

SUMHIT

Substance Use and Mental Health care InTegration

Accessibility of mental health services for people with substance use

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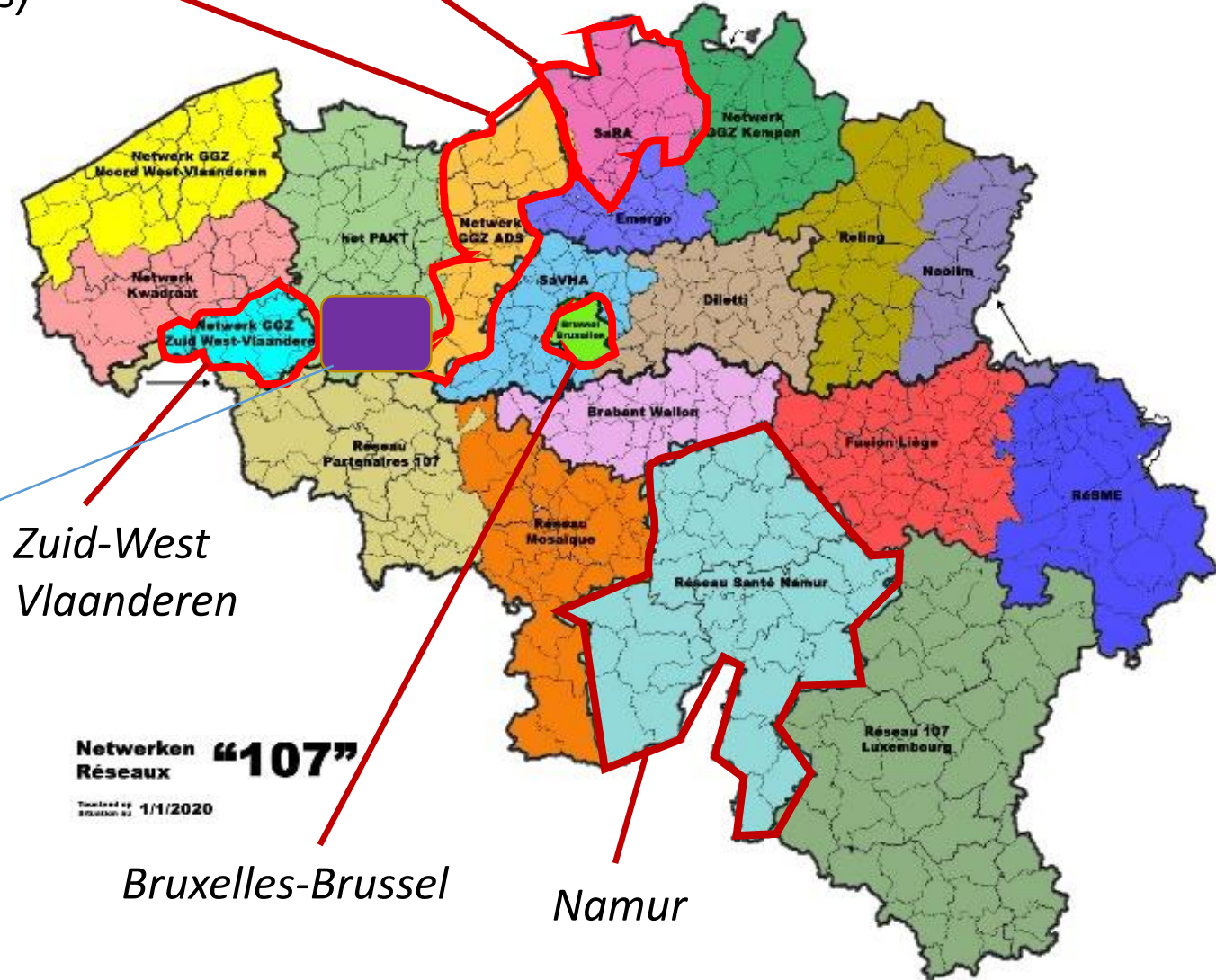
BACKGROUND

Accessibility to mental health services

- categorial organization of mental health - & substance use services in Belgium
- unclear whether available care effectively meets the needs for persons with addiction problems (KCE report, 2019)

5 mental health networks areas

ADS (Aalst–
Dendermonde–St-
Niklaas) SaRA (Antwerpen)



Zuid-West
Vlaanderen

Region Flemish Ardennes

**Netwerken
Réseaux "107"**
Timeline of
creation: 01/1/2020

Bruxelles-Brussel

Namur

Pilot Study

ACCESSIBILITY OF MENTAL HEALTH SERVICES FOR PERSONS WITH SUBSTANCE USE DISORDERS IN A NON-URBAN REGION:

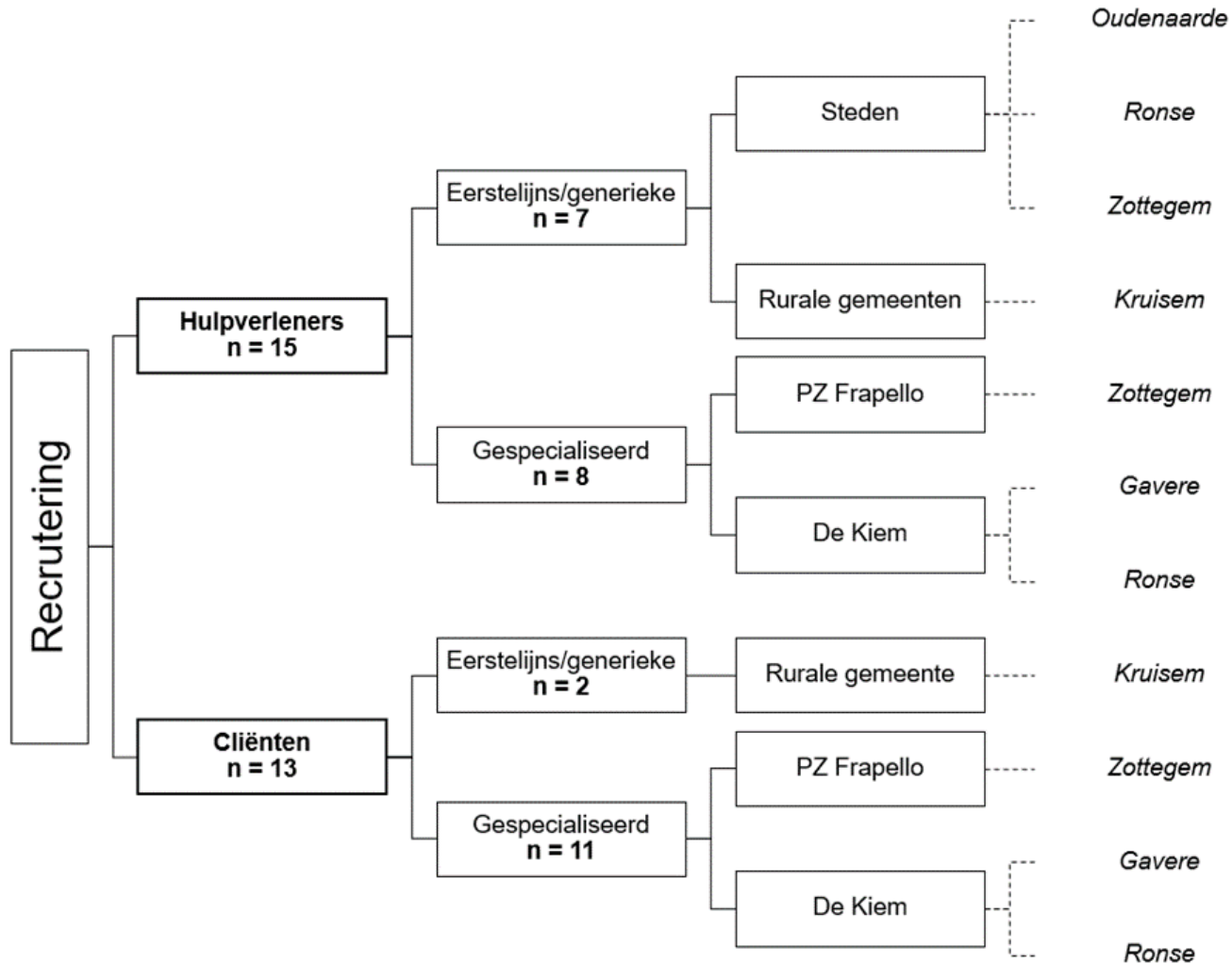
PERCEPTION OF CAREGIVERS AND CLIENTS IN THE FLEMISH ARDENNES REGION

Hellin, H., Magerman J., & Vanderplasschen W. (2022)

Pilot Study

Main research question:

*How do persons with substance-related disorders **perceive the accessibility** of mental health services in the Flemish Ardennes region?*



Methodological triangulation:
 13 in-depth interviews
 5 group interviews

MAIN RESULTS PILOT STUDY

a. Structural barriers

- **Waiting lists and –time**
- **Intake criteria**
 - *Motivation*

“Every day you had to call to show you were motivated. [...], so at some point you come from above and then if you don't call, you move up again and it's the next one that they call back. So, sometimes that's a week, two weeks that you have to call. That is for someone who is heavily in crisis, then that can be fatal.” (Client 11)

- *Actively engaged network*
- *Age limits*
- *Specific groups:*

without domicile, homeless, legal status, limited intellectual abilities, non-native clients, illiterate, disability (physical, vision, hearing), 65+, chronic problems

a. Structural barriers

- **Knowledge gap and experience first-line services**
 - ⇒ less “clinging”
 - ⇒ complicates indicated referrals
 - ⇒ uncertainty of action
- **Financial aspects**
- **Lack of formal collaborative initiatives & care fragmentation**

“Actually, we are still very much each on our own island. In the sense that once that starts up and then that runs, we still get very little feedback around that. [...] There is very little overlap in our assistance programmes anyway. We often don't see clients again until three or four years later.” (Caregiver 4)

a. Structural barriers

- Short treatment pathways with narrow focus on addiction problems
- Residential care ‘silver bullet’

b. Client barriers

- **Stigma+++**

- ⇒ Society (superficial knowledge, guilty model)
- ⇒ Care (psychiatric, terminology, generic care)

“I had tendonitis on my foot. [...] I had a spot in that place that I've had for years from a syringe wound. And that specialist asked if it was there. And I said: "Yes, no, that's from before, from using drugs. That's actually a syringe wound that I've had for years." And that doctor had immediately a whole different attitude towards me. Actually, in two minutes I was out of there” (Cliënt 13)

- ⇒ Among substance users
- ⇒ Self-stigma

b. Client barriers

- **Influence context**

- ⇒ *Absence of support*

- ⇒ *(Non- drug)using environment*

- ⇒ *Pressure to return early (children, far from home context, partner)*

- **Fear of eroding intact life domains (e.g. work)**

c. Facilitating structural elements

- **Authentic contact with regular caregiver/casemanager**
 - ⇒ Possibility to fast contact (e.g. chat applications)
 - ⇒ Long term relationship throughout different stadia of care and -transitions

“But I was sent from pillar to post every time. I was there for 14 days to 3 weeks and I had to leave. [...] And I was always there for that to resolve, I was always alone. [...]. And then I said, “Isn’t there an agency or a coach who can help me in all areas, homework, etc., with those issues?” And then x came into my life. [...] I was allowed to call him day and night. [...] Who often went through fire for me “ (Cliënt 3)

- **Centralised location** ⇒ referral possibilities
- **Peer workers** ⇒ rol model, hope, connectedness, ‘special status’

Conclusion

- **Integration of care?**
- **Importance first line services**
- **Stepped care**
- **Stigma**
- **Casemanagement**

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