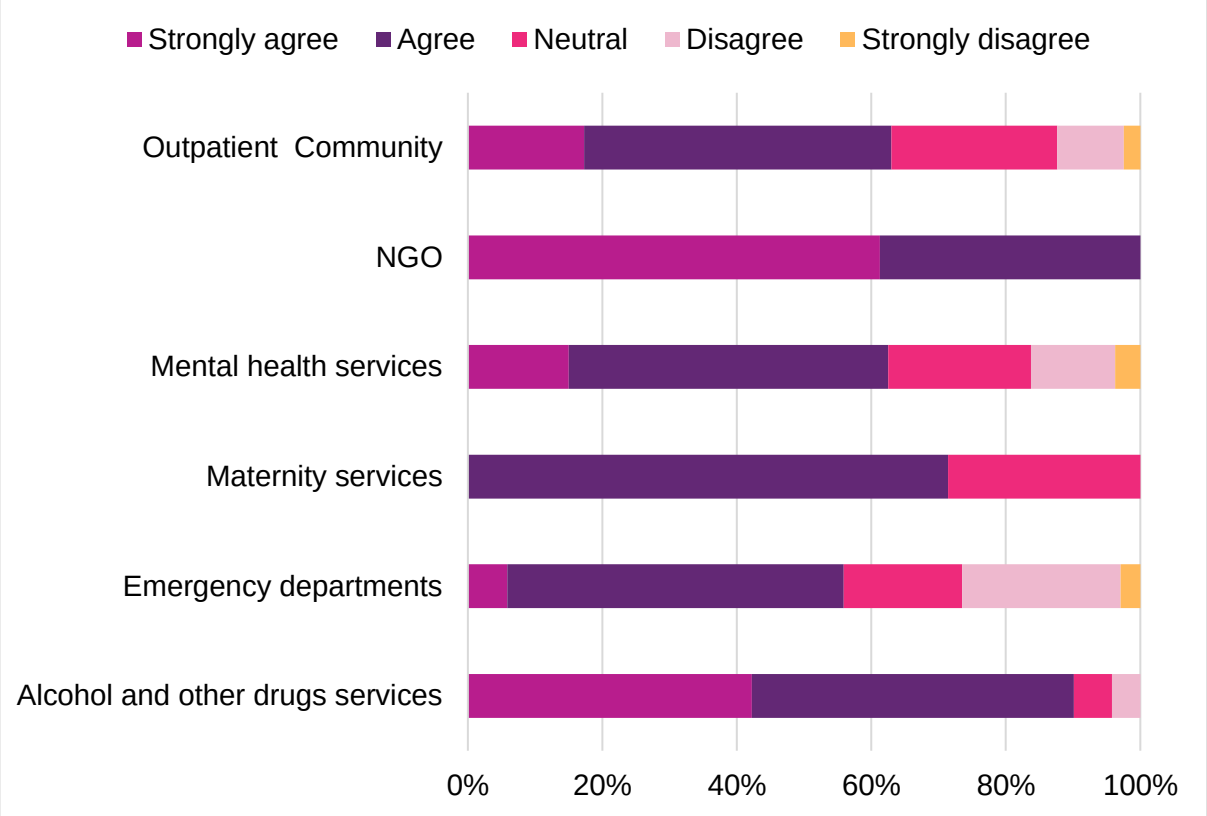
Participants also felt that raising awareness of and providing education on topics such as prevention, harm minimisation, and other AOD issues, using various media forms, would be helpful.

Motivation enablers

BUILD ON READINESS FOR POSITIVE CHANGE

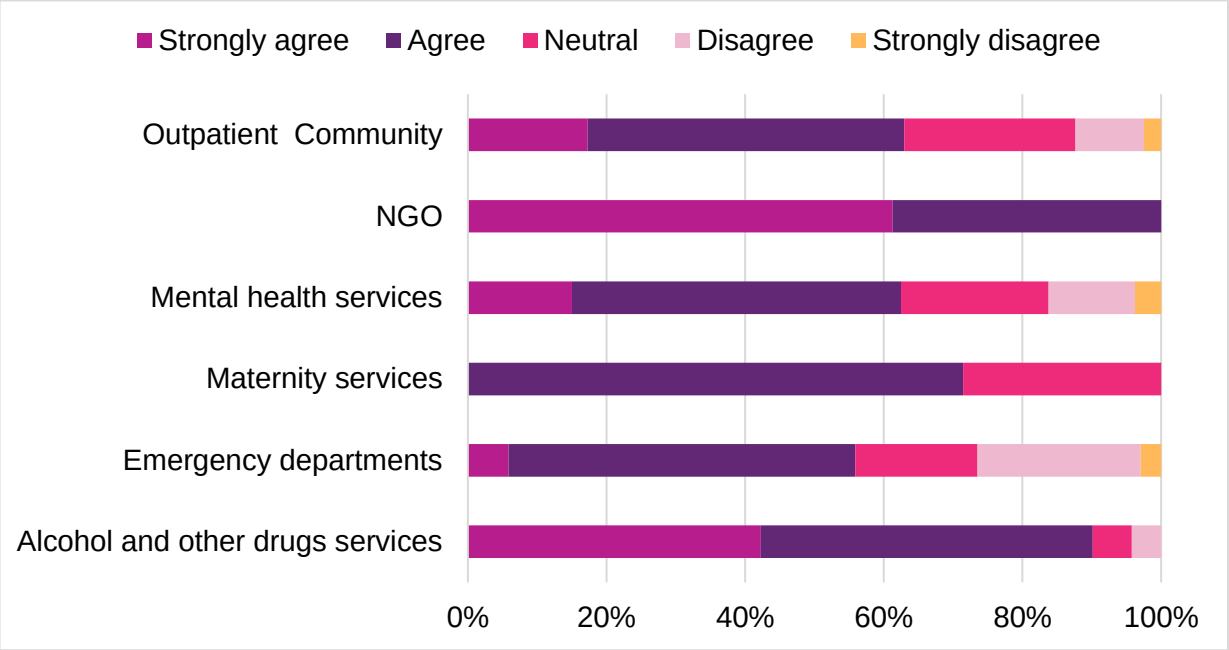
Among survey respondents, public and NGO AOD services were most likely to feel a sense of responsibility to reflect on their attitudes, beliefs and behaviours towards people who experience harm from AOD use, followed by maternity services. ED services were least likely not to feel a sense of responsibility (see Figure 17).

Figure 17: Response to "I feel a sense of responsibility to reflect on my attitudes, beliefs and behaviours towards people who experience harm related to their AOD use". Agreement expressed as a per cent of respondents per service type (N = 323).



All NGO AOD respondents (100%) and most public AOD service respondents (85%) identified themselves and their colleagues as having (or having the capacity to develop) positive attitudes towards people who experience harm from AOD use. Also valid to a lesser extent for maternity services agreed (60%). Respondents in ED expressed the lowest optimism level, with more than 30% disagreeing (see Figure 18).

Figure 18: Response to "I feel optimistic that my team/organisation can promote and display positive attitudes and behaviours towards people who experience harm related to their alcohol and other drugs use". Agreement expressed as a per cent of respondents per service type (N = 323).



5. Findings by service type

This section identifies patterns within participant responses and reports them by service type (ED, mental health, maternity and specialist public or NGO AOD services). The patterns emerged in terms of barriers to and enablers of reducing stigma and discrimination, mapped against capability, opportunity and motivation.

These findings are based on thematic analysis of qualitative data from the key informant interviews and focus groups, and supported by quantitative survey data. The themes illustrated do not seek to generalise the opinions, beliefs, and attitudes of all people working within a service type, but rather highlight patterns among participants in this research.

Overall attitudes

When survey participants were asked directly about their current attitude towards people who experience harm from AOD use, those working in emergency departments were most likely to have negative attitudes (31% self-reported their attitude as 'very negative' or 'negative'), while those from specialist public and NGO AOD services were most likely of all service types to report 'positive' or 'very positive' attitudes (Figure 19).

When asked about a hypothetical friend or relative experiencing harm from AOD use, those working in NGO AOD and maternity services were the least likely participants to advise their friends or relatives against disclosing this harm to anyone (Figure 20). At the same time, a smaller proportion of people working in emergency departments would advise against disclosure than participants working in public sector AOD services.

Figure 19: Response to survey question 'How would you describe your current attitude towards people who experience harm from AOD use?' Proportion of responses by service type (n=323)

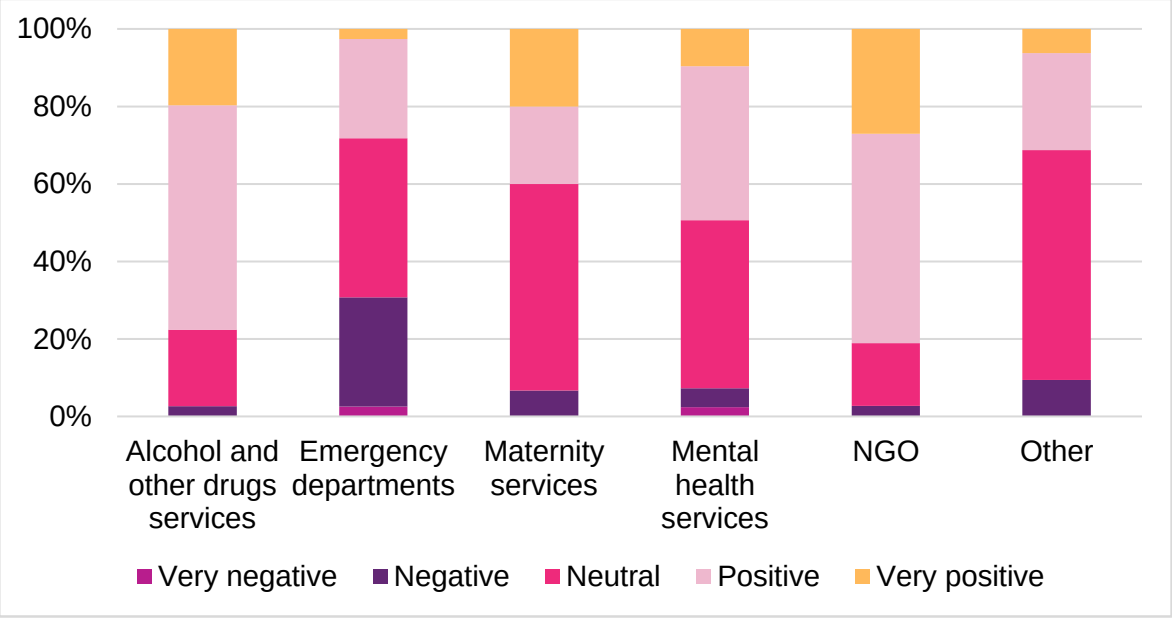
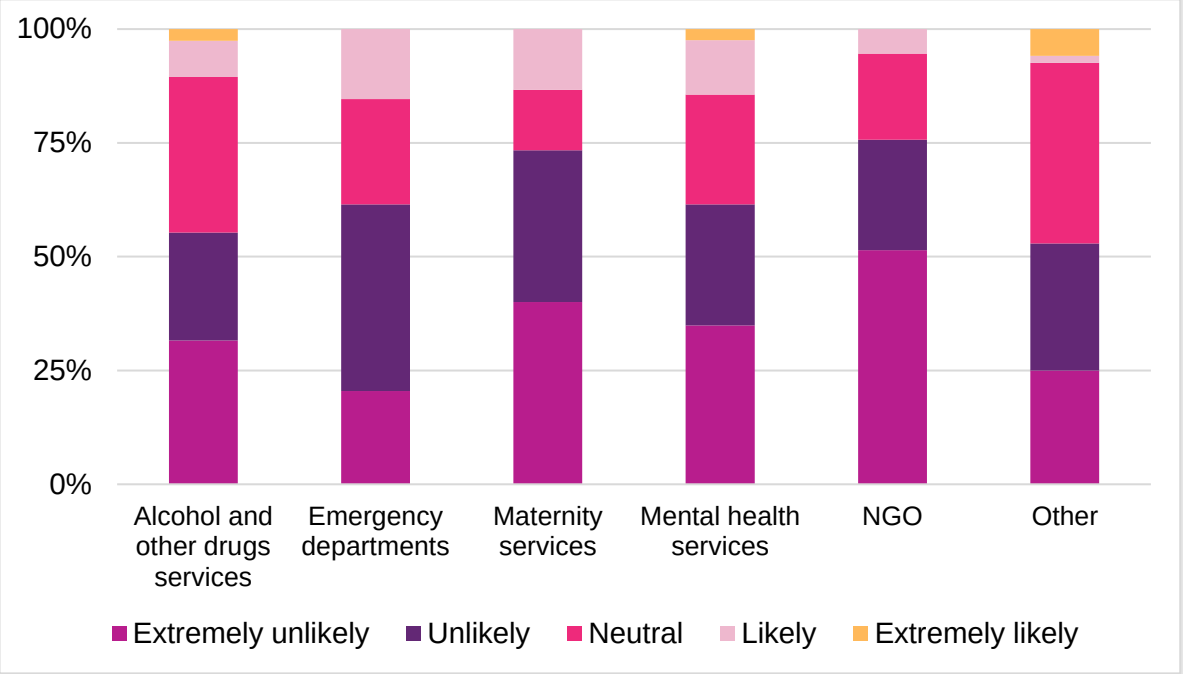


Figure 20: Proportion of survey participants from each service type hypothetically likely or unlikely to advise friends or relatives against disclosing harm from AOD to anyone else (n=323)



Participants' exposure to people experiencing harm from AOD use

Survey participants were asked about whether they had personal or close friend/family experience of harm from AOD use. They were also asked about the frequency with which they interact with someone experiencing harm from AOD use in their current professional role.

Personal life exposure

- Across all service types, more than 60% of participants had themselves experienced, or knew someone in their personal life who had experienced, harm from AOD use
- Eighty percent or more of participants working in NGO AOD services (89%), emergency departments (82%) and maternity services (80%) reported this experience in their personal life.

Work life exposure

In terms of interactions with people experiencing harm from AOD use during the course of their work:

- More than 70% of people working in public sector AOD services reported that they exclusively worked with clients experiencing harm from AOD use
- Close to half of all emergency department participants reported at least five interactions with clients experiencing this type of harm during a typical working week
- Participants from maternity services had the least frequent interactions, with 60% reporting that they had such interactions less than once a week.

Public alcohol and other drugs services

73%

Have a personal experience of harm associated with AOD use, or know of someone who has

71%

Work exclusively with this client group

Service context

Public alcohol and other drug (AOD) services provide treatment and support for people who experience harm from AOD use. Services include outpatient and inpatient drug and alcohol services, hospital-based services such as AOD consultation/liaison services, and specialist programs such as Substance/Chemical Use in Pregnancy Service and Needle and Syringe Programs.

Barriers and enablers

Capability: The public AOD workforce understand the complexity of AOD issues and how their clients' experience of stigma and discrimination can impact their quality of care and outcomes. They can also clearly articulate the barriers to and strategies for providing optimal care to these clients. Public AOD workers appreciate the vital role that the peer workforce can play in educating others, to reduce stigma and discrimination within and outside of specialist AOD services.

Opportunity: Public AOD workers were aware of the existing pressures and constraints in other services such as ED, but would like to see more related communication from these services, as well as more screening among this client group. People working within this service type noted the challenge of the attitudes of staff within other services. Participants noted the frequency of 'chicken and egg' conversations with mental health services regarding clients with comorbid mental health and AOD issues. Participants recognised that AOD services may be underfunded, in terms of both infrastructure, and staffing

Motivation: Some public AOD workers described a 'revolving door' in reference to the multiple relapses of some clients. The workforce working in this service type may be subject to abusive language and may be vulnerable to burnout and compassion fatigue.

Examples of stigma

One participant reflected on a scenario where an Aboriginal client sought treatment in a location by the river closer to country.

"I feel clients sometimes have a sense of entitlement wanting to choose the location of their rehab".

– *Public alcohol and other drugs focus group participant*

NGO alcohol and other drugs services

Specialised NGO alcohol and other drugs services

89%

Have a personal experience of harm associated with AOD, or know of someone who has

43%

Work exclusively with this client group or interact more than five times a week

Service context

Specialist NGO AOD services play a key role in providing specialised treatment and care to people who experience harm from AOD use, such as rehabilitation and helping clients to access mainstream services. These services will also provide support for peripheral issues such as housing, finances and counselling.

Barriers and enablers

Capability: The NGO AOD workforce has strong confidence and capability in supporting clients, understand the complexity of AOD issues, and appreciate the role of peer workforce in educating others to reduce stigma and discrimination.

Opportunity: Participants noted that the NGO AOD workforce would benefit from more organisational support and increased access to relevant support resources, particularly following traumatic incidents experienced at work. Participants mentioned that peer workers could experience stigma within their organisation if they relapse, for example after witnessing a traumatic incident. Participants noted a lack of funding for NGO AOD services and the staffing shortages this can lead to, for example high numbers of short-term contracts leading to high staff turnover. As well as impacting continuity of care, staffing shortages may lead to clients experiencing feelings of rejection.

Motivation: NGO AOD workers are likely to be supportive and empathetic towards people who experience harm from AOD use. They are also likely to be willing to be involved in implementing changes which will support the provision of optimal care for this client group. A motivation barrier for NGO AOD workers was being made to feel like 'lesser' clinicians by other services and in some cases being subject to stigma themselves. The NGO AOD workforce described the primary source of stigma towards their clients as external to their services i.e. when clients interact with other services, citing ED and primary care as examples.

Examples of stigma

Some clients are legally mandated to receive treatment and so may not be receiving treatment by choice. One participant described such clients as “contaminating” their AOD NGO service, because staff experience of these clients can increase their judgement of other clients who are receiving treatment by choice.

Emergency departments

Emergency services in LHDs

82%

Have a personal experience of harm associated with AOD, or know of someone who has

51%

Interact more than five times per week with this client group

Service context

Emergency care services are responsible for treating people with acute presentations. In addition, people experiencing harm from AOD are often brought in to ED by police and paramedics under a Mental Health Act Schedule.

Barriers and enablers

Capability: Some ED participants reported that some staff have the skills to de-escalate a situation verbally without the use of sedation, but that even then this can be challenging due to competing priorities and time pressure. Some ED workers perceived that they lack the skills or knowledge to appropriately respond and manage clients, for example the skills to verbally de-escalate a situation without sedation, where safe to do so.

Opportunity: Some ED participants reported that at times they find it helpful to place clients in a room with walls rather than curtains to provide a calmer environment. However, this was rarely possible due the layout and physical characteristics of many EDs and the high volume of patients.

ED services are often under pressure due to high demand, short-staffing and long hours. Staff may experience burnout and compassion fatigue, impacting the level of care provided. People who are experiencing harm from AOD often present out of hours when appropriately experienced staff may not be available. It can also be challenging to de-escalate situations involving distressed or intoxicated clients, because the environment is highly stimulating.

Motivation: A barrier to motivation for ED staff can be that they are sometimes subject to abusive or threatening behaviour from clients.

Examples of stigma

Participants noted that ED staff might be swift to sedate clients in certain situations where they do not have the skills or time to de-escalate a situation verbally. ED staff may be more judgemental towards clients if the client has a history of IV drug use or alcoholism, or if the client frequently relapses. People who experience harm from AOD use are often treated as bothersome and talked down to by ED staff. ED staff can be less empathetic if clients have injured someone else whilst under the influence of AOD, for example through drink or drug driving, or through violent behaviour.

ED staff may not perceive intoxication as a ‘real’ health issue or emergency, resulting in clients not being seen as quickly as they might otherwise. Additionally ED workers are more likely to provide higher quality care to

those with what they perceive as 'acceptable' intoxication (for example veterans, or young people on a night out) than those they perceive as unacceptably intoxicated (for example, clients intoxicated with illicit drugs).

"Lots of people in ED dealing with this person – taking away from people who are acutely unwell".

– *ED focus group participant*

Mental health services

Mental health services in LHDs

61%

Have a personal experience of harm associated with AOD, or know of someone who has

35%

Interact between either 4-5 or more than five times a week with this client group

Service context

Mental health services can sometimes become 'quasi AOD' services out-of-hours if AOD services are unavailable during these hours. Clients presenting to mental health services may have both mental health and AOD issues.

Barriers and enablers

Capability: Participants reported a perception within some mental health services that AOD issues are not 'core business'. Furthermore, staff might lack confidence in managing AOD clients, or lack the understanding of intergenerational trauma on substance use, and the knowledge that comorbid mental health and AOD issues are common.

Opportunity: Mental health services might be conflicted between the clinical/medical and psychosocial recovery-based models of care. They also noted the challenge of mental health services providing evidence-based trauma-informed care within existing resource constraints. Furthermore, inpatient admission criteria for psychiatric treatment often requires a specified duration of detoxification which was seen as a key barrier to accessing services. Participants felt it challenging to achieve integration between services, for example between withdrawal support services and mental health treatment. They also reported inadequate access to resources and services, particularly in regional areas.

Motivation: Mental health participants noted a loss of empathy among their staff towards clients who relapse.

"…you lose empathy, motivation to be a nurse in mental health from abuse or constant drug use causing mental illness - but when people come clean and return to their baseline mental health, it's rewarding".

– *Mental health focus group participant*

Example of stigma

Mental health services may 'cherry-pick' clients for treatment, a behaviour which is perceived to be driven by a deeply entrenched belief that the role of mental health services is to primarily to treat mental health. Furthermore, services are under-resourced which may lead to staff being inclined to choose ‘less challenging’ clients. Participants also reported that some complex clients might benefit from involuntary treatment.

"You're too complicated. Let's give you this diagnosis".

– *Mental health focus group participant*

Maternity services

Maternity services in LHDs

80%

Have a personal experience of harm associated with AOD, or know of someone who has

60%

Rarely interact or interact less than once a week with this client group

Service context

Maternity services understand the importance of child protection and are aware of legal responsibilities. Antenatal clients with neonatal abstinence syndrome (NAS) babies often require more intensive support from health workers.

Barriers and enablers

Capability: Maternity services may have a limited understanding of intergenerational trauma and limited training and knowledge in managing cases involving AOD. Additionally staff may not know how or where to seek help if AOD clients present with challenging behaviour.

Opportunity: Participants reported that maternity services usually experience high workloads. This workforce pressure can often result in a ‘box-ticking’ approach to care and a failure to adequately listen to the client or make a holistic assessment. Maternity workers are also sometimes inclined to refer to AOD services prematurely without involving the patient in the decision.

Mothers and babies are often separated in early life when facilities are inadequate to accommodate both. This can interfere with critical mother-baby bonding and perpetuate the cycle of intergenerational trauma.

Motivation: Maternity services may not be aware that clients' fear of DCJ can mean some mothers avoid antenatal care, leading to poorer outcomes.

Examples of stigma

Participants reported that maternity services might judge and label clients for using substances (either currently or in the past).

In focusing on keeping the baby safe, maternity workers may overlook the importance of ensuring the healthcare environment is psychologically and culturally safe for the mother. Participants also reported an emerging reluctance in maternity services to provide pain medication.

Additionally, there may be a tendency from maternity workers to educate clients in a way that could impact the client and their confidence negatively. For example, by highlighting the harm that use of AOD is doing as opposed to a strengths-based focus.

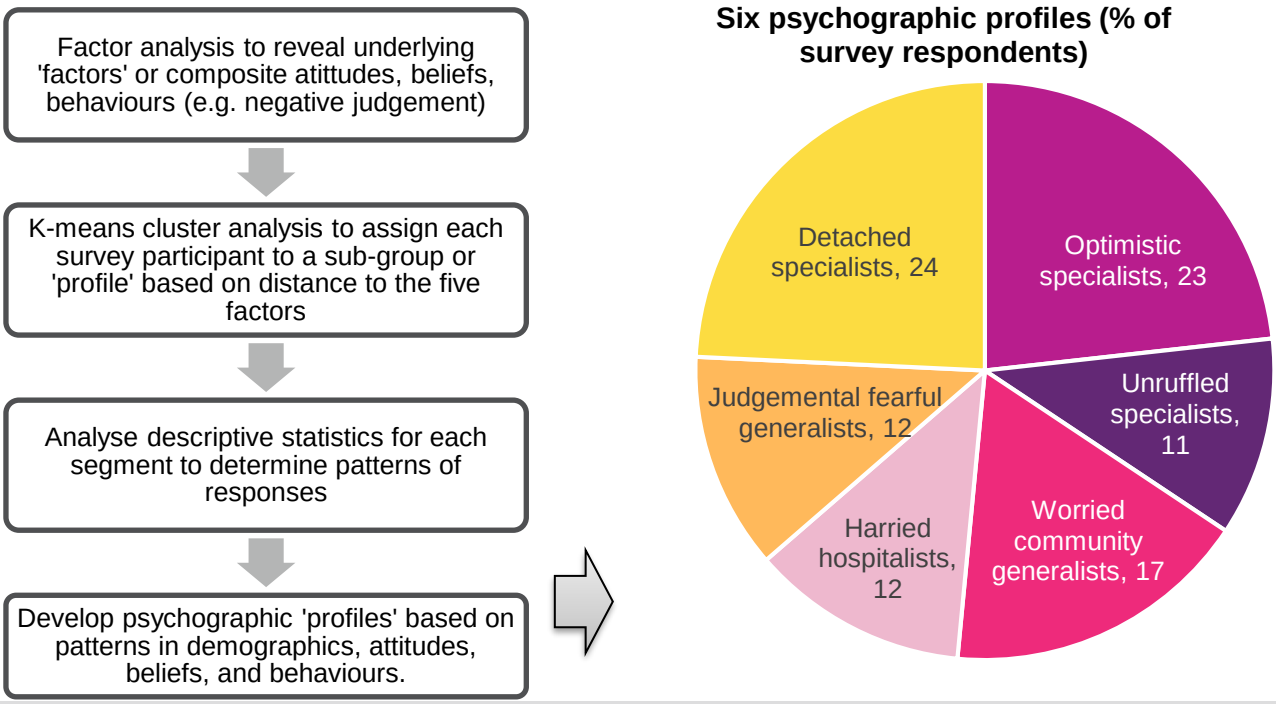
6. Findings by psychographic segment

The findings reported in this section are based on a **two-stage quantitative analysis** of survey responses to develop psychographic segment profiles. More than 300 survey responses provided quantitative information about participants' levels of agreement with statements known to reflect stigmatising and discriminatory beliefs, attitudes and behaviours.

Segmentation analysis of participants' survey responses resulted in the development of **six mutually exclusive groupings (segments). Each segment displays a** characteristic pattern of participant responses in terms of attitudes, beliefs and behaviours. The distribution of demographic, workplace and experience characteristics were analysed to create a '**profile'** for each segment (i.e. a 'typical' member of the segment). Profiles include both demographic and psychographic (attitude, belief and behaviour) attributes.

Refer to section the Methods section for information on the Psychographic Segmentation process or see Figure 21 below for a summary.

Figure 21: Summary of process for developing psychographic profiles (left) and proportion of participants in each segment profile (right)



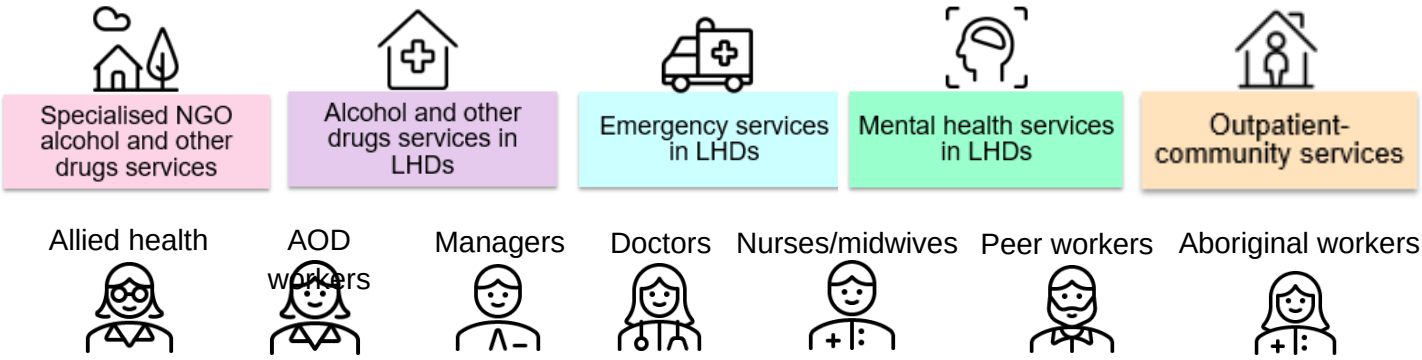
See **Appendix E** for the psychographic profiles analysis results tables.

Psychographic profiles legend

Demographics

The demographic features, services, professions, professional exposure levels, age group and gender, illustrate where particular services, professions etc. had far greater representation (proportionately) in the segment than in the survey respondent cohort overall.

SERVICES AND PROFESSIONS REPRESENTED



Psychographics

For each segment's psychographic features, the arrows represent the average for this segment for relevant survey questions in comparison to other segments' averages. For example, where a segment has three arrows in one direction, this demonstrates 'far from the average' (see Table 3 below).

Table 3: Psychographics key

Stigma		Capability, opportunity and motivation	
↓↓↓	Minimal levels of stigma	↑↑↑	High motivation, high perception of capabilities/opportunities
↓↓	Moderately low stigma	↑↑	Good motivation, perception of capability/opportunities
↓	Low levels of stigma	↑	Some motivation, perception capabilities/opportunity
↑	Some stigma	↓	Low motivation, perception capability/opportunity
↑↑	Moderately stigmatising	↓↓	Moderately low motivation, perception capability/opportunity
↑↑↑	Detrimental stigma levels	↓↓↓	Minimal motivation, perception capability/opportunity

EXPOSURE TO AOD SCORES

Professional

- Work exclusively with the client group
- More than 5 times a week
- Less than once a week
- No clear pattern

Personal

- Work exclusively with the client group
- In line with average ↔
- Below/above average ↕

Segment profile I: Optimistic Specialist

"I work in public sector or NGO AOD services, usually as a drug and alcohol worker or an allied health professional. I've had personal experience with harm from AOD use or know of someone close who has. I don't hold negative judgments about my clients' choices, and I know my clients may not be treated equally in the health system. I'm aware of what could be improved to reduce stigma and discrimination, and I'm ready to promote this change."

Demographics

SERVICES

Alcohol and other drugs services in LHDs

34.3% segment
23.6% overall

Specialised NGO alcohol and other drugs services

27% segment
10.4% overall

PROFESSIONS

Allied health

23% segment
15% overall

AOD workers

21% segment
9% overall

GENDER

78.6% segment
71.7% overall

AGE

40 – 49

Psychographics

STIGMATISING ATTITUDES, BELIEFS AND BEHAVIOURS

Minimal levels of stigma exhibited but possibly burnt out

Optimistic specialists were least likely to have negative judgements about the choices and motivations of clients. They were most likely to sympathise with clients and were most likely to feel hope, empathy, and concern, but negative emotions were also relatively high, perhaps indicating burnout.

AOD EXPOSURE

Professional

38% segment work exclusively w/ client group

Personal

81% segment

PERCEIVED CAPABILITY AND OPPORTUNITY FOR CHANGE

Good perception of capabilities and opportunities

A large proportion (91%) of Optimistic specialists are rarely/never emotionally impacted by their clients' interactions. Optimistic specialists perceive improvements in leadership (32%) and more opportunities to improve skills and knowledge (40%) as the most critical factors for their organisations to promote and display positive attitudes towards people experiencing harm from AOD use.

MOTIVATION FOR CHANGE

High motivation to promote change

Optimistic specialists firmly believe that clients are mistreated in the health system (84%). They believe clients deserve equal treatment and are the most likely group to say that their clients always or often show appreciation (83%). Optimistic specialists regularly reflect on their attitudes and behaviours (87%) towards clients, are highly motivated, acknowledge the need for change, and are confident that they can reduce stigma and discrimination

Segment II: Unruffled Specialist

11%

"I work either as a drug and alcohol worker, manager or doctor, usually in public AOD services, but you won't see me working in ED. I'm not likely to hold judgement towards clients, but I also am not hopeful and concerned. I'm not worried about my skills or knowledge, and I occasionally feel a responsibility to self-reflect, but time and capacity are my biggest barriers. I believe everyone deserves equal treatment in the health system, but I'm ambivalent about whether the health system mistreats clients."

Demographics

SERVICES	PROFESSIONS			GENDER	AGE
Alcohol and other drugs services in LHDs	AOD workers	Managers	Doctors	⟷	50 – 59
38.2% segment 23.6% overall	14.7% segment 9.4% overall	12% segment 5% overall	12% segment 7.4% overall	In line with avg.	

Psychographics

STIGMATISING ATTITUDES, BELIEFS AND BEHAVIOURS

↓ **Low stigma but also low levels of positive emotional engagement**

Unruffled specialists were less likely to hold negative judgments about clients' choices and motivations. Conversely, they also have low levels of positive emotion, including hope and concern. A reasonable proportion of this group would advise a friend or family member to disclose their treatment from AOD use.

SELF-PERCEIVED CAPABILITY AND OPPORTUNITY FOR CHANGE

↑↑↑ **High perception of capabilities and good perception of opportunities**

Unruffled specialists are the most likely group to not worry about their skills or knowledge (74%) and least likely to perceive any capability barriers (8%). Just under half of the unruffled specialists consider time and resources (47%) as opportunity barriers and see improvements in leadership and skills and knowledge as somewhat necessary in their organisations to promote and display positive attitudes to clients.

AOD EXPOSURE

Professional
47% work exclusively

Personal ⟷
In line with avg.

MOTIVATION FOR CHANGE

↑ **Some motivation to promote change**

Unruffled specialists (100%) believed that clients deserve equal care standards to everyone else. They are also the group least likely to experience anger, fear or frustration and report experiencing physical violence. Motivation to change may be affected by their neutrality on whether clients are mistreated in the health system and low likelihood to self-reflect (54%) on their attitudes.

Segment III: Worried Community Generalist

"I am more likely than members of other segments to work in outpatient, community or primary care settings and more likely to be a manager, and I'm a little older than my colleagues. I don't feel much sympathy for clients, I think they can be dangerous sometimes, and I'm not always hopeful or concerned. I get worried that I don't have the skills or knowledge required to support clients, and on occasion, time and capacity is an issue for me. I don't think the health system mistreats AOD clients, and I firmly believe I do not need to reflect on my attitudes and behaviours. Changes to policy, procedures and knowing my team and others want to see a change might make a differe"

Demographics

SERVICES	PROFESSIONS	GENDER	AGE
Outpatient-community services	Managers	⟷	> 50
40.4% segment 26.3% overall	9.6% segment 5% overall	In line with avg.	

Psychographics

STIGMATISING ATTITUDES, BELIEFS AND BEHAVIOURS

Moderately stigmatising and low sympathy for client circumstances

Worried community generalists would be about just as likely (54%) to avoid people experiencing harm from AOD than not. They have some judgement and negative emotion towards clients. A few in this group think that clients are dangerous. They are the least sympathetic.

SELF-PERCEIVED CAPABILITY AND OPPORTUNITY FOR CHANGE

Moderately low perception of capabilities and opportunities

Worried community generalists are most concerned about their skills or knowledge. Only a tiny proportion think that improvements in leadership and in skills and knowledge are critical to promoting positive attitudes towards people experiencing harm from AOD. However, they recognise that positive changes to policies and procedures, and knowing that their colleagues want to see a difference, is important.

AOD EXPOSURE

Professional — No clear pattern

Personal — In line with avg.

MOTIVATION FOR CHANGE

Moderately low motivation to (promote) change

Worried community generalists have the lowest (54%) sense of responsibility for self-reflection of all the segments. A reasonable proportion do not think that clients are mistreated by the health system.

12%

Segment IV: Pressured Hospitalist

"I work as a Nurse in a busy emergency department or mental health unit, treating patients with a wide variety of needs. A few people with problematic and historic AOD use might come into my service during the week. You won't find me working in AOD services either in the public sector or NGO as I tend to avoid them. I think there are many barriers to providing optimal care, but I don't think the issue is with me or my service. I get frustrated with clients as they can be verbally abusive or violent. I don't think they appreciate my help, and I'm not convinced that the health system mistreats them"

Demographics

SERVICES

Emergency services in LHDs

44.4% segment
11.4% overall

Mental health services in LHDs

36.1% segment
26% overall

PROFESSIONS

Nurses/midwives

88.6% segment
58.4% overall

GENDER

41.7% segment
27% overall

AGE

30 – 39

Psychographics

STIGMATISING ATTITUDES, BELIEFS AND BEHAVIOURS

Detrimental levels of stigma and low sympathy for client circumstances

Pressured hospitalists are the most judgemental group, and a reasonable proportion thinks clients are dangerous. They have low sympathy for the client's life circumstances and are least likely to feel hope or concern. They are likely to advise their friends or family not to disclose harm from AOD use.

SELF-PERCEIVED CAPABILITY AND OPPORTUNITY FOR CHANGE

Moderately low perception of capabilities and high expectation of opportunity barriers

Some Pressured hospitalists worry about their skills and knowledge, and only a few think that improvements in knowledge, skills and training are critical to promoting positive attitudes (14%). This group is most likely to expect barriers to optimal care within their service.

MOTIVATION FOR CHANGE

Minimal motivation to (promote) change

Pressured hospitalists were the least likely group to believe that clients are mistreated in the health system, were least optimistic for change, and least likely reported positive attitudes towards clients (17%). They are most likely to feel frustrated with clients and least likely to experience appreciation from clients (8%).

AOD EXPOSURE

Professi

>5 times a week

Persona

In line with avg.

Segment V: Fearful Generalist

"I work either in outpatient community services or in mental health services, usually as an early-career Nurse. I work with people experiencing harm from AOD quite a bit, and they can be generally dangerous. I feel a bit of sympathy for them, but mostly, I'm fearful, angry and frustrated. I don't have the skills required, and there are many obstacles to providing optimal care, but I am aware of what needs to change. Whether they deserve equal care depends on the situation - I'm often subject to verbal abuse and, to a lesser degree, physical violence, which affects my motivation to promote change."

Demographics

SERVICES

Outpatient-community services

35.1% segment
26.3% overall

Mental health services in LHDs

35.1% segment
26% overall

PROFESSIONS

Nurses/midwives

70.3% segment
58.4% overall

GENDER

81% segment
71.7% overall

AGE

21 – 29

Psychographics

STIGMATISING ATTITUDES, BELIEFS AND BEHAVIOURS

Highly stigmatising but some sympathy for client circumstances

Fearful generalists are the second most judgemental group, have the most negative emotions and are the most likely to perceive clients as dangerous. Conversely, they do feel some sympathy but little hope or concern. A proportion would advise their close friend or family not to disclose their AOD harm.

SELF-PERCEIVED CAPABILITY AND OPPORTUNITY FOR CHANGE

Minimal perception of capability, with several opportunity barriers

Fearful generalists are most likely to worry about the emotional impact of interacting with clients and most likely to think of their capability as barriers to providing care. They are most likely to encounter several opportunity barriers such as time, resources, policies and processes.

AOD EXPOSURE

Professional

50% segment >5 times a week + work exclusively

Personal

In line with avg.

MOTIVATION FOR CHANGE

Moderately low motivation to promote change

Fearful generalists were the least likely to agree that clients deserve equal care to everyone else. Their motivation may be influenced by their negative emotional experiences when interacting with clients, being the most likely to experience fear, anger and frustration, and the most likely to often or always experience or observe verbal abuse (87%) or physical violence (62%) from this client group.

24%

Segment VI: Detached Specialist

"I primarily work in public AOD services as a late-career allied health professional or a doctor. I have limited personal experience with harms from AOD, and I see clients with AOD issues less than once a week at work. I'm usually quite hopeful and concerned and don't hold negative judgement towards them. I'm not aware of the barriers to optimal care for clients, and I'm not particularly worried about my skills or knowledge. I don't feel anger, fear or frustration and at times reflect on my attitudes and behaviours. I do think that they are mistreated and deserve equal care."

Demographics

SERVICES

Alcohol and other drugs services in LHDs

33.8% segment
23.6% overall

PROFESSIONS

Allied health

20% segment
15% overall

Doctors

11.4% segment
7.4% overall

GENDER

In line with avg.

AGE

60 +

Psychographics

STIGMATISING ATTITUDES, BELIEFS AND BEHAVIOURS

Moderately low levels of stigma

Detached specialists are not likely to express judgement towards people experiencing harm from AOD, nor experience negative emotions, and don't think clients are dangerous. They are hopeful and concerned for clients.

SELF-PERCEIVED CAPABILITY AND OPPORTUNITY FOR CHANGE

Some perception of capabilities and ambivalent on opportunity barriers

Detached specialists are more or less not worried about their skills or knowledge in AOD. They also don't feel strongly about the impact of opportunity barriers such as time, resources, or policies and are most likely to say that there are no barriers to providing optimal care in their service (28%).

AOD EXPOSURE

Profession: Mixed

- once a week
  21% segment
  17% overall
- Work exclusively
  25% segment

Personal: Limited

MOTIVATION FOR CHANGE

Moderately high motivation to (promote) change

Detached specialists agree that clients are mistreated by the health system and deserve equal care. They recognise a slight sense of responsibility to self-reflect on their attitudes and behaviours and have positive attitudes towards clients. They are likely to rarely or never feel anger, fear and frustration towards clients. They seldom experience verbal abuse or violence and sometimes see appreciation from clients.

7. Discussion

Consistency of findings with existing evidence

Our evidence review and behavioural research with the selected segments of the NSW health workforce (both public and NGO) indicates that stigma and discrimination experienced by people with AOD issues/related harm are created and perpetuated at several levels. Health workers face several barriers to providing optimal care for clients, including:

- Capability: inadequate skills, training and experience in AOD, lack confidence in dealing with AOD clients, lack understanding of intergenerational trauma on substance use, and comorbidities
- Opportunity: staff under pressure due to short-staffing and long hours, resulting in burnout, and organisational cultures, policies and processes that act as barriers to providing optimal care
- Motivation: observed and experienced negative behaviours including health workers subject to abusive language or physical violence, compassion fatigue when clients frequently relapse

These barriers are also compounded by several structural barriers that can increase the experience of stigma and discrimination. Consistent with the evidence review, this research found that healthcare professionals' stigmatising and discriminatory attitudes and behaviours are known to adversely affect the quality of care delivered to people who experience harm from AOD use.

Key challenges and lessons

Data limitations

Participants were recruited using purposive sampling to target the selected health services; therefore, findings cannot be generalisable to the broader NSW health workforce. Furthermore, given participants self-selected to partake in the study and described their experiential attitudes and beliefs, there might be more negative attitudes in those who did not participate (self-selection bias).

Due to the limited numbers of participants from maternity services, peer workers and Aboriginal health workers it was not possible to draw any meaningful patterns from the psychographic segmentation analysis to reveal distinct differences in clusters of attitudes, beliefs or behaviours.

Future research may consider a larger scale, blind study (e.g. survey) distributed to all public and NGO health workforce within NSW, using as many recruitment networks and channels as possible to gain further reach, providing a clearer picture of the stigma and discrimination across the NSW health workforce, building on the findings from this research.

Initial engagement and timelines

Although largely unavoidable, the timing of the COVID-19 pandemic during the data collection phase impacted health workers' availabilities and the initial engagement/interest from services/networks to participate in focus groups. The research schedule experienced some delays due to the requirement by HREC to obtain LHD site approvals, which were not anticipated/expected by the research team.

8. Recommendations

Moving from findings to recommendations

The ‘findings by service type’ and the ‘psychographic segmentation’ findings represent two different ways of grouping the participants in this research, based on their responses to questions posed during focus groups, interviews and surveys.

Thematic analysis of focus group and interview data, as well as open-ended survey responses, provided a rich understanding of participants' perceptions in the context of their day-to-day work in Emergency, Maternity, Mental Health and public and NGO AOD services. From the focus group discussions, participants revealed their level of awareness and perceptions about their own and others' capabilities and confidence; the complex aetiology of client challenges and the accessibility and quality of health care; contextual barriers and enablers to reducing stigma and discrimination in their workplace setting; and potential strategies to overcome challenges and obstacles.

The quantitative analysis of survey responses, including the development of psychographic segments, was a different way to 'cut' the participant 'pie'. It did not start with any assumption that attitudes, beliefs and behaviours would be similar among participants who worked in the same type of service.

At the end of the analysis, however, there was considerable alignment between psychographic segment membership and place of work.

The messaging and recommendations in this chapter are tailored to each of the six psychographic segments.

Structure of the segment-specific recommendations

The COM-B framework allows assessment of capability, opportunity and motivation factors that are prominent among a group of people (such as the psychographic segments developed in this research) to form a ‘diagnosis’ about what enables or constrains a desirable change in attitude or behaviour (such as stigma reduction).

This recommendations chapter directly links:

1. A summary of patterns found in capability, opportunity and motivation factors for each of the six segments
2. Example messaging to be used consistently across all stigma reduction initiatives aimed at that segment, acknowledging the constraining factors and emphasising the enabling factors identified in (1)
3. Recommended strategic approaches to supporting members of the segment to play a role in reducing stigma and discrimination (based on the Behaviour Change Wheel intervention categories)
4. Suggested behaviour change techniques and enablers for each recommended strategic approach, adapted from the Theory and Techniques Tool

Segment I: Optimistic Specialists

Profile summary

Members of the Optimistic Specialist segment are professionals who often work in settings and roles which specialise in the support and treatment of people who experience harm from AOD use. Within both public sector-based and NGO-based AOD services, these individuals are more likely than members of other segments to have had some form of exposure to harm from AOD use in their personal life, and are also more likely to exclusively work with this client group during their everyday work.

Motivation to change

ATTITUDES AND BELIEFS ABOUT PEOPLE EXPERIENCING AOD HARM

The Optimistic Specialists reported the most positive overall attitudes of any segment towards people experiencing harm from AOD use, with 84.3% holding positive or very positive attitudes. Their

They were less likely than all or most segments to endorse stigmatising or discriminatory attitudes and beliefs towards this client group on measures such as deservingness of equal treatment and need for compulsory treatment programs. Optimistic Specialists were the most likely segment to disagree that they would avoid people experiencing harm from AOD use where possible.

EXPERIENCES AND EMOTIONS

The Optimistic Specialists were the most likely segment to report that they often or always experience clients as appreciative, and least likely to have experienced or witnessed verbal abuse on a regular basis (4.3%). They were the second least likely segment to report always or often experiencing or observing physical violence (10% of segment).

Despite these relatively positive experiences of clients, Optimistic Specialists had a greater proportion (77%) of members than other Specialist segments reporting feeling frustration at least some of the time when interacting with client. This group were also more likely to experience worries about the potential emotional impact of interactions at least some of the time than other Specialist segments (57% of members).

BELIEF IN THE NEED FOR, AND FEASIBILITY OF, CHANGE

The Optimistic Specialists start from a high level of current awareness of stigma and discrimination among the health workforce, and are the segment with the greatest proportion of members who agree that people experiencing harm from AOD use are mistreated in the health system (at 84.3%). The Optimistic Specialists therefore recognise that there is a valid problem to be tackled, an important factor in motivation to play a role in change.

Perceived capability and opportunity to change

CONFIDENCE IN KNOWLEDGE AND SKILLS

The self-reported level of concern about their knowledge and skills when interacting with clients experiencing harm (57% of this group worried at least some of the time about this) was much higher than Unruffled Specialists (24%) but about the same as Detached Specialists.

SOCIAL AND ENVIRONMENTAL OPPORTUNITY

Alongside the other Specialist segments, Optimistic Specialists were less likely than the generalist segments to see time constraints as barriers to providing optimal care in their organisation or service. Like all other segments, resources barriers were most often nominated as environmental constraints on what Optimistic Specialists could do in terms of optimal care.

Salient enablers for this segment in reducing stigma

Optimistic Specialists were the most likely segment to agree that they have a personal responsibility to reflect on their own attitudes and behaviours (87.1% believed this, while three other segments had fewer than 60% of members agreeing). Although 83% of this segment were optimistic about the future ability of their service to promote positive attitudes towards people experiencing harm from AOD use, Optimistic Specialists do believe that there are some critical organisational and system enablers that need to be in place to support this effort.

They were the most likely of all the segment groups to say that leadership on reducing stigma and discrimination in their service or organisation is a critical enabler of change, and were more likely than most segments to say that they may experience environmental and social barriers to delivering their ideal standard of care (such as policies, managers and colleagues). They were also most likely to cite improvement in knowledge, skills and training as critical factors supporting stigma reduction among the workforce.

Tailored narrative messaging for Optimistic Specialists

You are key allies in efforts to reduce stigma and discrimination among the health workforce. Your extensive knowledge, skills and expertise are drawn from your daily professional exposure to and interaction with people experiencing harm from AOD use. Your work has made you very aware of the impact that stigma and discrimination can have on your clients in terms of their often poor experiences and outcomes from health care.

Research shows that a combination of education and contact with people with lived experience can help to reduce stigma and discrimination among health service workers, especially those working outside of specialist AOD settings.

Your role as a champion of stigma reduction initiatives is crucial, because you understand the impact these attitudes and behaviours can have on people you support. You also have the experience, skills and knowledge to mentor other health workers and, importantly, to build confidence among your clients to tell their stories.

Recommendation for segment-specific stigma reduction support

Their overall self-reported positive attitudes towards, and experiences of, their client group reflect a belief among Optimistic Specialists that reducing stigma and discrimination is a real and important issue, and their high level of optimism that their service can support and promote positive attitudes shows that they also have a belief in the possibility of change.

Where individuals have a strong belief in the need for change, and a view that change is possible, they have a greater readiness to change their own behaviour or support others to do the same. For Optimistic Specialists, this readiness and awareness of the need for change is a valuable resource that can be used to help persuade others with less positive attitudes.

To support members of this segment to play their role in reducing stigma and discrimination, the most important strategic approach is enablement. Optimistic Specialists should be enabled to become:

- stigma reduction 'champions' and influencers
- train-the-trainers of other health workers
- mentors to clients who wish to become part of contact-based training or develop a peer support work career.

Strategic approach	Change mechanisms	Examples of behaviour change enablers and techniques
Enablement	Professional development	Professional development opportunities to become stigma reduction champions – e.g. in mentorship and delivering stigma reduction training to non-specialists.
	Recognition, reinforcement and social influence	Creation of role/endorsement as a stigma reduction champion based on completion of above training.
		Public recognition of expertise of AOD specialists and role of stigma reduction champions via social media and professional networks.
		Creation of a stigma reduction community of practice online
	Guidance and information provision	Guidance and toolkit on supporting clients to tell their stories as part of stigma reduction training to health workers, and mentoring clients to train as peer support workers
	Reducing contextual barriers	Dedicated time for developing expertise in stigma reduction and delivering training.

Segment II: Unruffled Specialists

Profile summary

Members of the Unruffled Specialist segment are often professionals who often work in settings and roles which specialise in the support and treatment of people who experience harm from AOD use. Compared to the overall survey participant sample, this segment had a greater proportion of AOD workers, doctors and managers represented in this group. Members exhibit low emotional engagement in their work with this client group, either positive or negative. They report lower levels of hope and concern when interacting with clients than some other segments, but at the same time are the least likely of all segments to experience anger, fear or frustration during interactions.

Motivation to change

The Unruffled Specialists do not hold judgemental attitudes towards people experiencing harm from use of AOD, being the least likely to perceive this client group as being unpredictable or dangerous. A full 100% of participants belonging to this segment agreed that people experiencing harm from AOD use deserve equal care standards to everyone else. This segment was also the most likely of any segment to be optimistic about the possibility of reducing stigma and discrimination.

They were also the least likely to experience or observe physical violence from clients. The two main motivational blocks to change among the Unruffled Specialists are that they:

- are less likely than Optimistic Specialists and Detached Specialists to believe that people experiencing harm from AOD use are currently mistreated in the health system
- may not agree that it is their personal responsibility to reflect on their own attitudes and behaviours.

The Unruffled Specialists may therefore not have as strong a belief as some other groups that there is a valid problem to be tackled in terms of stigmatising and discriminatory treatment and may not immediately perceive their own potential role in this. However, given their strong foundation in non-judgemental view of clients, the Unruffled Specialists have a reasonably high motivation to support change overall even though they may not immediately see the need to change themselves.

Perceived capability and opportunity to change

The self-reported level of capability (knowledge, confidence and skills) when interacting with clients experiencing harm from AOD use was high among Unruffled Specialists – they were the least likely to perceive any capability barriers to providing optimal care in their own service, and were the least likely to worry about their own level of skills and knowledge when interacting with people experiencing harm from AOD use.

Unruffled Specialists were the second least likely of the segments to perceive time and other resources as barriers to their service delivering optimal care, and were no more or less likely than the participant sample overall to consider improvements in leadership, or in knowledge, skills and training as critical to reducing stigma and discrimination in their service or organisation

Salient enablers for this segment in reducing stigma

Although relatively unconcerned about their own capabilities, Unruffled Specialists do believe that there are some critical organisational and system enablers that need to be in place to support delivery of an optimal standard of care.

They were the most likely of all the segment groups to say that leadership on reducing stigma and discrimination in their service or organisation is a critical enabler, and were more likely than most segments to say that they may experience environmental and social barriers to delivering their ideal standard of care (such as policies, managers and colleagues). They were also most likely to cite improvement in knowledge, skills and training as critical factors supporting stigma reduction among the workforce.

Tailored narrative messaging for Unruffled Specialists

You are key allies in efforts to reduce stigma and discrimination among the health workforce. Your extensive knowledge, skills and expertise are drawn from your frequent professional exposure to and interaction with people experiencing harm from AOD use.

Research shows that this client group can often have a poor experience of services and be treated as less 'worthy' of equal treatment. They may be spoken down to, patronised, or have treatment delayed, and may then be reluctant to seek help in future. This then leads to and poor health outcomes, in a vicious cycle.

Stigma and discrimination may not seem to be a big issue in your service, but remember that discrimination can be built in to practices as the 'norm' without being consciously noticed. It is everybody's business to consistently reflect on their own assumptions, beliefs and behaviours to make sure that people with harm from AOD use are always treated with respect across the services they access.

Your role as a champion of stigma reduction initiatives is crucial. You also have the experience, skills and knowledge to mentor other health workers and, importantly, to build confidence among your close colleagues in specialist AOD services.

Recommendation for segment-specific stigma reduction support

Two strategic approaches would support Unruffled Specialists to become 'champions' for stigma reduction – **persuasion and enablement.**

The high levels of confidence in their own skills and knowledge, as well as the relative lack of environmental and social barriers perceived in their workplaces, means that Unruffled Specialists could play an important role alongside Optimistic Specialists in leading stigma reduction initiatives.

However, if they are to be enabled to do this, they may first require **persuasion** to raise their awareness of the systemic consequences of stigma and discrimination for client experiences and outcomes, and to support the development of reflective practice among this group

Recommended strategic approach	Recommended mechanisms	Examples
Persuasion	Education and training Reinforcement	Delivery of information and training activities through online modules, professional networks, and social media. All should include a component delivered by a person with lived experience, to reinforce: - How to spot stigma: increasing understanding of stigma and discrimination as sometimes unconscious processes that are reinforced by social or group 'norms' and built into practices and structures - Awareness of the personal and health consequences of experiencing stigma and discrimination when seeking help or accessing services - The importance of reflective practice and considering one's own attitudes and behaviours in the light of an increased ability to identify stigma and discrimination and to consider the consequences for clients.
Enablement of Unruffled Specialists to become: • stigma reduction 'champions' and influencers • train-the-trainers of other health workers • mentors to clients who wish to become part of contact-based training or develop a peer support work career	Education and training	Professional development opportunities to become stigma reduction champions – e.g. in mentorship and delivering stigma reduction training to non-specialists.
	Recognition, reinforcement and social influence	Creation of role/endorsement as a stigma reduction champion based on completion of above training.
		Public recognition of expertise of AOD specialists and role of stigma reduction champions via social media and professional networks.
		Creation of a stigma reduction community of practice online
	Guidance and information provision	Guidance and toolkit on supporting clients to tell their stories as part of stigma reduction training to health workers, and mentoring clients to train as peer support workers
	Reducing contextual barriers	Dedicated time for developing expertise in stigma reduction and delivering training.

Segment III: Worried Community Generalists

Profile summary

Members of the Worried Community Generalist (WCG) segment tended to be older (aged over 50) on average than most other segments. Four in ten (40.4%) of the segment members worked in generalist (non-AOD) outpatient or community healthcare settings, compared with 26.3% of the sample overall.

In contrast, only 5.8% of this segment worked in NGO AOD services, compared with 10.4% of the overall sample. The WCG segment included participants from a variety of professional backgrounds, but very few members identified their profession as drug and alcohol workers. Ten per cent of this segment identified their main role as 'manager', against 5% of the overall participant sample.

Motivation to change

ATTITUDES AND BELIEFS ABOUT PEOPLE EXPERIENCING AOD HARM

The WCG segment had the second lowest proportion of members who reported an overall positive attitude towards people experiencing harm from AOD use (34.6% positive or very positive).

Similarly to the other two generalist segments (fearful generalists and pressured hospitalists), about half (46%) of Worried Community Generalists disagreed that they would avoid clients experiencing harm from AOD use where possible, whereas this figure was more than 68% for all three specialist segments.

WCG members had relatively low levels of agreement that people experiencing harm from AOD use should be in compulsory treatment programs, at 15.4% - much lower than Pressured Hospitalists (27.8%) and Fearful Generalists (51.4%).

This segment had the lowest proportion of segment members who were likely or very likely to advise a person close to them not to disclose harm from AOD use to anyone else (3.8%).

EXPERIENCES AND EMOTIONS

The WCG segment is notable in consistently reporting experiences of clients and their own emotions that are more negative than the three Specialist segments, but more positive than the other two Generalist segments. Forty-two per cent of Worried Community Generalists reported that they often or always experienced or observed verbal abuse, while 34.6% reported that they often or always experienced or observed physical violence in the context of interactions with clients experiencing harm from AOD use. This pattern in comparison to other segments is repeated in terms of their own experience of fear or anger during interactions.

BELIEF IN THE NEED FOR, AND FEASIBILITY OF, CHANGE

The WCG segment was the least likely group to agree that they have a personal responsibility for reflection on their own behaviours and attitudes (53.8% agree, vs 87.1% of Optimistic Specialists). Combined with their tendency to report negative or neutral overall attitudes towards people experiencing harm from AOD use, this may make it difficult for them to recognise that there is a problem with stigma and discrimination against people experiencing harm from AOD and that they might need to reflect on their role in it. Reinforcing this tendency, members of this segment are the second least likely to agree

that this client group is mistreated in the health system (55.8% agreed, against 84.3% among Optimistic Specialists). Along with the other Generalist segments, the WCG segment also had a relatively low level of endorsement of the idea that people experiencing harm from AOD use deserve equal treatment to everyone else (92.3% agreed, against 100% of Unruffled Specialists).

Perceived capability and opportunity to change

CONFIDENCE IN KNOWLEDGE AND SKILLS

The WCG segment had a high level of worry and exhibited low confidence in their own capabilities with clients experiencing harm from AOD use. This segment had the lowest proportion of members who reported 'rarely' or 'never' worrying about their own skills or knowledge when interacting with a client experiencing harm from AOD use (28.8% vs 73.5% among Unruffled Specialists). WCGs had the second lowest proportion of members reporting that they 'rarely' or 'never' worried about the potential emotional impact of these interactions (36.5% vs 91.2% among Unruffled Specialists).

SOCIAL AND ENVIRONMENTAL OPPORTUNITY

Almost one quarter of WCG members could see no environmental or social barriers at all to providing optimal care for clients in their services. This segment was less likely than some others to nominate leadership on reducing stigma and discrimination in their service or organisation as a critical enabler of change, and were less likely than some other segments to view time and resources as barriers to providing optimal care (although these factors were still the most nominated by this segment).

Salient enablers for this segment in reducing stigma

Worried Community Generalists were relatively non-committal when it came to nominating changes to their services that support stigma reduction. Confusingly, while WCG members were often aware of and concerned about their own level of skills and knowledge at the level of interactions with individual clients experiencing harm from AOD, this segment was among the least likely to perceive improvement in the knowledge and skills of staff as a critical enabler of change to reduce stigma in their service.

Salient enablers for this segment would appear to be targeted at improving individual confidence during interactions, rather than at broader change to structures and environments.

Tailored narrative messaging for Worried Community Generalists

Staff working in non-acute public sector health services – such as outpatient clinics and community-based health services - do an incredible job of meeting the needs of a huge variety of patients every single day.

You may be aware that people who experience harm from use of alcohol and other drugs have worse physical and mental health outcomes than many others. You might not be aware, though, that you and other professionals have a vital role in minimising the chance of these poor outcomes and in supporting recovery.

This is because for people experiencing harm from AOD use, experiences of services as judgemental can create a vicious cycle of not seeking help in a timely way due to shame and fear about being judged

again – then only seeking help when desperate. Every encounter a person has with a health or other support professional influences their future willingness or ability to seek help before they get to a crisis stage.

To stop this vicious cycle, it is everybody's business to consistently reflect on their own assumptions, beliefs and behaviours to make sure that people with harm from AOD use are always treated with respect across the services they use.

Recommendation for segment-specific stigma reduction support

Worried Community Generalists have a low level of confidence in their own capability, knowledge and skills when interacting with a person experiencing harm from alcohol and other drugs, but relatively low belief that changes at the level of their department or service are essential to delivery of optimal care.

Strategic approaches to supporting the reduction of stigma and discrimination in this segment should include **education and training** to build confidence and to raise awareness about stigma and discrimination and the importance of reflecting on one's own attitudes and behaviours.

Strategic approach	Change mechanisms	Examples of behaviour change enablers and techniques
Education and training	Reflexive practice training	Incorporation of reflection on the potential and actual role of health professionals in perpetuating stigma and discrimination towards people with harm from AOD into: • existing training in reflexive practice in undergraduate health professional curricula • relevant CPD-endorsed training by professional colleges and associations.
	Information provision	Delivery of information from authoritative (research) sources about systemic stigma and discrimination against people experiencing harm from use of AOD and the impact on access to healthcare as well as ultimate health outcomes for this client group.

Strategic approach	Change mechanisms	Examples of behaviour change enablers and techniques
	Awareness raising and exposure to lived experience	Raising awareness of the lived experience of stigma and discrimination, and about what stigma and discrimination can look like in the healthcare setting, using channels such as online training modules, social media and professional networks. All should include a component delivered by a person with lived experience, to reinforce: - How to spot stigma: increasing understanding of stigma and discrimination as sometimes unconscious processes that are reinforced by social or group 'norms' and built into practices and structures - Awareness of the personal and health consequences of experiencing stigma and discrimination when seeking help or accessing services
Modelling	Mentoring by stigma reduction 'champions'	Opportunities for in-services or mentoring by stigma reduction champions from specialist services or from within the same hospital/service.
	Recognition, reinforcement and social influence	Creation of role/endorsement as a stigma reduction champion within the department or service
		Opportunity to earn CPD points from above
		Opportunity to join a stigma reduction community of practice as part of CPD

Segment IV: Pressured Hospitalists

Profile summary

Members of the Pressured Hospitalist (PH) segment were overwhelmingly people who worked in pressured environments, namely emergency departments (44.4% of this segment vs 11.4% of the overall sample) and mental health services (36.1% of this segment). There was no representation in this segment from professionals working in specialist AOD services, whether in the public or NGO sector.

The segment had the highest proportion of nurses of any segment (88.6% of this segment against 58.4% of the overall sample). Males were also overrepresented in this segment compared to the overall sample of survey participants (41.7% of PHs identified as male, as against 27% of the overall sample).

Pressured Hospitalists see many patients each day with many different types of needs. They see people with harm from AOD use frequently (most commonly more than 5 times per week), but no members of the segment worked exclusively with this client group.

Motivation to change

ATTITUDES AND BELIEFS ABOUT PEOPLE EXPERIENCING AOD HARM

The Pressured Hospitalists (PHs) appear to have the greatest motivational challenges of any segment to change their behaviour to reduce stigma towards people experiencing harm from AOD use. Pressured Hospitalists, alongside Fearful Generalists (Segment 5), tended to hold the most negative and judgemental attitudes overall towards people experiencing harm from use of AOD when compared to their colleagues in other segments, with only 16.7% of PHs reporting their overall attitude to be positive or very positive towards this client group (against the most positive segment, Optimistic Specialists, at 84.3%).

Stigmatising attitudes were also reflected in responses to questions about intended behaviour: this segment was the least likely to disagree that they would avoid clients with harm from AOD use where possible (41.7% disagreeing with this sentiment, against 77.1% disagreement from the Optimistic Specialist group). Pressured Hospitalists were the most likely segment to say they were likely or very likely to advise a friend or family member against disclosing harm from AOD use to anyone else (22.2% vs 3.8% of Worried Community Generalists).

EXPERIENCES AND EMOTIONS

Pressured Hospitalists reported frequently negative experiences and emotions related to interactions with people experiencing harm from AOD use, with 75% reporting ‘always’ or ‘often’ observing or experiencing verbal abuse, and 44.4% reporting ‘always’ or ‘often’ experiencing or observing physical violence during interactions. Their internal experience during interactions with people experiencing harm from AOD use was characterised by relatively frequent experiences of anger and fear compared to all other segments except Fearful Generalists (Segment 5).

BELIEF IN THE NEED FOR, AND FEASIBILITY OF, CHANGE

Members of this segment may find it difficult to believe that there is a problem with stigma and discrimination against people experiencing harm from AOD - they are the least likely to agree that this

client group is mistreated in the health system (44.4% agreed, against 84.3% among Optimistic Specialists). The segment had the second lowest level of endorsement of the idea that people experiencing harm from AOD use deserve equal treatment to everyone else (91.7% agreed, against 100% of Unruffled Specialists). The PH segment was the second most likely segment (after Fearful Generalists) to agree that people experiencing harm from AOD use should be in compulsory treatment programs (27.8% agreed with compulsory treatment, against 11.4% of Optimistic Specialists).

Further evidence that Pressured Hospitalists may have low motivation to change behaviour was the fact that they were the least likely segment to report experiencing hope or concern during interaction with people experiencing harm from AOD use, and were the least likely to be optimistic about the ability of their own service or department to promote positive attitudes towards people experiencing harm from AOD use.

Perceived capability and opportunity to change

Motivational barriers such as a relative lack of belief in the need for change, and negative experiences of and beliefs about clients, are compounded by perceived opportunity barriers to change in the workplace, even where the need for it is recognised.

SOCIAL AND ENVIRONMENTAL BARRIERS TO CHANGE

Perhaps reflecting their low optimism about the possibility of changes in their services, Pressured Hospitalists did not have a strong belief that changes in leadership around the issue of stigma and discrimination or to the level of knowledge or skills of staff would be critical enablers of change in their workplace. They were, however, the second most likely segment to nominate time and resources as critical barriers to optimal care.

A busy work environment and physical facilities that are not conducive to de-escalation could create additional barriers to change. The Pressured Hospitalists were the least likely of any segment to report that there were no barriers to optimal care in their department (11% compared to 28% among Detached Specialists).

Salient enablers for this segment in reducing stigma

The pattern of responses among the Pressured Hospitalist segment appears to show that they find it difficult to see people with harm from AOD use in a positive or hopeful light, and that their belief in the possibility of change to allow optimal care delivery is relatively low. The circumstances of their workplace – most particularly in terms of time and resources – appear to block Pressured Hospitalists' ability to prioritise recognition and reduction in stigmatising attitudes and beliefs.

The Pressured Hospitalists did not have a notably high or low confidence in their own capabilities (skills and knowledge) when compared to other segments, particularly when presented with a specific acute presentation scenario.

In this context, the salient enablers for this group appear therefore to be rapid access to support from specialists in AOD work, as well as to physical spaces within their workplaces that support de-escalation.

Tailored narrative messaging for Pressured Hospitalists

Staff working in our busiest healthcare environments – particularly in emergency departments and mental health services – do an incredible job of balancing many priorities and quickly assessing and addressing a huge variety of patient needs every single day. This requires a great breadth of knowledge as well as a depth of skill.

The emergency department is often the place where people experiencing acute harm related to their use of alcohol or other drugs seek help at the most unwell and difficult times in their life. This can be very stressful for the person (especially if they have been brought in by police) and for the staff members who are treating and helping them. Sometimes it is difficult to see how to help a person in the context of repeated presentations or in the context of a physical environment that can be over-stimulating and non-therapeutic. Supporting them can seem to take more time than you have in your type of job.

For those working in mental health services, especially in acute inpatient environments, the immediate harm a person is experiencing from their AOD use may be overwhelming in the context of trying to support their mental health and recovery.

It can be hard to remember at these times that every encounter a person has with a health or other support professional can influence their future willingness or ability to seek help before they get to a crisis stage.

Research shows that poor prior experiences of healthcare can create a vicious cycle of not seeking help in a timely way due to shame and fear about being judged, and only seeking help when desperate. It's not everyone's job to understand and solve complex problems, but it is every staff member's job to treat people respectfully and with compassion, even when this feels very difficult.

It is everybody's business to consistently reflect on their own assumptions, beliefs and behaviours to make sure that people with harm from AOD use are always treated with respect across the services they use.

Recommendation for segment-specific stigma reduction support

Pressured Hospitalists may hold judgements that are based on exclusively seeing the 'sharp end' of a client's acute presentation with harm from alcohol and other drugs. From this perspective, changing one's own behaviour or supporting others to do the same would appear to have a high level of complexity and to require a high level of effort because of the current physical structure of emergency settings, lack of time and competing priorities.

To support members of this segment to play their role in reducing stigma and discrimination, strategic approaches include:

- education and training
- modelling
- Environmental restructuring.

Pressured Hospitalists may also benefit from mentoring by Optimistic Specialists and Unruffled Specialists, including exposure to the stories of people with lived experience to see the 'bigger picture' of how poor encounters with healthcare affect their lives.

Strategic approach	Change mechanisms	Examples of behaviour change enablers and techniques
Education and training	Information provision	Delivery of information from authoritative (research) sources about systemic stigma and discrimination against people experiencing harm from use of AOD and the impact on access to healthcare as well as ultimate health outcomes for this client group. Practical, short information resource about referrals and local services.
	Awareness raising and exposure to lived experience	Raising awareness of the lived experience of stigma and discrimination, and about what stigma and discrimination can look like in the healthcare setting, using channels such as online training modules, social media and professional networks (e.g. ECI) All should include a component delivered by a person with lived experience, to reinforce: - How to spot stigma: increasing understanding of stigma and discrimination as sometimes unconscious processes that are reinforced by social or group 'norms' and built into practices and structures - Awareness of the personal and health consequences of experiencing stigma and discrimination when seeking help or accessing services - The importance of reflective practice and considering one's own attitudes and behaviours in the light of an increased ability to identify stigma and discrimination and to consider the consequences for clients.
Modelling	Mentoring by stigma reduction 'champions'	Opportunities and dedicated time for in-services, de-briefing or mentoring by stigma reduction champions from specialist services or from within own service.
	Recognition, reinforcement and social influence	Creation of role/endorsement as a stigma reduction champion within the service or department, recognised and publicised by professional networks and associations.
		Opportunity to earn CPD points from above
		Opportunity to join a stigma reduction community of practice as part of CPD.
Environmental restructuring	Policy and procedure review	Audit of emergency department policies, procedures and practices related to management of people with acute intoxication Use of evidence-based tools to identify any barriers to best practice care in the ED and rapid transfer to more appropriate environment when indicated

Strategic approach	Change mechanisms	Examples of behaviour change enablers and techniques
	Access to within-hospital support	Access to on-call nurse or social worker within the hospital to support access to other services or less stimulating room/environment.

Segment V: Fearful Generalists

Profile summary

Members of the Fearful Generalist (FG) segment were more likely than any other segment to be in their 20s, and also had a greater proportion of females (81%) than the overall participant sample (71.7%). Fearful Generalists came from a variety of service sectors, but the proportion of members from outpatient and community services (35.1% of this segment vs 26.3% of all participants) and from mental health services (35.1% of this segment vs 25.9% of all participants) was greater than in the overall sample.

The segment had the second highest proportion of nurses of any segment (70.3% of this segment against 58.4% of the overall sample). There was no representation in this segment from drug and alcohol workers and very low representation from specialist AOD services.

Members of this segment see people with harm from AOD use reasonably frequently, with 50% of the segment seeing this client group more than five times per week.

Motivation to change

ATTITUDES AND BELIEFS ABOUT PEOPLE EXPERIENCING AOD HARM

The Fearful Generalists, alongside their Pressured Hospitalist and Worried Community Generalist colleagues, tended to hold judgemental attitudes towards people experiencing harm from use of AOD when compared to their colleagues in Specialist segments.

The Fearful Generalists had the lowest level of endorsement of the idea that people experiencing harm from AOD deserve equal treatment to everyone else (86.5% agreed, against 100% of Unruffled Specialists). This was also (by far) the most likely segment to agree that people experiencing harm from AOD use should be in compulsory treatment programs (54.4% agreed).

This segment was less likely than Pressured Hospitalists to reflect stigmatising attitudes in intended behaviour: this segment was the third least likely segment to be neutral or agree that they would avoid clients experiencing harm from AOD use where possible (49%). The Fearful Generalist segment had the second highest proportion of members to say they were likely or very likely to advise a friend or family member against disclosing harm from AOD use to anyone else (16.2%)

EXPERIENCES AND EMOTIONS

Overall, Fearful Generalists reported the most negative experiences and emotions related to interactions with people experiencing harm from AOD use of any segment. Every member of this

segment reporting experiencing frustration at least some of the time during such interactions, as well as the highest proportion of members reporting experiencing worry about the potential emotional impact of the interaction (91.9%) at least some of the time. The segment also had by far the greatest proportion of members experiencing fear and/or experiencing anger during interactions at least some of the time.

This segment had the highest proportion of members reporting 'always' or 'often' experiencing verbal abuse (86.5%) and 'always' or 'often' experiencing or observing physical violence during interactions.

BELIEF IN THE NEED FOR, AND FEASIBILITY OF, CHANGE

Despite the level of negative emotion during interaction and negative experiences of interacting with people experiencing harm from AOD, two thirds of the members agreed that this client group is mistreated in the health system (against the Pressured Hospitalists at 44.4% and Optimistic Specialists at 84.3%). However, this situation may not be seen necessarily as a problem that needs to be solved – given that this segment has the lowest level of agreement (86.5%) that this client group deserves equal treatment to everyone else.

Belief in the feasibility of change in the context of their workplace may be low amongst this segment, due to the frequency with which they experience fear, anger and frustration during interactions, and the frequency with which they nominated barriers to change in their service.

Perceived capability and opportunity to change

A greater proportion of Fearful Generalists than any other segment nominated barriers to providing optimal care to a person experiencing harm from AOD use in the context of their service, across all categories of barrier. These barriers included time and resources; policies, managers and peers not agreeing with their approach; and lack of confidence, knowledge or skills.

This segment was the second most likely (after Optimistic Specialists) to nominate improvement in their service in terms of leadership on reducing stigma and discrimination, as well as improvement in knowledge, skills and training, as critical enablers of change.

Salient enablers for this segment in reducing stigma

The pattern of responses among the Fearful Generalist segment appears to show that they find it difficult to see people with harm from AOD use in a positive or hopeful light. However, the segment responses indicated a willingness in 70% of members to see reflection on attitudes and behaviours as a personal responsibility – indicating that behaviour change techniques could acknowledge and build on this reflective capacity.

Tailored narrative messaging for Fearful Generalists

Staff working in non-acute public sector health services – such as outpatient clinics and community-based health services - do an incredible job of meeting the needs of a huge variety of patients every single day.

You may be aware that people who experience harm from use of alcohol and other drugs have worse physical and mental health outcomes than many others. You might not be aware, though, that you and

other professionals have a vital role in minimising the chance of these poor outcomes and in supporting recovery.

This is because for people experiencing harm from AOD use, experiences of services as judgemental can create a vicious cycle of not seeking help in a timely way due to shame and fear about being judged again – then only seeking help when desperate. Every encounter a person has with a health or other support professional influences their future willingness or ability to seek help before they get to a crisis stage.

For staff, it can sometimes feel stressful, scary and frustrating when a person's needs seem to go beyond what the service has time, resources or capability to meet.

However, to stop this vicious cycle, it is everybody's business to consistently reflect on their own assumptions, beliefs and behaviours to make sure that people with harm from AOD use are always treated with respect across the services they use.

Recommendation for segment-specific stigma reduction support

Fearful Generalists appear to experience a great deal of negative emotion and have observed or experienced frequent verbal abuse or violence during their work. From this perspective, changing one's own behaviour or supporting others to do the same would appear to have a high level of complexity and to require a high level of effort because of the degree of negative feeling and belief around people who experience harm from AOD use.

A strength of this segment is that members do recognise the importance of reflecting on their attitudes and behaviours. To support members of this segment to play their role in reducing stigma and discrimination, strategic approaches include:

- education and training
- modelling.

Fearful Generalists may also benefit from mentoring by Optimistic Specialists and Unruffled Specialists, including exposure to the stories of people with lived experience to see the 'bigger picture' of how poor encounters with healthcare affect their lives.

Strategic approach	Change mechanisms	Examples of behaviour change enablers and techniques
Education and training	Support for staff wellbeing	Therapeutic communication, de-escalation, and stress management coaching/training
	Awareness raising and exposure to lived experience	Raising awareness of the lived experience of stigma and discrimination, and about what stigma and discrimination can look like in the healthcare setting, using channels such as online training modules, social media and professional networks All should include a component delivered by a person with lived experience, to reinforce: - How to communicate therapeutically with someone who is acutely affected by alcohol or other drugs - How to spot stigma: increasing understanding of stigma and discrimination as sometimes unconscious processes that are reinforced by social or group 'norms' and built into practices and structures - Awareness of the personal and health consequences of experiencing stigma and discrimination when seeking help or accessing services - The importance of reflective practice and considering one's own attitudes and behaviours in the light of an increased ability to identify stigma and discrimination and to consider the consequences for clients.
Modelling	Recognition, reinforcement and social influence	Opportunities and dedicated time for in-services, de-briefing or mentoring by stigma reduction champions from specialist services or from within own service. Creation of role/endorsement as a stigma reduction champion within the service or department, recognised and publicised by professional networks and associations.

Segment VI: Detached Specialists

Profile summary

The Detached Specialist segment was the most likely segment to have members aged over 60 years. The group was characterised by their diversity in profession, but there was greater representation among this segment of allied health (20% of segment vs 15% of cohort) and medical staff (11.4% of segment vs 7.4% of cohort). A greater proportion of this segment worked in public sector AOD services than in the overall sample (33.8% of segment vs 23.6% of cohort).

Detached Specialists are also diverse in terms of their professional exposure to clients with harm from AOD use, with some members reporting interacting with this client group less than once per week, while one quarter reported working exclusively with them. Members of this segment were the least likely of any segment to report experience of harm from AOD use in their personal lives either themselves or in someone close to them (61% reported this experience).

Motivation to change

ATTITUDES AND BELIEFS ABOUT PEOPLE EXPERIENCING AOD HARM

The Detached Specialists were much less likely than the Optimistic Specialists to report positive or very positive overall attitudes towards people experiencing harm from AOD use (60.6% of DS vs 84.3% of OS). However, they also had much higher endorsement of positive attitudes than any of the three Generalist segments.

Detached Specialists had similar patterns of responses to the other Specialist segments in terms of low rates of endorsement of stigmatising or discriminatory attitudes and beliefs towards this client group on measures such as deservingness of equal treatment (98.6% agreed deserve equal treatment) and need for compulsory treatment programs (14.1% agreed). Detached Specialists were the second most likely segment to disagree that they would avoid people experiencing harm from AOD use where possible, after Optimistic Specialists.

EXPERIENCES AND EMOTIONS

The Detached Specialists were less likely than members of most other segments to report experiencing negative emotions during interactions. They were the least likely segment to experience fear and the second least likely to experience anger or frustration during interactions with people experiencing harm from AOD use. 63.4% of Detached Specialists reported ‘rarely’ or ‘never’ worrying about the potential emotional impact of an interaction.

However, they had a higher rate of experiencing or observing verbal abuse and especially physical violence ‘always’ or ‘often’ than their colleagues in other Specialist segments. One in five (21.1%) reported always or often experiencing or observing physical violence.

BELIEF IN THE NEED FOR, AND FEASIBILITY OF, CHANGE

Detached specialists were among the most hopeful segments in terms of their clients’ recovery but were less optimistic about the ability of their own service to promote positive attitudes towards people experiencing harm form AOD use (71.8% of the segment agreed they were optimistic). They were, however, the segment with the second highest proportion of members agreeing that people with harm from AOD use are mistreated in the health system (74% agreed), and 70% indicated a sense of personal responsibility for reflecting on their own attitudes and behaviours.

This belief in the existence of a problem alongside low levels of stigmatising attitudes and reflective capacity, indicate that this group has a good foundation to engage in promoting reduction in stigma and discrimination, if they are given the tools to support them in this. Motivational barriers may be the relatively high levels of experience of verbal abuse and physical violence.

Perceived capability and opportunity to change

Twenty-eight per cent of Detached Specialists endorsed the statement that 'there are no barriers to optimal care of this client in my service' – the highest endorsement of any segment. However, they were also the most likely of the Specialist segments to report time and resources as barriers to providing optimal care.

Detached Specialists were the least likely of any segment to nominate improvements in leadership on reducing stigma and discrimination as a crucial change in their service.

Salient enablers for this segment in reducing stigma

Although relatively unconcerned about changes to be made or barriers to overcome in their own service, Detached Specialists do experience relatively high levels of physical violence or verbal abuse. They do not appear to translate this into negative emotions towards clients during interactions, however, so appear to be comfortable in their own capacity to support clients.

Tailored narrative messaging for Unruffled Specialists

You are key allies in efforts to reduce stigma and discrimination among the health workforce. Your extensive knowledge, skills and expertise are drawn from your experience in supporting people experiencing harm from AOD use.

Research shows that this client group can often have a poor experience of services and be treated as less 'worthy' of equal treatment. They may be spoken down to, patronised, or have treatment delayed, and may then be reluctant to seek help in future. This then leads to and poor health outcomes, in a vicious cycle.

Stigma and discrimination may not seem to be a big issue in your service, but remember that discrimination can be built in to practices as the 'norm' without being consciously noticed. It is everybody's business to consistently reflect on their own assumptions, beliefs and behaviours to make sure that people with harm from AOD use are always treated with respect across the services they access.

Your role as a champion of stigma reduction initiatives is crucial. You also have the experience, skills and knowledge to mentor other health workers and, importantly, to provide mentorship in emotional resilience to colleagues in specialist AOD services.

Recommendation for segment-specific stigma reduction support

The most important strategic approach for Detached Specialists is to use the resources of their long experience and emotional resilience to help support others in stigma reduction activities.

Their relatively high levels of confidence in their own skills and knowledge, as well as the relative lack of environmental and social barriers perceived in their workplaces, means that Detached Specialists could play an important role alongside the other Specialist segments in leading stigma reduction initiatives.

Recommended strategic approach	Recommended mechanisms	Examples
Enablement of Detached Specialists to become: • stigma reduction 'champions' and influencers • train-the-trainers of other health workers • mentors to clients who wish to become part of contact-based training or develop a peer support work career	Education and training	Professional development opportunities to become stigma reduction champions – e.g. in mentorship and delivering stigma reduction training to non-specialists, especially in: - emotional resilience and de-escalation skills - How to spot stigma: increasing understanding of stigma and discrimination as sometimes unconscious processes that are reinforced by social or group 'norms' and built into practices and structures - Awareness of the personal and health consequences of experiencing stigma and discrimination when seeking help or accessing service - The importance of reflective practice and considering one's own attitudes and behaviours in the light of an increased ability to identify stigma and discrimination and to consider the consequences for clients.
	Recognition, reinforcement and social influence	Creation of role/endorsement as a stigma reduction champion based on completion of above training.
		Public recognition of expertise of AOD specialists and role of stigma reduction champions via social media and professional networks.
		Creation of a stigma reduction community of practice online
	Guidance and information provision	Guidance and toolkit on supporting clients to tell their stories as part of stigma reduction training to health workers, and mentoring clients to train as peer support workers
	Reducing contextual barriers	Dedicated time for developing expertise in stigma reduction and delivering training.

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Appendices

Appendix A – Participant inclusion criteria

The specific inclusion criteria given below relate to the Ministry of Health, ACI and NADA's aim to understand stigma and discrimination among those staff members who commonly encounter these patients during their work.

Participants will:

- Be aged 18 years or over
- Be available and willing to participate during the data collection period
- Be currently employed either in an NSW public health provider organisation or service or in a non-government organisation operating in NSW, where the service's primary focus is on:
- Alcohol and other drug treatment, rehabilitation, support or harm minimisation in public and non-government sectors
- Perinatal health and obstetric services based in a public hospital
- Emergency departments of public hospitals
- Specialist mental health services in both public and non-government sectors.
- Be currently employed in the above services in clinical or other directly patient-facing roles or in a policy or management position
- Have prior experience of delivering treatment, care or other professional support directly to a person or persons who experience dependence on alcohol or other drugs
- Have access to a telephone line or mobile device through which to participate in a teleconference focus

Appendix B - Data collection tools

Key informant interview guide

	Question	Focus area
1	Can you tell me about your role and the type of work you do with people who experience harm relating to use of AOD? a. How does your organisation interact with, or on behalf of, people who experience harm relating to the use of alcohol or other drugs?	Icebreaker
Section 1: Exploring healthcare professionals' attitudes, beliefs and behaviours		
2	I'd like to start by getting you to reflect on the factors that do or should create positive health and social care interactions for people who experience harm from alcohol or other drugs use. a. Can you tell me about a time when you personally have experienced or observed a positive interaction or relationship, and what made it positive? b. Thinking more broadly, what do you believe are the key ingredients for a positive **interaction** between people who experience harm from alcohol or other drugs and those who provide support or treatment? c. What do you think are the most important ingredients for a sustainable **ongoing relationship** between a person who experiences harm from alcohol or other drugs with those who provide support or treatment? d. In your opinion, what factors influence the likelihood that interactions and relationships will be positive? *Prompts* • *Setting where assistance is being sought?* • *Reason for seeking assistance – AOD, other health related issue or unrelated to AOD use?* • *Individual characteristics of the staff member of person seeking help?* • *To what extent do organisational and structural factors, including staff culture, play a part in creating positive interactions?* • *What about broader social attitudes and norms?*	Behaviour Opportunity Motivation

3	Now looking at the opposite situation, where a person may be treated in a way that is unfair or marks them out as 'different' by individual staff or by the health service in general: a. In your opinion, is this a problem that is currently encountered by those who experience harm relating to alcohol or other drugs when seeking support or treatment? b. To what extent is this seen within NSW Health or non-government organisations providing treatment or support for alcohol or other drugs? Are there specific sectors where this problem exists to a greater extent that others? c. What would you describe as the impact of this problem on: • The nature of the experience and the quality of healthcare delivered to the person seeking assistance? • Healthcare and the non-government workforce? d. In what ways have you seen or heard about people being treated unfairly? *Prompts* • *To what extent do organisational and structural factors, including staff culture, play a part in creating negative interactions?* • *What about the role of broader social attitudes and norms?* • *Individual characteristics of the staff member or the patient?*	Behaviour Opportunity Motivation
Section 2: Factors which influence the development of healthcare professionals' attitudes, beliefs and behaviours		
4	a. In your opinion, what are the factors that shape the development of norms, attitudes and behaviours in the first place (both positive and negative)? b. What factors maintain or perpetuate these attitudes, systems and behaviours over time? *Prompts* *Personal experiences or beliefs, such as religious beliefs* *Education, training, presence or confidence in professional skills* *Individual/organisational culture, environment* *Expectation of outcome*	Capability Opportunity Motivation
Section 3: Interventions that can influence the development and maintenance of healthcare professionals' attitudes, beliefs and behaviours		

5	Let's turn to interventions that may help to address some of the factors influencing the development and maintenance of norms, attitudes or behaviours that may positively or negatively affect the experience and outcome of healthcare for people experiencing harm from alcohol or other drugs use. Given the sensitivity of the topic, and the extent to which people may or may not be aware of the reasons for, or the impact of their attitudes and behaviour, what do you think is the best way to approach this issue (through communications, training etc.) with the workforce in NSW? a. What do you anticipate will help or hinder efforts to reduce stigma and discrimination among the workforce? b. Do you think the approach should be same or different for users of alcohol or other drugs? c. Are you aware of any current or previous initiatives (anywhere in the world) that have addressed this issue? How did they go? Why did they succeed or fail? d. What role do you see 'communications' (such as campaigns) having in supporting this change? e. If there was one thing that you could do to change negative responses to people experiencing harm from alcohol or other drugs use, what would it be?	Interventions
6	That brings me to the end of my questions. Is there anything else that you would like to add? *Thank you for taking the time to talk with me today. If you have any questions, or think of anything else you'd like to add, please don't hesitate to contact me.*	

Focus group guide

QUESTIONS 1 & 2 – FOR USE IN ALL FOCUS GROUPS

	Question	Purpose
1	**To get things started, can I ask you to introduce yourselves and to say a little bit about why you were interested in attending the discussion today?** *Prompts* *Work setting and role* *Nature of their interaction with people with AOD issues*	Icebreaker
	MODERATOR: We would like to begin by exploring some of your previous experiences and observations during your work as healthcare providers. *These can be from your own interactions or from interactions you have witnessed between a healthcare provider and a person who has an illness or injury from their use of alcohol or other drugs.*	
2	**First of all, can you share with the group a particular memory of an interaction or series of interactions with such a person who came to your service?** For group discussion: • What were your initial thoughts and feelings about the situation? • What happened, and what decisions did you have to make? • What was the outcome for the person and for you? How familiar or common is this type of experience in your practice [and does it sound familiar to the rest of the group]?	Elicit reflection on a particular direct experience, orientation to the issues (capability, opportunity, motivation)
	NOTE for moderator: *DURING Question 2, if conversation is difficult or participants seem reluctant to speak in this direct way, skip to presenting scenarios and then proceeding from Question 2 as shown in 'OPTION 2: SCENARIOS' below. Otherwise continue with Question 3 in 'OPTION 1: DIRECT EXPERIENCES' below.*	

OPTION 1 (PREFERRED) – DIRECT EXPERIENCE QUESTIONS

3	**Thinking again about the experiences you each shared, we'd like to ask you to reflect on your response to the situation at the time.**	Gauge confidence, self-reflective

	Did you find yourself reflecting on the interaction afterwards? What did you feel went well/ what did you learn/ what did you wish you'd done differently? What strengths, resources and skills did you find helpful to draw on during the interaction? What do you think were the key influences on your approach to the interaction and the decisions you made? ***Prompts*** *Your prior experiences managing this type of presentation* *Factors beyond your control that affected your decisions and actions?* *Accepted behaviours and practices in the workplace* *Service factors, policies, resources*	capacity, beliefs about cause of challenges, gaps in skills. *(Motivation, capability)*
4	**Did you find particular aspects of the situation challenging?** • What was challenging? • Is this a common experience among the group? • Why do you think it was challenging? ***Prompts*** • *Personal factors (self or patient)* • *Structural or environmental* • *Organisational culture*	Gauge confidence, self-reflective capacity, beliefs about cause of challenges, gaps in skills. *(Motivation, opportunity, capability)*
5	**In an ideal world, is there anything you would change about the situation you described or your response to it – or anything you would try to put in place for a similar situation in future?** • What would the ideal immediate response be when this person presented - in terms of interacting with them and in addressing their needs? • What do you think would be the ideal experience from the perspective of the person seeking support? Again in an ideal world, what would the responding staff member need to know, who might they need to ask for assistance, and what resources might they need, in order to provide an optimal experience and outcome for the person?	Elicit reflection on own beliefs, attitudes and behaviours *(Opportunity, capability)*
6	**Do you believe that there are changes that would realistically make a difference to you and your colleagues in being able to provide an optimal experience for both staff and people seeking help?** Changes at the policy or government level?	Gauge belief in case for change *(motivation)* Acceptability and

	Organisational level? Team level? As an individual? *[Additional prompt wording if necessary] if you were to design a strategy to support health professionals across NSW in recognising and overcoming some of the challenges, what do you think would be its key ingredients?*	appropriateness of *interventions*
7	**Moving to a broader perspective, we are interested in exploring your views about how to ensure an equal opportunity to access high quality, safe healthcare for people with injury or illness from use of alcohol or other drugs.** Do you think this is an issue of concern? Is there currently equality of opportunity? Have there been situations in which you have witnessed behaviours or attitudes of healthcare staff that you would describe as stigmatising or discriminatory? What impact do you think it has on these patients in terms of the presenting issue? How about in terms of their access to healthcare more broadly?	Acceptability and appropriateness of *interventions* (especially comms-related)
8	**Finally, I'd like to explore your views about the concepts of stigma and discrimination towards people who use AOD**. Can you recall seeing, hearing or reading about the topic of stigma or discrimination towards people who use alcohol or other drugs at a harmful level during the last 12 months? In general, what is your instinctive reaction when you see, hear or read about stigma and discrimination in relation to people who use AOD? What do the concepts mean to you? How could the issue of stigma and discrimination be communicated about in a way that does not cause people to reject it, or assume it only happens with others? What sort of messaging, tone and language might be appropriate? What role do communications approaches (information, training, social media, mass media campaigns etc.) play (if any) in addressing stigma – or what role could they play in future?	Elicit reflection on a particular direct experience, orientation to the issues (Capability Opportunity Motivation)
9	**That brings me to the end of my questions. Is there anything else that you would like to add?** *Thank you for taking the time to talk with me today. If you have any questions, or think of anything else you'd like to add, please don't hesitate to contact me.*	

Survey questions

Start of Block: Section 1: About you

Q1 **Which of the following best describes your current work role?**

- ☐ Medical practitioner (e.g. consultant/staff specialist, registrar, resident, intern) (1)
- ☐ Nursing or midwifery (e.g. nurse practitioner, clinical nurse consultant, nurse manager, midwife, clinical midwife consultant, registered nurse) (2)
- ☐ Allied health professional (e.g. pharmacist, physiotherapist, occupational therapist, social worker, mental health clinician/psychologist) (3)
- ☐ Drug and alcohol worker (e.g. caseworker, case manager, care coordinator, support worker) (4)
- ☐ Aboriginal health worker/practitioner (5)
- ☐ Peer worker/advocate (6)
- ☐ Other (please specify) (7) _____

Q2 **Which of the following best describes the organisation in which you spend most time working?**

- ○ Local Health District (LHD) or Specialty Health Network (SHN) (1)
- ○ Non-government organisation (2)
- ○ Other (please specify) (3) _____

☐ *Skip To: Q5 If 2. Which of the following best describes the organisation in which you spend most time working? = Non-government organisation*

☐ *Skip To: Q5 If 2. Which of the following best describes the organisation in which you spend most time working? = Other (please specify)*

Q3 **In which Local Health District (LHD) or Specialty Health Network (SHN) are you located?**

- ○ Central Coast LHD (1)

- ○ Illawarra Shoalhaven LHD (2)
- ○ Nepean Blue Mountains LHD (3)
- ○ Northern Sydney LHD (4)
- ○ South Eastern Sydney LHD (5)
- ○ South Western Sydney LHD (6)
- ○ Sydney LHD (7)
- ○ Western Sydney LHD (8)
- ○ Far West LHD (9)
- ○ Hunter New England LHD (10)
- ○ Mid North Coast LHD (11)
- ○ Murrumbidgee LHD (12)
- ○ Northern NSW LHD (13)
- ○ Southern NSW LHD (14)
- ○ Western NSW LHD (15)
- ○ Sydney Children's Hospitals Network (16)
- ○ Justice Health and Forensic Mental Health Network (17)
- ○ Other (please specify) (18) _____

Q4 **Which of the following best describes the service/department in which you spend the most time working?**

- ○ AOD services (1)
- ○ Emergency departments (2)
- ○ Maternity services (3)

- ○ Mental health services (4)
- ○ Other (please specify) (5) _____

Q5 **How often, in an average working week, do you interact with patients experiencing harm from their use of AOD?**

- ○ I work exclusively with this client group (1)
- ○ More than 5 times per week (2)
- ○ 4-5 times per week (3)
- ○ 2-3 times per week (4)
- ○ Once a week (5)
- ○ Less than once a week (6)
- ○ Rarely (7)
- ○ Never (8)
- ○ Other (please specify) (9) _____

Q6 **Have you had a personal experience of harm associated with the use of AOD, or know of someone (for example, family, close friends) who has?**

- ○ Yes (1)
- ○ No (2)
- ○ I prefer not to answer (3)

Q7 **What is your age?**

- ○ 18-20 (1)
- ○ 21-29 (2)
- ○ 30-39 (3)

- ○ 40-49 (4)
- ○ 50-59 (5)
- ○ 60 or older (6)
- ○ I prefer not to answer (7)

Q8 **What is your gender?**

- ○ Male (1)
- ○ Female (2)
- ○ Prefer to self-describe (please specify) (3) _____
- ○ Prefer not to disclose (4)

End of Block: Section 1: About you

Start of Block: Section 2: Attitudes, beliefs and behaviours

The following section will present a series of statements relating to people experiencing harm related to AOD* use.
**The term 'other drugs' used in this section includes illicit and licit substances such as cannabis, methamphetamine, heroin, cocaine, ecstasy, and prescription drugs (for example, opioids).*

Q9 **Please rate your level of agreement with each of the following statements, using the scale provided.**

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
People who experience harm related to their use of alcohol or other drugs have a right to their lifestyle, if that's the way they want to live. (1)	○	○	○	○	○
Regular and consistent use of alcohol or other drugs is a lifestyle for some that should not be negatively judged by others. (2)	○	○	○	○	○

People who experience harm related to their use of alcohol or other drugs should be in compulsory treatment programs. (3)	○	○	○	○	○
People who experience harm related to their use of alcohol or other drugs deserve the same level of medical care as others. (4)	○	○	○	○	○
People who experience harm related to alcohol or other drug use are mistreated in our health system. (5)	○	○	○	○	○
People who regularly and consistently use alcohol or other drugs are not employable. (6)	○	○	○	○	○
I avoid people who are experiencing harm related to their alcohol and other drug use when possible. (7)	○	○	○	○	○

Q10 **Please rate your level of agreement with each of the following statements, using the scale provided.**

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
Most people who experience harm associated with AOD are personally responsible for their situation. (1)	○	○	○	○	○
Most people who experience harm associated with AOD can stop whenever they want to. (2)	○	○	○	○	○
Most people who regularly and consistently use AOD use these substances as a way of dealing with issues. (3)	○	○	○	○	○
In most cases, adverse life circumstances are likely to be	○	○	○	○	○

responsible for a person's use of AOD to harmful levels. (4)					
A common reason for people who use drugs at harmful levels presenting to a hospital is to seek drugs for their habit. (5)	○	○	○	○	○
People experiencing harm related to their use of AOD have weak characters. (6)	○	○	○	○	○
Given appropriate treatment and support, people who experience ongoing harm from their use of AOD can recover. (7)	○	○	○	○	○

Q11**Using the scale provided, how frequently do you experience or observe the following behaviours from people presenting to your service for reasons related to their AOD use?**

	Never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)
Patients engaging as active participants in their care. (1)	○	○	○	○	○
Verbal abuse towards you or colleagues. (2)	○	○	○	○	○
Patients engaging in criminal behaviour (for example, stealing). (3)	○	○	○	○	○
Physical violence towards themselves or others. (4)	○	○	○	○	○
Expressing appreciation for the support provided. (5)	○	○	○	○	○
Consistently following through on an agreed treatment plan. (6)	○	○	○	○	○

Q12 **On the items you rated as 'Sometimes', 'Often', or 'Always' for the previous question, how do these experiences impact the way you provide treatment and support to those who present to your service for a reason related to their AOD use?**

Q13 H**ow frequently do you experience each of the following emotions when providing support or treatment to people who present to your service for a reason related to their AOD use?**

	Never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)
Anger (1)	○	○	○	○	○
Frustration (2)	○	○	○	○	○
Fear (3)	○	○	○	○	○
Disappointment (4)	○	○	○	○	○
Empathy (5)	○	○	○	○	○
Concern (6)	○	○	○	○	○
Stress (7)	○	○	○	○	○
Anxiety (8)	○	○	○	○	○
Hope (9)	○	○	○	○	○

Q14 **On the items you rated as 'Sometimes', 'Often', or 'Always' for the previous question, what do you think are the reasons you feel those emotions during interactions with people who experience harm related to their AOD use?**

Q15 **How frequently do you experience the following worries with people who present to your service for a reason related to their AOD use?**

	Never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)
You do not have the resources to support the person. (1)	○	○	○	○	○

The person may become violent. (2)	○	○	○	○	○
You may be emotionally impacted by the interaction. (3)	○	○	○	○	○
The person is lying to you and doesn't want help. (4)	○	○	○	○	○
You do not have the appropriate skills or knowledge to support the person. (5)	○	○	○	○	○
The person may be unpredictable during your interaction. (6)	○	○	○	○	○

Q16 **How likely or unlikely would you be to advise a close friend or relative who has been treated for AOD not to tell anyone else about it?**

- ○ Extremely unlikely (1)
- ○ Unlikely (2)
- ○ Neutral (3)
- ○ Likely (4)
- ○ Extremely likely (5)

End of Block: Section 2: Attitudes, beliefs and behaviours

Start of Block: Section 3A: Scenario testing (LHD or SHN respondents only)

This section will ask you about your approach to dealing with scenarios that you may experience in your everyday work.

Scenario
Please read the following scenario before progressing to the questions.

Rachel, a 30-year-old woman, shows up to your health service complaining of severe stomach pains. She has arrived on her own, appears slightly unkempt, is crying and is telling staff that she is in "a lot of pain". You can smell alcohol on her breath, and Rachel appears increasingly agitated as she waits for medical attention.

Q17 **Thinking about Rachel's scenario, what is your instinctive reaction to this situation?**

Q18 **Thinking about Rachel's scenario, please describe what you would typically expect to happen next in your service.**

Q19 **Do you believe that this typical response is the best response?**

Q20 **If you were present at Rachel's scenario, what factors might currently impact you and your colleagues' ability to respond better to the situation?**

- [ ] Time (1)
- [ ] Resources (e.g. staffing supports) (2)
- [ ] Concern that Rachel may be drug-seeking (3)
- [ ] My colleagues or senior managers not agreeing with my approach (4)
- [ ] Policies and procedures may not allow my approach (5)
- [ ] Being unsure of my confidence in managing this situation (6)
- [ ] Being unsure of my skills to manage this situation (7)
- [ ] Being unsure of appropriate referral pathways (8)
- [ ] I do not feel that there are any current barriers to an optimal approach in my service (9)
- [ ] Other (please specify) (10) _____

End of Block: Section 3A: Scenario testing (LHD or SHN respondents only)

Start of Block: Section 4: Support for positive attitudes and behaviour

This final set of questions will ask about future efforts to change attitudes and behaviours.

Q25 **How would you describe your current overall attitude towards those who experience harm related to their use of AOD?**

- ○ Very negative (1)
- ○ Negative (2)
- ○ Neutral (3)

- ○ Positive (4)
- ○ Very positive (5)

Q26 **To what extent do you agree with the following statement?**

"I feel a sense of responsibility to reflect on my attitudes, beliefs and behaviours towards people who experience harm related to their AOD use".

- ○ Strongly disagree (1)
- ○ Disagree (2)
- ○ Neutral (3)
- ○ Agree (4)
- ○ Strongly agree (5)

Q27 **To what extent do you agree with the following statement?**

"I feel optimistic that my team/organisation can promote and display positive attitudes and behaviours towards people who experience harm related to their AOD use".

- ○ Strongly disagree (1)
- ○ Disagree (2)
- ○ Neutral (3)
- ○ Agree (4)
- ○ Strongly agree (5)

Q28 **How much impact could the following have in helping you, your team, and your organisation promote and display positive attitudes and behaviours towards people who experience harm related to their AOD use?**

	None (1)	Minor only (2)	Moderate (3)	Major (4)	Critical (5)
More leadership and management support (1)	○	○	○	○	○
Positive changes to policies and procedures (2)	○	○	○	○	○
More opportunities to improve confidence, knowledge and skills (3)	○	○	○	○	○
More access to resources (for example guidelines, training, specialist staff) (4)	○	○	○	○	○
Knowing that others in my team want to see a change (5)	○	○	○	○	○
Other (please specify) (6)	○	○	○	○	○

Q29 **Do you have any further thoughts or reflections about the issues addressed in this survey?**

End of Block: Section 4: Support for positive attitudes and behaviour

End of Block: End text

Start of Block: Section 3B: Scenario testing (NGO respondents only)

This section will ask you about your approach to dealing with scenarios that you may experience in your everyday practice.

Scenario
Please read the following scenario before progressing to the questions.

Rob is a 36-year-old man who has a history of polydrug use and is accessing your service due to the impact of his methamphetamine use. His long-term partner has told him that if he doesn't stop using, he will be kicked out. He has also recently lost his job due to conflict with his workmates that escalated into a fistfight. Rob had accessed your service before and was at the time exited for returning to the service intoxicated after an outing.

Q21 **Thinking about Rob's scenario, what is your instinctive reaction to this situation?**

Q22 **Thinking about Rob's scenario, please describe what you would typically expect to happen next in your service?**

Q23 **Do you believe that this typical response is the best response?**

Q24 **If you were present at Rob's scenario, what factors might impact your and your colleagues' ability to respond better to the situation?**

- ☐ Time (1)
- ☐ Resources (e.g. staffing supports) (2)
- ☐ Concern that Rob may not be motivated enough to participate in treatment (4)
- ☐ My colleagues or senior managers not agreeing with my approach (3)
- ☐ Policies and procedures may not allow my approach (5)
- ☐ Being unsure of my confidence in managing this situation (6)
- ☐ Being unsure of my skills to manage this situation (7)
- ☐ Being unsure of appropriate referral pathways (8)
- ☐ I do not feel that there are any current barriers to an optimal approach in my service (9)
- ☐ Other (please specify) (10) _____

Start of Block: End text

Thank you for taking the time to complete this survey.

Should you have any questions about this survey, or about the project in general, please email Zest at consulting@zest.com.au

If this survey has raised issues that you would like to discuss confidentially with a support service, please contact the Alcohol and Drug Information Service on 1800 250 015.

Should you have any concern or complaint about this survey or research, please email Hunter New England LHD Human Research Ethics Committee at HNELHD-HREC@health.nsw.gov.au.

Contact If you would like to be involved in initiatives arising from this research, please leave your contact details below. Initiatives may include programs to improve care and support for people experiencing harm from AOD use.

Your details will not be associated with your responses to this survey. Providing your details is not a commitment to be further involved, and you may still decline if you are contacted in the future.

○ Email address (1) _____

○ Phone number (2) _____

Name (3) _____

Appendix C – Survey data cleaning and recoding

Data cleaning

- Cases were deleted if completed in less than 3 minutes or if they were less than 50% complete
- A large number of respondents selected "other" in their responses to questions on profession and workplace.
- These responses were categorised by ACI.

Recoding

The five workforce sectors of interest are:

1. AOD services
2. Emergency departments
3. Maternity services
4. Mental health services
5. NGO

Three additional sectors were identified during recoding. For the purposes of comparisons between sectors these respondents are grouped together under "other"

6. Outpatient Community
7. Acute inpatient Hospital
8. Management Administration
9. Other unknown

SAMPLE SIZE BY SERVICE

N	Valid	Missing
AOD services	76	0

Emergency departments	39	0
Maternity services	15	5
Mental health services	83	0
NGO	37	0
Other	64	4
Total	314	9

Appendix D – Factor analysis method

We used factor analysis to develop an initial understanding of attitudes towards people experiencing harm from alcohol and drugs across NSW Health and NGO workforce and how these may differ across the different clinical networks.

The purpose of factor analysis is to detect latent factors that explain the variation in participants' responses. The latent factors reflect patterns in the type of attitudes that often appear together. By examining the group of attitude questions found to fall on a particular factor, a name can be given to the group of meaningful attitudes in the analysis context and helps understand the relationship between groups of attitudes.

Factor analysis is a method for reducing data to identify broad patterns and trends in the data.

- Analysis based on 306 valid responses
- Factor analysis with maximum likelihood extraction (eigenvalues >1) with direct Oblimin rotation
- Five factors accounted for 38% of the variance in attitude data
- Factor scores are named to reflect the items they are comprised of and are normalised with a mean of zero
- Boxplots of factor scores broken down into networks indicate broad attitudinal patterns that are consistent with interview and focus group data
- Differences between services indicate broad service level themes and do not reflect the views of anyone individual.

FACTOR CORRELATION MATRIX (PEARSON'S R)

	Clients are irresponsible	Negative emotion	Clients have challenging circumstances	Clients are dangerous	Empathy and hope
Clients are irresponsible	--				
Negative emotion	.299**	--			

Clients have challenging circumstances	-.222**	-0.035	--		
Clients are dangerous	.417**	.422**	-.157**	--	
Empathy and hope	**-.510****	-0.107	.347**	-.179**	--

**correlation is significant at the 0.01 level (2-tailed).
Correlations ~.5 indicate large effect size, ~.3 are moderate effect size, ~.1 are small effect size (Cohen, 1988, 1992).

Across the whole sample, there is a strong negative correlation between "clients are irresponsible" and "empathy and hope", indicating that those who view people who experience harm from AOD use as being of poor character are less optimistic about their prospects recovery. On the other hand, those who appreciate the challenges people who experience harm from AOD use experience in their lives tend to be more optimistic.

Those who believed clients were dangerous tended to have more negative attitudes and emotion.

Interpreting box plots

Box plots display the distribution of data around a mean of zero. The black line represents the median or middle score of the distribution.

The blue box represents the interquartile range, or the middle 50% of scores. When two blue boxes do not overlap, there is likely to be a difference between the groups.

The whiskers represent the ends of the distribution and indicate how stretched out the rest of values are. The circles represent outliers, or scores that are very different.

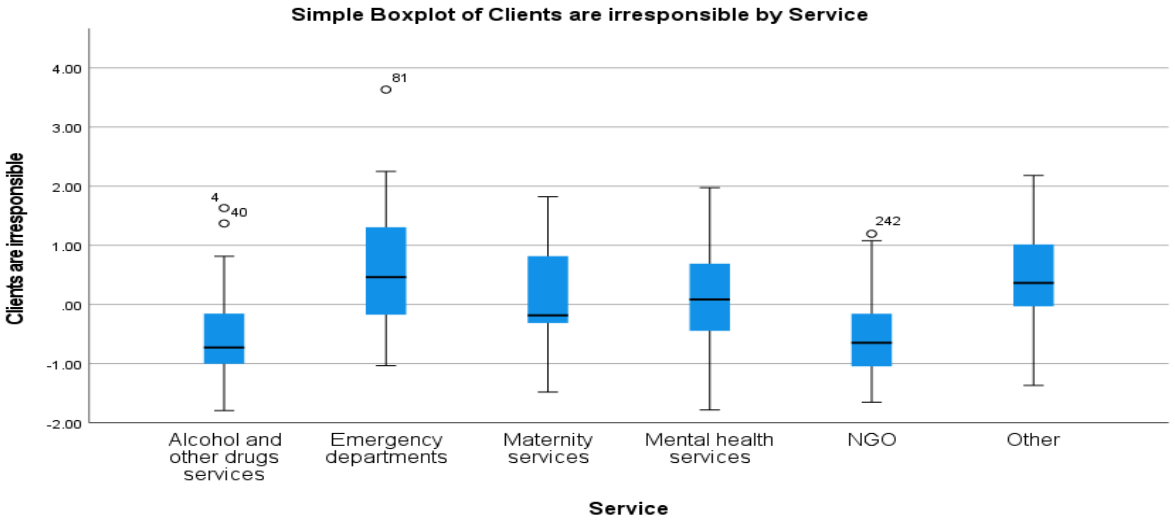
These plots are included here to illustrate patterns in the data, and are not accompanied by formal statistical (p-value) testing.

Positive and negative judgements toward clients

Participants had positive or negative judgements about people who experience harm from AOD use and beliefs about the drivers of the harm they experience. At the positive end of the spectrum are respect for people minimising harm, and at the other are negative beliefs about character, employability, and drug-seeking behaviour. Higher scores (above zero) are more negatively judgemental.

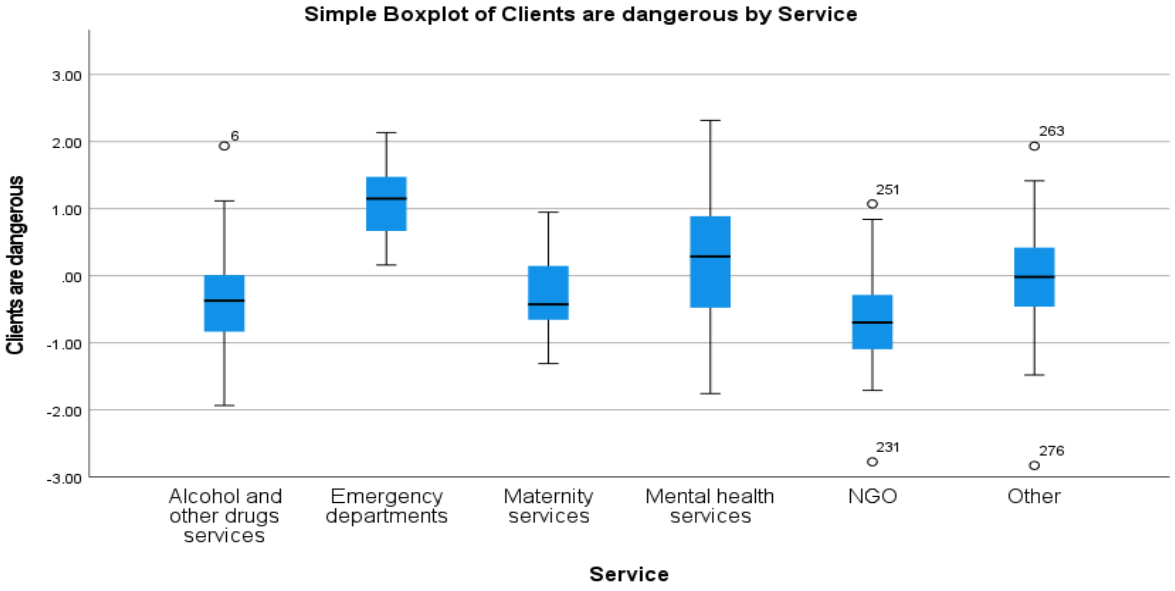
As the series of box plots below show, negative judgements are more often seen in Emergency Departments, and are moderately associated with perceptions that people who experience harm from AOD use may be abusive, unpredictable, or violent. Unsurprisingly, those with more negative judgmental attitudes tend to be less empathic, concerned, and hopeful for people who experience harm from AOD use.

At the other side of the spectrum, less judgmental attitudes are found in AOD services, including NGOs, and are moderately associated with empathy and hope.



Clients are unpredictable or dangerous

Statements referring to abuse, physical violence and unpredictable behaviour from intoxicated persons towards health workers form this factor. Across services, people working in Emergency Departments tended to have the highest scores, followed by people working in mental health. People working in AOD services and NGOs and maternity settings tended not to express fear towards clients in this way.



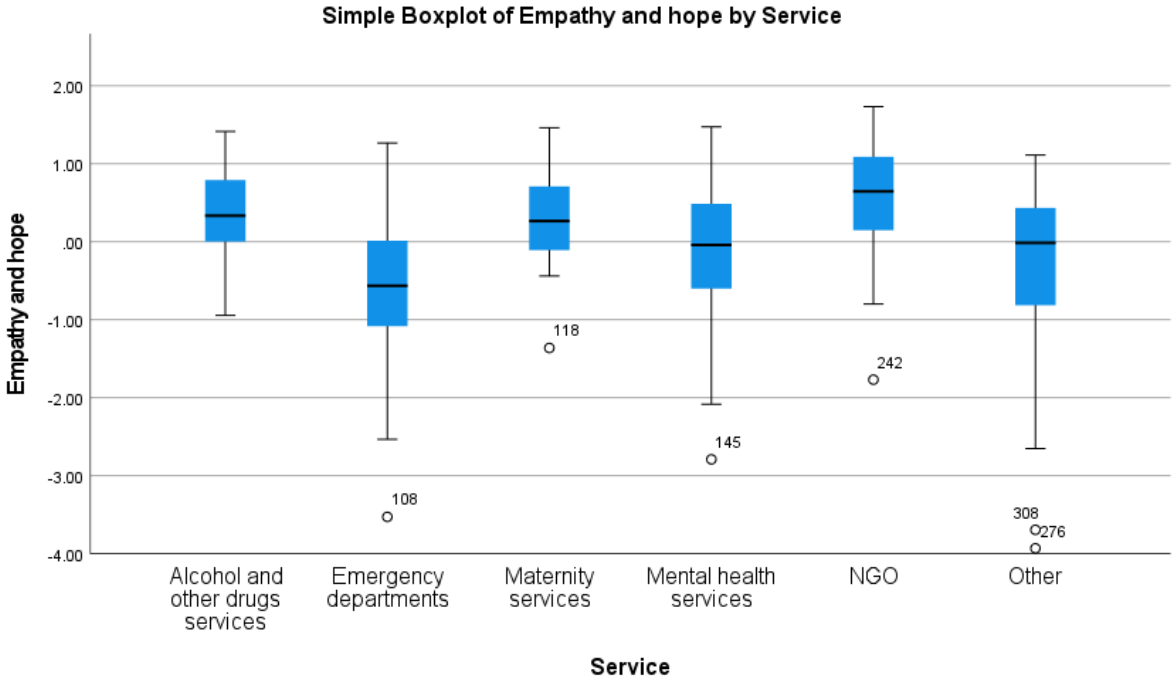
Negative emotion

A range of negative emotions including fear, stress, anger, and frustration make up this factor, which has a small correlation with 'negative judgement' and a moderate correlation with 'clients are dangerous'. There were

no clear service-level differences on this factor, and (from the qualitative data) respondents appear to have interpreted it in different ways. Thus "fear" may refer to fear for self, but it may also refer to fear for the client who is experiencing harm.

Empathy and hope

People expressing more hope, concern, and empathy for people experiencing harm from the use of AOD tended to be less judgemental and less fearful of clients. These empathetic attitudes were most likely to be held by people working in NGO settings.



Appendix E – Psychographic segmentation results tables

Summary of segment demographics and work

Segment name	Age group	Gender	Professions	Service types	Personal life exposure to harm	Professional exposure frequency
Optimistic specialists	↑40-49	↑ Females	↑ AOD workers ↑ Allied health ↓ Managers ↓ Nurses midwives	↑ NGOs ↑ Public AOD ↓ Mental health ↓ Maternity^ ↓↓ Emergency	↑ Personal life exposure	↑ Exclusively
Unruffled specialists	↑50-59	↔ in line with average	↑ Managers ↑ AOD workers ↑ Doctors ↓ Nurses midwives	↑ Public AOD ↓↓ Emergency	↔ in line with average	↑ Exclusively
Worried community generalists	↑>50	↔ in line with average	↑ Aboriginal health workers^ ↑ Managers ↑ Peer workers^ ↓ AOD workers	↑ Outpatient-community ↓ NGOs	↔ in line with average	↔ no clear pattern
Harried hospitalists	↑30-39	↑ Males	↑ Nurses midwives ↓↓ AOD workers	↑ Emergency ↑ Mental health ↓↓ Public AOD ↓↓ NGOs	↔ in line with average	↑ >5 times per week ↓↓ Exclusively

Fearful generalists	↑21-29	↑ Females	↑ Nurses midwives ↓↓ AOD workers	↑ Outpatient-community ↑ Mental health ↓↓ NGOs	↔ in line with average	↑ >5 times per week
Detached specialists	↑60+	↔ in line with average	↑ Allied health ↑ Doctors ↓ Managers	↑ Public AOD	↓ Personal life exposure	↑ < once a week ↑ Exclusively

Stigmatising attitudes, beliefs, behaviours

Segment name	Overall attitude profile (from scores on each of the five factors)					Stigmatising behaviours	
	Judgemental	**Negative emotion**	**Dangerous**	**Sympathy with circumstances**	**Hope concern**	**Disagree they avoid client group where possible**	**Agree they would advise friend not to disclose AOD**
Optimistic specialists	↓↓↓	↔	↓↓	↑↑↑	↑↑↑	↑↑↑ **77%**	↔
Unruffled specialists	↓↓	↓↓↓	↓↓↓	↑	↓↓	↑	↓↓
Worried community generalists	↑	↑↑	↑	↓↓↓	↓	↓↓	↓↓↓ **4%**
Pressured hospitalists	↑↑↑	↔	↑↑	↓↓	↓↓↓	↓↓↓ **42%**	↑↑↑ **22%**

Fearful generalists	↑↑	↑↑↑	↑↑↑	↑↑	↓	↓	↑↑
Detached specialists	↓	↓↓	↓	↔	↑↑	↑↑	↔

Motivation for change

Segment name	Readiness for change (motivation)					Internal experience			Experience of client group		
	Agree mistreated in health system	Agree deserve equal treatment	Self-reported positive attitude toward	See self-reflection as a responsibility	Optimistic	Rarely or never feel anger	Rarely or never feel fear	Rarely or never feel frustration	Often or always experience or see appreciative clients	Often or always verbal abuse	Often or always physical violence
Optimistic specialists	↑↑↑ 84%	↑↑	↑↑↑ 84%	↑↑↑ 87%	↑↑	↑↑	↑	↔	↑↑↑ 83%	↓↓↓ 4%	↓↓
Unruffled specialists	↔	↑↑↑ 100%	↑↑	↓	↑↑↑ 85%	↑↑↑ 100%	↑↑↑ 97%	↑↑↑ 68%	↑	↓↓	↓↓↓ 6%
Worried community generalists	↓↓	↔	↓↓	↓↓ 54%	↑	↓	↔	↔	↓	↑	↑
Pressured hospitalists	↓↓↓ 44%	↔	↓↓↓ 17%	↓	↓↓↓ 50%	↓	↔	↓↓↓ 6%	↓↓↓ 8%	↑↑	↑↑
Fearful generalists	↔	↓↓ 86%	↓	↑	↓↓	↓↓↓ 27%	↓↓↓ 8%	↓↓↓ 0%	↓	↑↑↑ 87%	↑↑↑ 62%

Detached specialists	↑↑	↑↑	↑	↑	↔	↑↑	↑↑	↑	↑	↓	↓

Self-perceived capability and opportunity for change

Segment name	Perceived capability			Perceived opportunity				
	Rarely or never worry about own skills or knowledge	Rarely or never worry about emotional impact	Individual capability barriers	Critical that there is improvement in leadership on issue	Critical that there is improvement in knowledge skills and training	Structural barriers (time, resources)	Service barriers (policies, managers, peers)	No barriers to optimal care in my service
Optimistic specialists	↔	↑↑↑ 91%	↑↑	↑↑↑ 32%	↑↑↑ 40%	↓	↑	↔
Unruffled specialists	↑↑↑ 74%	↔	↓↓↓ 8%	↑	↓	↓↓ 47%	↔	↔
Worried community generalists	↓↓↓ 29%	↔	↓↓	↓	↓↓ 14%	↓	↓↓ 9%	↔
Pressured hospitalists	↓↓	↔		↓↓	↓↓ 14%	↑	↔	↓↓↓ 11%
Fearful generalists	↓↓	↓↓↓ 8%	↑↑↑ 23%	↑↑	↑↑	↑↑↑ 72%	↑↑↑ 28%	↓↓
Detached specialists	↔	↑		↓↓↓ 12%	↑	↔	↔	↑↑↑ 28%

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