VAADA's Response to the Victorian Government Discussion Paper on the Forensic Drug Treatment System

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Introduction

> Drug diversion programs have become increasingly popular in recent years for many reasons. These include the increased levels of incarceration of people for drug-related offences across much of the developed world, the growing evidence that punitive responses alone have been unsuccessful in preventing the use of illicit drugs and the criminal activity associated with their use, and increasing awareness that, for many offenders, custodial sentences further compound the harms associated with their drug use (Australian Institute of Health and Welfare 2008, p.16).

Forensic drug treatment services are a vital component of the Victorian Government's response to illicit drugs and of national diversion programs for drug-related offenders. We welcome the Victorian Government's review of the Forensic Alcohol and other Drug Treatment system and the opportunity to respond to the *Discussion Paper on the Forensic Drug Treatment System* released by the Department of Human Services in April 2009. We hope this review process provides stakeholders and service providers with the opportunity to work collaboratively with the Victorian Government to identify and enhance the strengths of the current forensic service system and to identify areas requiring improvement and reform.

The Victorian forensic drug treatment system has generally served the community well. A range of benefits have been derived for both individuals and the general community. However, it is unfortunate that a systemic review has not occurred earlier. It is now ten years since the introduction of forensic drug treatment programs and services. The lack of system-wide review has contributed to fragmentation of elements of the service system and has meant that a number of systemic issues have remained unresolved.

VAADA's submission examines a number of separate but related issues pertaining to the operation of the forensic drug treatment system. Unfortunately, the Discussion Paper produced by the Department of Human Services (DHS) did not examine systemic issues in any detail and failed to recognise the barriers to good practice created by system design. VAADA believes that only by reviewing the work of agencies together with the broader features of the system can we identify barriers to good practice and develop a more effective and sustainable forensic drug treatment system.

VAADA's submission is based on a comprehensive consultation with VAADA members and alcohol and other drug (AOD) agencies delivering forensic drug treatment services. The consultation process involved:

- A half day forum on the forensic drug treatment system held on Monday 20 April 2009. The forum was attended by 11 agencies;

- A short questionnaire distributed to VAADA Members and AOD agencies involved in our CEO/Managers Network. A total of 13 agency responses were received;
- Ongoing discussions with agencies and individuals as well as general meetings and email correspondence. Discussion at a recent CEO/Managers Network Meeting provided additional information for our submission; and
- A number of AOD service providers provided VAADA with copies of their submissions to the Discussion Paper.

In the course of framing our submission, VAADA also undertook a review of relevant policy documents, protocols, guidelines and research literature.

Our consultation has identified consistent themes across agencies despite their diverse programs, budgets and staffing. A number of AOD agencies have been in conversation with DHS and Community Offenders Advice and Treatment Services (COATS) for some time, raising concerns about the administration of the forensic system, payment processes and unit costing. VAADA too has been in conversation with DHS over the past 6 months in relation to what many agencies view as an increasingly untenable financial situation. Indeed a number of AOD agencies are reporting significant financial losses, reductions in staffing and are talking about a forensic funding crisis. It is critically important that funding issues are addressed as a matter of priority.

A diversity of opinion exists amongst service providers with regard to the challenges facing the system and the direction we should be moving to address those issues. VAADA has represented these variations throughout our submission wherever possible but the final submission, including any recommendations, represents the view of VAADA.

We are eager to see the forensic system further enhanced and its viability improved, and we look forward to working with Government to address the issues identified in this submission. We hope the outcomes of this review process will enhance the current service system and produce a sustainable treatment system that offers a valuable service to forensic clients. To do so will require a commitment from all parties including justice personnel, AOD agencies, DHS, COATS and VAADA.

Recommendations

The review process

1. VAADA recommends that a rigorous evaluation of Victoria's forensic drug treatment system be undertaken to build and expand the publicly available evidence base.

2. As part of the evaluation, we recommend that the Department commission research on best practice for forensic drug treatment to build a stronger evidence base. This evidence should inform any changes to the current system.

3. VAADA recommends that DHS develop a draft policy and practice framework for forensic drug treatment services as part of this review.

4. VAADA recommends that the draft policy and practice framework should then be subject to further consultation with the AOD sector and other stakeholders before a final framework is developed and disseminated.

5. VAADA recommends that DHS develop and disseminate a revised and agreed policy and practice framework (see previous two recommendations) for the delivery of forensic drug treatment services. The framework should identify key principles of service delivery and the roles and responsibilities of government authorities and non-government service providers.

6. VAADA recommends that a final report outlining the key findings of the review be produced and actively disseminated to service providers in order to inform future work in the forensic area. This report should be made available to the public in an effort to build the available evidence base.

Funding options

7. VAADA recommends that DHS, as a matter of priority, review the forensic unit cost and the overall funding arrangements for the provision of forensic drug treatment through the brokerage system currently managed by COATS.

8. VAADA recommends that DHS consider the strengths and weaknesses of the five proposed funding options introduced in this submission (see pages 19-23). Any changes to the current funding model should be canvassed with the sector prior to implementation.

9. VAADA recommends that in the absence of additional funding, DHS consider other temporary options to ease the financial pressure on agencies. These options could include a reduction in targets and caseloads, and should be developed in consultation with the sector.

Other recommendations

10. VAADA recommends that the following options be considered by DHS as possible strategies to facilitate after-hours appointments:

- Funding support to cover the costs of staffing in line with OH & S requirements and penalty rates for workers
- The establishment of an after-hours EOC at a rate that adequately compensates for the increased running costs of after-hours appointments
- Full payment for DNAs so that agencies can recoup some of the administrative costs of offering after-hours services

11. VAADA recommends that DHS fund the establishment of a network of forensic AOD service providers to come together and share information and knowledge. These forums could be run on a quarterly basis and convened by VAADA.

12. VAADA recommends that the existing COATS reporting and accounting systems be reviewed as part of the broader forensic review process. Options for moving from a paper-based to electronic system should be considered. This could include the development of an intranet service, accessible to forensic clinicians.

13. VAADA recommends that DHS review the role of COATS in determining partial and full payments for forensic EOC. If this responsibility remains with COATS, then a clear and agreed set of criteria for determining payments must be established and communicated to all AOD forensic service providers.

14. VAADA recommends that DHS consider the utility of each of the following strategies as a means of bolstering recruitment and retention of forensic staff:

- Adequate remuneration of staff
- Funding that provides for further training and professional development
- A reduction in the forensic EOC targets
- Opportunities to participate in clinical supervision
- Opportunities for peer support and networking
- Opportunities for secondments and rotations.

These strategies are outlined in further detail on pages 17-18 of the submission.

Key Themes of the Discussion Paper

Consumer Focus

VAADA believes that a fundamental question needs to be answered. That is, what is the overarching goal of forensic drug treatment? This needs to be clearly defined for all stakeholders. While DHS and COATS may have an agreed position, there is confusion amongst AOD service providers with regard to the goals of forensic drug treatment and the primacy of objectives related to reducing harm, improving health outcomes and reducing re-offending. The Discussion Paper suggests forensic drug treatment has a dual role of reducing drug use as well as re-offending.

Some agencies have argued very strongly that the objectives of 'modifying behaviour', 'behaviour change' and the aim that 'treatment purchased for forensic clients is for therapeutic, behaviour modification interventions' (Forensic Drug Treatment Guidelines and Business Rules 1 July 2008) are at odds with accepted practice and clinical decision-making. Neither the Framework for Service Delivery nor the recent Blueprint for Alcohol and Other Drug Treatment Services identify behaviour change as an agreed performance measure. Rather, Section 3.4 of the COATS, Community Correctional Services and Drug Treatment Services Protocol states:

> COATS and the Alcohol and Drug Treatment Services operate within a health framework. The primary role is to conduct a clinical assessment to determine the client's treatment and support needs. The aim of developing and implementing an appropriate treatment plan is to contribute to a positive health outcome for the client (ACSO, Community Correctional Services, Drugs Policy and Services 2006, p.5).

Agencies highlighted inconsistencies within various policy and guideline documents. Service providers do not recall any consultation process on the changes to the aims of forensic drug treatment as outlined in the Guidelines and Business Rules 2008. Agencies report that these changes have been implemented without discussion or consultation with the sector.

While behaviour change may be deemed an appropriate goal of forensic drug treatment in order to reduce recidivism, this should not be the sole or primary focus of treatment. It should not limit the ability of a service to offer support and assistance around a range of health, relationship, and other underlying issues. Appropriate treatment goals should be determined by the client together with their clinician.

Timely access

Forensic services can at times overwhelm the capacity of agencies, impacting on waiting lists for voluntary clients. Despite ongoing and increasing pressures, forensic clients receive priority and agencies generally provide an initial appointment to clients within the prescribed 5 working days.

Agencies ensure timely access in a variety of ways. Some have established separate forensic teams to help manage the current work. In a number of these agencies, a forensic team leader or coordinator will manage intake and allocate referrals and appointments. In some agencies the team leader or coordinator is also responsible for administration of the program, overseeing report writing, file maintenance as well as carrying a forensic case load.

After-hours appointments

The main barrier to the provision of after-hours appointments is the lack of funds to cover reception and clinical staffing costs in line with OH&S requirements. This can be frustrating for agencies which, in response to the perceived need, would like to offer an after-hours service for clients.

> VAADA recommends the following options be considered as possible strategies to encourage after-hours appointments:
>
> - Funding support to cover the costs of staffing in line with OH&S requirements and penalty rates for workers
> - The establishment of an after-hours episode of care (EOC) at a rate that compensates for the increased running costs of after-hours appointments
> - Full payment for cases of non-attendance (DNAs) so that agencies can recoup some of the administrative costs of offering after-hours services[1].

Rural and regional agencies: the tyranny of distance

The forensic service system must be responsive to local need. Many of the issues outlined in this submission impact on metropolitan *and* rural agencies alike. However, there are some specific issues faced by rural and regional agencies in the delivery of forensic drug treatment. As one service provider commented, ‘the greatest hurdle to providing services in rural regions is the tyranny of distance’. Clancey & Howard (2006) use the term ‘justice by geography’ to describe the significant geographic disparity in rates of diversion and access to forensic drug treatment both in rural and regional locations across Australia and other parts of the world.

[1] These strategies are derived from the submissions of agencies delivering forensic drug treatments.

In VAADA's consultations, rural agencies reported particular difficulties in meeting targets due to travel times required to engage outreach clients. The size of the area covered by Rural Outreach Diversion Workers (RODWs),[2] for example, can act as a barrier to effective intervention. Costs for rural and outer urban agencies are inflated by travel time and limited public transport options for clients. Travel is not accounted for in the current system, despite the significant impact this can have on capacity to meet targets. Further, much of the outreach and prevention work undertaken in these communities is not even captured in data collection, according to feedback from rural service providers.

Research tends to support the anecdotal evidence provided by stakeholders:

> In Victoria, the Rural Outreach Diversion Worker Program was introduced in 2002 to provide diversion in rural areas not well served by the established CREDIT program. An evaluation of the program found that it was limited by gaps in general services, such as public housing. The evaluation also found that rural agencies struggled with resources and support, found it hard to do outreach because of the sheer size of the area they served, and struggled with the ramifications of small communities for people seeking drug treatment (Porter Orchard & Associates 2005). A case management model helped to address some of the limitations found in rural areas. Outreach, in terms of home visiting, helped to overcome difficulties associated with limited public transport (AIHW 2008, p.29).

Some rural agencies also reported difficulties in building understanding and rapport with local police and magistrates. Police can have limited understanding of diversion and the role of forensic drug treatment and considerable time can be taken up in networking and efforts to establish relationships. Similarly, it can be difficult for AOD agencies to establish relationships with magistrates in regions serviced by a rotating roster of magistrates. Practitioner feedback suggests court referrals in rural areas can be dependent on the understanding and willingness of one magistrate to utilise diversion programs on offer. This is supported by research that has found therapeutic jurisprudence will not be available to local communities where magistrates do not support such an approach (King 2003, cited in AIHW 2008).

[2] Similarly, clinicians working in outer urban regions who are required to travel long distances are not able to complete reporting requirements and paperwork until they return to head office.

Partnerships

To work effectively, the forensic system requires cooperation among all stakeholders - including drug treatment providers, police, courts, corrections and other health and welfare services (AIHW 2008). The cultural differences between services, different operating frameworks and perspectives can act as barriers to collaboration.

These systems can, and often do, have different goals and objectives for forensic drug treatment (AIHW 2008). For instance, 'police and courts may focus on the reduction of criminal activity while treatment providers focus on improved health for their clients. The two systems need to reach a common understanding if diversion programs are to be effective' (AIHW 2008, p.22). The Australian Institute of Health and Welfare suggests these fundamental role disparities can lead to frustrations between police/judiciary and treatment providers (2008). Many in the AOD sector recognise that effective partnering and collaboration requires greater understanding and recognition of the complementary skills and strengths of each system. How we begin to foster that understanding and appreciation is the challenge.

Enhancing information sharing and communication

VAADA believes that information sharing and communication between AOD agencies, justice services, COATS and DHS needs to be improved. At present, communication is largely driven by problems rather than being grounded in a more sustained, proactive and productive communicative relationship.

The Discussion Paper outlines a number of AOD stakeholder responsibilities relating to information sharing and communication. It states that AOD stakeholders have a responsibility '...for informing and educating partners about success factors relating to treatment and the chronically relapsing nature of addiction.' The Paper also suggests AOD stakeholders must work to ensure they maintain strong communication with justice personnel so that there is increased cooperation and collaboration on goal setting for forensic clients. Many agencies already undertake a lot of this relationship-building work, but it is difficult to maintain over time with changing staff and limited resources.

We believe there are some examples of good practice in this regard. The Regional Drug Diversion Network (RDDN) project provided some agencies with additional resources to build and maintain relationships through regular networking. It also allowed the provision of timely and accurate responses to inquiries and requests for support within a local area.

While we are not aware of any formal or public evaluation of the RDDN project, VAADA understands the project had varied success across the different regions. Some regions have reported very positive

outcomes, while the project was seen to be less beneficial in other regions. Providers in the Southern Metropolitan Region reported significant benefits from the networking and coordination offered by the Drug Diversion networker. In a report on rural and regional diversion programs across Australia, the AIHW point to the Victorian Drug Diversion Networker role as a positive example of diversion initiatives:

> One of the added benefits of the role is that it has the potential to improve program stability and the perception of program continuity among the courts and police. This can be achieved even when workers move on because one of the Diversion Network Officer's roles is to establish and maintain networks that can support a new worker (AIHW 2008, p.102).

The role also provided support for new and inexperienced clinicians and provided an important communication channel between AOD services and police, courts and corrections officers.

At the present time, there are few opportunities for networking or regular meetings amongst forensic service providers. Networking needs to be supported and promoted by funding bodies. A number of agencies expressed interest in opportunities to develop informal and formal networks and have recommended the establishment of a forensic AOD network.

> With regard to partnerships, communication and information, VAADA recommends that DHS fund the establishment of a forensic AOD network for services to come together and share information and knowledge. These forums could be run on a quarterly basis and convened by VAADA.

Evidence-Based Practice

'Evidence-based practice' is often called for but is rarely well defined. The Victorian Alcohol and other Drug Quality Framework describes evidence-based practice as 'encourag[ing] the use of client knowledge, clinical knowledge, research evidence and statistical data when developing new programs and interventions' (DHS 2008a, p.3). With this description in mind, it quickly becomes apparent that numerous barriers to evidence-based practice exist within the current forensic drug treatment system.

For instance, research cited in the Discussion Paper suggests that forensic clients would benefit from extended time in treatment (approximately one year) (Hussain & Cowie 2005 cited in DHS 2009), yet the current system provides no financial incentive to maintain clients on a longer-term basis. Further, current targets for forensic clients limit the time available to clinicians to work with this client group. Achieving sustainable change can require multiple sessions but the current system does not allow re-episoding of forensic clients in the same way as is possible in the voluntary system.

On reading the Discussion Paper, it appears that DHS would like to see longer-term intervention delivered through the forensic drug treatment system. If this is the case, VAADA offers the following comments for consideration:

- Longer-term clients could impact on the responsiveness of agencies and their ability to provide priority access to COATS referrals. That is, longer-term clients could 'clog' the system; and
- Longer-term interventions can lead to what has been termed 'net-deepening' whereby individuals are kept in the 'net' of a service system for longer periods of time and subjected to greater levels of intervention than for those individuals who are *not* diverted into such programs.

Best practice in forensic drug treatment

In a summary of drug diversion programs in Australia, Hughes and Ritter write:

> Many researchers have identified best practice examples of diversion. These include the need for a broad range of diversion programs with different levels of interventions, access for all offenders regardless of age, gender, ethnicity or substance of use and careful targeting using clear eligibility criteria (ADCA 1996; Bull 2005). There is a particular need to ensure responses to not infringe on client rights and hence that responses are not more onerous or intrusive than the traditional criminal justice response. Finally, there is a need for clear aims and well documented procedures for diversion (2008, p.5).

While there is a commitment to best practice among AOD service providers, there are barriers to adopting this. Not least of which is the type of research available upon which to base programs. The evidence-base in this field is growing yet much research is still needed to inform future policy decisions. Research is needed to ensure we are not widening or deepening the net[3] for individuals who are diverted into drug treatment. We also need to ensure that treatment interventions are appropriate and tailored to the needs of the individual.

[3] Net-widening is a term used to describe the effects of alternatives to incarceration such as diversion programs. While diversionary programs were designed to reduce the number of people in contact with the criminal justice system, it has been found that the total number of people now in contact with the state has increased thereby 'widening the net of social control' (for further discussion of net widening see Cohen 1989).

The Alcohol and other Drug Council of Australia (ADCA) identified a number of informing principles for best practice in an early evaluation of the Victorian Drug Diversion Pilot in 1999:

- Shared philosophical principles of harm reduction within a social view of health
- A range of options for different types of offences and levels of drug use
- Coherent legislation across different jurisdictions
- Planning that includes the major stakeholders
- Information about the program
- Clear definition of roles within the program
- A client charter that guarantees procedural fairness and the right to choose between the diversion program and the criminal justice system
- A program that is accessible and available to people regardless of their background, age, gender, geographic location and main substance used
- Follow-up of those clients who need additional support services
- Training for those people administering the program
- Sufficient funding for the program on a three-year cycle
- Evaluation of the program to ensure it is meeting its objectives.

(McLeod & Stewart 1999 cited in ADCA 2003, p.6)

While these principles are now over ten years old, our recent consultation with AOD stakeholders seems to suggest that some of these principles have not yet been successfully integrated into the Victorian forensic drug treatment system. We therefore recommend that DHS consider the best practice principles outlined by ADCA as part of this review, with a view to determining their applicability and utility in the present Victorian context.

The need for evaluation

In their study of diversion programs in Australia, Hughes & Ritter noted that 'evaluation is essential, not only of the individual programs but of the system themselves' (2008, p.43). As one service provider at VAADA's recent forensic forum noted 'Where is the evidence to tell us that the way we currently deliver forensic services is the best way? How do we know that the current system works for forensic clients? How do we know we are achieving what we set out to do?'.

To date, very few drug diversion programs (including forensic drug treatment) have been rigorously evaluated. '...[T]here remain many more evaluations of pilot programs than of ongoing programs' according to research conducted as part of the Illicit Drug Monitoring Program (Hughes & Ritter 2008, p.42). Moreover, very few evaluations have looked beyond individual programs to the broader system of diversion to undertake jurisdictional, multi-program evaluations (Hughes & Ritter 2008). Of those

evaluations that have occurred, very few are publicly available. VAADA believes that a rigorous evaluation of the Victorian forensic drug treatment system is required to build the publicly available evidence base.

> VAADA recommends that a rigorous evaluation of Victoria's forensic drug treatment system be undertaken to build and expand the publicly available evidence-base.

The evaluation should be informed by an extensive review of the literature:

> As part of the evaluation, we recommend that the Department commission research on best practice for forensic drug treatment to build a stronger evidence base. This evidence should inform any changes to the current system.

The research and literature review should include thorough analysis of process, impact and outcome evaluations; qualitative and quantitative studies; comparative studies and meta-analyses.[4] The results from the literature should inform the broader review process including the development of a draft policy and practice framework for forensic drug treatment service delivery. The draft policy and practice framework should then be subject to consultation with the AOD sector before a final framework is developed and disseminated.

The results of the research together with feedback gathered through the consultation process should be used to develop a draft policy and practice framework for forensic drug treatment service delivery.

> VAADA recommends that DHS develop a draft policy and practice framework for forensic drug treatment services as part of this review.

> VAADA recommends that the draft policy and practice framework should then be subject to further consultation with the AOD sector and other stakeholders before a final framework is developed and disseminated.

> VAADA recommends that the final policy and practice framework should identify key principles of service delivery and the roles and responsibilities of government authorities and non-government service providers.

[4] According to Bull (2005) research in this area has been fraught with methodological problems including weak study designs, no control groups for comparison, small or insufficient sample sizes and a lack of longitudinal research.

A cautionary note: Net-widening and net-deepening

The forensic drug treatment model of drug diversion brings many benefits but also some risks. While recognising the importance of these programs, we also need to be aware of the potentially counter-productive impacts of forensic drug treatment programs, most notably, the possibility of net-widening. Research has found some evidence that forensic drug treatment programs have contributed to net-widening (Clancey & Howard 2006; Ritter & Hughes 2008). For instance, diversionary programs (mainly police diversion) established to prevent young people entering the criminal justice system have inadvertently brought more young people into contact with police (Clancey & Howard 2006, p.380).

Continuous Quality improvement

AOD agencies across Victoria are committed to delivering quality treatment and support to all clients, irrespective of whether they are forensic clients. Many have undergone accreditation processes in recent years and have demonstrated that they provide quality services and programs. Moreover, a number of agencies are working toward improved client participation mechanisms, information management systems, improving their governance arrangements and processes, and building organisational capacity and capability.

Many service providers offer a suite of services to both forensic and voluntary clients and do not discriminate on the basis of forensic status.

Quality improvement was a topic of discussion at VAADA’s forensic forum on 20 April 2009. Service providers identified a range of issues that acted as barriers to good practice in this area, including:

- Assessment and referral processes: Under the current system, clients are often assessed in terms of what service is available rather than a genuine assessment of their clinical needs and the best treatment and interventions available;
- The criteria for service delivery differ for forensic and non-forensic clients yet the clinical interventions remain largely the same. The review should examine *how,* if at all, treatment differs for forensic clients from voluntary clients;
- The current system provides no capacity to utilise funding for purposes beyond clinical work such as quality improvement processes, clinical supervision, training and education;
- Unit costs need to be adjusted to reflect holistic needs of clients and strive to achieve these; and
- The current level of scrutiny by COATS demonstrates an apparent lack of respect for existing quality standards and agency processes.

Quality improvement at a system level

DHS must also demonstrate a commitment to continuous quality improvement at a system level. This review is the first step in that process. As part of the Department's commitment to continuous quality improvement in the forensic area, this review should:

- Culminate in a final report outlining key findings that are actively disseminated to service providers in order to inform future work in the forensic area, and to the public in an effort to build the available evidence base;
- Address the need to provide adequate access to training and workforce development with a view to developing the knowledge and skill base of AOD clinicians in forensic service delivery;
- Provide the basis for the development of a sustainable forensic service system that supports the development and delivery of programs resulting in improved outcomes for clients; and
- Inform a revised and agreed policy and practice framework for the delivery of forensic drug treatment services. Such a framework should identify key principles of service delivery and the roles and responsibilities of government authorities and non-government service providers.

Workforce Development

VAADA agrees 'there is currently debate about the most appropriate composition and structure of the forensic AOD workforce' (DHS 2009, p.10). Some agencies have developed specialist forensic teams while others believe that the ability to work with forensic clients is a skill required of all AOD clinicians, arguing that the generalist AOD workforce should be supported to enable effective work with this client group. There are several reasons for this latter position. Firstly, agencies do not wish to see further fragmentation of the AOD sector through the development of a specialist forensic workforce. Secondly, feedback from agencies suggests that the core skills required to work with forensic clients are not unique but are typical of the skills required of experienced clinicians. Thirdly, clients rarely fit into particular categories and may have a range of issues requiring support across multiple domains. Fourthly, a discrete forensic workforce would reduce access to timely treatment for forensic clients by further narrowing the pool of available clinicians. Finally, further specialisation within the AOD workforce could further fragment the service system. VAADA generally supports these arguments.

However, agencies should not be precluded from developing or maintaining their forensic services. VAADA believes that some agencies will benefit from developing a specific forensic team while others may find it best to integrate their treatment of forensic clients within their general service delivery. This choice should be left to individual agencies. We believe this issue requires further discussion with the sector.

Recruitment and retention issues

Our consultations suggest that agencies require ongoing support and resourcing to recruit, train, supervise and retain a skilled workforce, capable of providing effective interventions and treatment to forensic clients.

Agencies report ongoing difficulties with recruitment and retention of experienced AOD clinicians. While many agencies support the DHS minimum qualification requirements, they continue to note difficulties in recruiting staff with all the appropriate qualifications.

A system of ongoing professional development is supported by VAADA but one in which all AOD workers are provided with opportunities to enhance their skills. We need to build capacity within the sector to provide support to the current forensic workforce through clinical supervision, improved access to training and opportunities for networking and peer support.

To this end, we suggest the following strategies to assist with recruitment and retention:

1. **Adequate remuneration of staff**
   Agencies currently employ staff in salary classifications that do not recognise their qualifications and experience.
2. **Funding that provides for further training and professional development**
   At present, there is a need for training in a number of areas:
   - New forensic clinicians: a structured and funded induction program is required which introduces new forensic clinicians to the forensic service system including operational guidelines, COATS paperwork and report writing;
   - Senior clinicians: require training in the provision of clinical supervision;
   - Ongoing specialist training: This could include one-off training sessions in areas such as 'appearing as an expert witness in court' and 'understanding the broader criminal justice system', for example.
3. **A reduction in the forensic EOC targets**
   Agencies suggest a reduction from 110 to 75. A reduction would reduce the administrative burden, relieve stress, and enable participation in training and professional development and reflect a more realistic workload.
4. **Opportunities to participate in clinical supervision**
   Clinical supervision, especially in the early years of practice, is widely accepted as being important for professional development to ensure optimal client outcomes (Bambling 2003). It is also acknowledged as an important key lifelong learning activity for many in the health care setting (McMahon, 2006). The relevance of Clinical Supervision to workforce development and as a quality control/improvement measure is acknowledged in many sectors, including the AOD sector (NSW Health 2006; Kavanagh et al 2002). Recent Turning Point research

indicates that Clinical Supervision is not routinely provided to sector staff. Almost 45% indicated that they 'never' or 'rarely' receive clinical supervision.

5. **Opportunities for peer support and networking**
   As noted earlier in this submission, VAADA believes there is value in the development of a forensic AOD network. Network meetings could be run on a quarterly basis and could be convened by VAADA with appropriate resourcing.
6. **Opportunities for secondments and rotations**
   Under current conditions, it is difficult for agencies to allow staff to participate in rotations and secondment due to limited provision for back-fill.

> VAADA recommends that DHS consider the utility of the strategies outlined above as part of the forensic service system review.

The role of COATS

The reporting system

Agencies continue to experience enormous confusion regarding the reconciliations and payments from DHS and COATS. For some, there are considerable discrepancies between what an agency believes they have earned in any given period and what appears in their bank accounts. Quarterly reports are difficult to understand and do not adequately reflect the work undertaken between the clinician and the client. The system is unnecessarily complex, difficult to understand and time consuming for agencies when reconciling reports and financial statements. Options for improving the current paper-based system must be considered as part of the review.

> VAADA recommends that DHS/COATS review the existing COATS reporting system. Options for moving from a paper-based to electronic system should be considered. This could include the development of an intranet service, accessible to forensic clinicians for a range of purposes including submitting reports and reconciling financial reports.

Partial and full payments

Agencies have expressed concerns that COATS' decision-making around partial and full-payments is arbitrary and inconsistent. They report that there is no guide or criteria from COATS around what constitutes an EOC or partial EOC. Moreover, at the present time there appears to be no clear process for appealing a COATS decision.

The Treatment Completion Advice (TCA)/Exit Report provides only minimal space to detail relevant information and yet it is this form which is often used to determine payments. The TCA form requires modification. It does not provide scope for agencies to detail the work undertaken, barriers to their work or recommendations for future client treatment and support.

VAADA recommends that DHS review the role of COATS in determining partial and full payments for forensic EOC. If COATS remain responsible for reviewing payments for forensic service delivery, a clear and agreed set of criteria for determining payments must be established and communicated to all AOD forensic service providers.

During our ongoing consultations with agencies over the past 6 months, the role of COATS in the delivery of forensic drug treatment services and the utility of the COATS brokerage service has been questioned. Some of those consulted have questioned whether this is a relevant and worthwhile use of public money and feel that the funding could be better spent on service delivery.

VAADA recommends that the role of COATS in the forensic drug treatment system and the utility of COATS as a brokerage service be examined as part of the review.

A revised funding model

Not surprisingly, funding was consistently identified by AOD agencies as a shortfall of the current forensic system. VAADA argues that sufficient and ongoing funding needs to be provided for forensic drug treatment services to continue to grow and function well. Funding has been identified by the AIHW as a key issue in implementation of diversion programs, stating 'funding needs to take account of both the cost of direct service provision, and all the tasks associated with establishing an effective diversion program' (AIHW 2008, p.24).

VAADA argues for the development of a revised funding model which accommodates the complex needs of forensic clients, takes account of the time required to meet their goals and incorporates the costs of direct service provision and all the tasks associated with running effective forensic programs.

'Certain' funding (Bull 2003, cited in AIHW 2008), rather than short-term contract funding, allows agencies to recruit and retain appropriate staff. In Victoria, agencies operate without assurance of funding including uncertainty over ongoing National Illicit Drug Strategy (NIDS) funding as well as fluctuations in income created by the current state-based referral system.

This has created problems in maintaining services over the first two phases of the Illicit Drug Diversion Initiative (IDDI). At the time of writing, agencies are waiting for advice about the arrival of NIDS-IDDI funding. Some agencies are concerned about the future of their services post-July 1 2009

because they have not yet received information or advice about continued funding. Uncertainty over funding impacts on staffing as workers find alternative employment or are told their contract cannot be renewed because program funding is not assured.

VAADA believes that the current forensic funding model requires urgent review. Reform of the current funding model is supported by a growing number of agencies[5] to ensure the ongoing viability of the forensic service system. VAADA is of the opinion that many of the issues identified by agencies can be resolved with the right reform of the funding model.

The major problems pertaining to the current funding model include, but are not limited to, the following:

- An inadequate unit-cost that has been undermining the integrity of the system for some time. For example, agencies report a shortfall of between $15,000-$20,000 per EFT for forensic Counselling, Consultancy & Continuing Care (4Cs, or CCCC);
- Reliance on ACSO/COATS to provide a sufficient number of referrals for agencies to meet their forensic targets. While some agencies are over-burdened, those with fewer referrals may struggle to meet their targets and lose funding. The fluctuation in referrals makes financial planning and forecasting difficult;
- A system where clinical decisions are 'second guessed' by COATS in the determination of what constitutes a partial or full EOC;
- Recent changes to the prepayment/fee for service payments; and
- A funding model that is inadequate in covering the costs of direct service provision and does not provide for infrastructure costs such as clinical supervision, training backfill and administration.

The existing brokerage system is inadequate and does not meet the needs of funding bodies and the drug treatment agencies providing services. Most importantly, the current model may not be supporting optimal clinical treatment for forensic clients.

Participants at VAADA's forensic forum proposed five options for reform. We then surveyed the sector to ascertain their views on a preferred model. Due to limited return rates, we are unable to put forward a preferred option. Instead, we have provided an outline of each model together with comments from agencies regarding the strengths and weaknesses of the model.

[5] Funding issues appear to be one of the major unifying issues amongst AOD agencies regardless of size and scope of the forensic services offered. Small, medium and large agencies alike report financial stress and uncertainty. A growing number of agencies report significant financial losses and staff reductions due to funding.

Options for reform of existing forensic funding model	Comments from the sector
Option 1: Retainer based model This model would incorporate the forensic funding within core recurrent funding. An allocation of funding would be made to each service based on through put from the previous three years. Targets for forensic would be set at about 70% of the voluntary target for community based services like CCCC and youth outreach. Eg. 70 EOC for 1 EFT CCCC in recognition of the additional administrative requirements and inability to re-episode. Agencies would receive referrals directly from Justice services and courts. Agencies would undertake assessments and treatment in much the same way as 4Cs is undertaken. A separate audit-system may need to be in place to ensure access timelines are met. Key benefits are decreased in admin burden and no reliance on through put payments.	• A review of the sustainability of the 4Cs unit cost model would be required • Could assist agencies with small forensic EFT to use time created by target reduction to mange day-to-day business • Agencies with larger EFT would still not have funding for a team leader • Smaller agencies with EFT based on throughput could face the loss of EFT • Need option for over-achievement of targets – how would this be compensated • The impost on agencies completing all their own assessments would be great. An increase in number of clinicians would be required
Option 2: Capping the number of sessions in an EOC The number of sessions per client would be capped at 6 to 8 sessions and agencies would either be paid extra for each session over the designated number or able to re-episode. Re-episoding of clients could occur based on business rules applied in generalist/voluntary services.	• Would create difficulties when setting the recommended target • COATS financial reports would be more difficult to understand
Option 3: Sessional payments Agencies would receive a payment for every session offered to forensic clients rather than per episode. This could operate as a tiered model dependent on complexity of client presentation. Payment could vary according to level of complexity. For instance: Level 1 Baseline: $100 per hour (AOD issues only)	• Workload could be more easily managed but would require clear criteria for classifications of Levels 1, 2 & 3 and agreed to by all parties

Level 2: $150 per hour (AOD plus another issue. Eg. mental health, physical health issues, ID) Level 3 $180 per hour (highly complex clients with various issues over and above AOD). Treatment would be capped at a maximum of 10 sessions per client. This would not include DNAs and reschedules. DNAs and reschedules would be paid for at an amount to be determined –perhaps half the amount paid for level 1. Agencies could have the option to re-episode at 10 sessions for highly complex clients.	• Need to have a clear agreement on who assesses clients and determines complexity • Others felt this model would be very confusing and difficult to implement and may reduce financial viability even further
Option 4: The Caseload Model Under this model agencies would be provided with direct funding per EFT based on previous through puts. A negotiated acceptable caseload would be established, ie. 25 (or 30) clients per CCCC worker, and COATs would nominate clients directly into the agreed caseload. Eg. Agency A would receive funding for 4.0 EFT CCCC. The agreed caseload for this team would be 100 clients at any given time. COATS would maintain the client list and when a client is discharged could fill that space with another. This model is currently utilised by the Drug Court.	• This model provides certainty for funding of staff. It would require agreement on the per EFT compensation • A suggestion has been made to set caseloads at 25 per EFT • Agencies could provide DHS with quarterly report • The emphasis would shift from throughput to clinical outcomes • Could support service planning • Some felt this model could clog up the system
Option 5: Core Flexible Funding The agency would receive core recurrent funding based on previous throughput and not tied to treatment types. The agency could utilise these funds to develop an appropriate local service. The agency would not report directly on targets or throughput but rather annual, or 6 monthly, descriptive reports on agency activity within negotiated parameters.	• Could allow agencies to manage caseload s in terms of planned annual leave and unplanned sick leave • Quarterly activity reports would be required • Accreditation process could be attached to funding requiring attendance at a minimum amount of training • Flexibility for rural conditions would be required • Most like the voluntary model

VAADA recommends that DHS consider the strengths and weaknesses of each of the proposed options as part of its review. Any changes to the current funding model should be canvassed with the sector prior to implementation.

VAADA recommends that DHS review the unit cost of forensic service provision and the overall funding arrangements for the provision of forensic drug treatment through the brokerage system currently managed by COATS.

VAADA recommends that in the absence of additional funding, DHS consider other temporary options for easing the financial pressure on agencies. These options could include a reduction in targets and caseloads and should be developed in consultation with the sector.

A note on Residential funding

While much of the discussion thus far has focussed on the forensic 4Cs funding model, we acknowledge that residential services have particular funding challenges. It has been suggested that the funding model for residential services should reflect that expenditure is not linear with time. That is, many costs associated with resi services appear 'up front' and reduce over time once the initial assessment is made and immediate health and physical needs are addressed. Realignment of bed numbers and systemic inflexibility have created substantial financial losses for agencies.

A final note on risk

A number of agencies have raised the issue of operational risk. Agencies carry significant financial risks by operating forensic drug treatment services. These include:

- The risk carried by agencies when clients either do not attend or do not complete their treatment;
- The risk associated with determination of partial and full-payments. As noted earlier, a clinician may determine that a treatment episode is complete but COATS may then assess the episode as a partial payment. This limits the capacity of agencies to predict and plan income;
- The risk associated with the current referral system. Agencies rely on COATS referrals and fluctuations can affect staff workloads and the ability to meet targets.

The financial risk borne by agencies under the current system is unacceptable and needs to be addressed.

Conclusion

The forensic service system established in Victoria in 1997 has generally served our communities well. A range of benefits have been derived for both individuals and the wider community. It is unfortunate that a systemic review has not occurred at any point during the past decade. This lack of review and reform has contributed to fragmentation of elements of the service system. VAADA's submission has identified a number of areas of in need of serious attention and critical reform including:

- The current funding model;
- Quality improvement issues; and
- Workforce support and development.

The burden currently shouldered by treatment agencies in delivering quality services places the system in serious jeopardy. A failure to address issues raised in this submission will have serious consequences for forensic clients, agencies entrusted to deliver these services, and the broader Victorian community. We look forward to the opportunity to continue our contribution to discussions around redevelopment of the Victorian forensic treatment system.

References

Alcohol and Drug Council of Australia (ADCA) (2003). *Policy Position on Diversion*, September 2003

Bambling, M. (2003) *Clinical Supervision: Its Influence on Working Alliance and Client Outcome in the Brief Treatment of Major Depression*. University of Queensland

Bull, M. (2005). A comparative review of best practice guidelines for the diversion of drug related offenders', *International Journal of Drug Policy*, 16, 223-234

Clancey, G. & Howard, J. (2006). Diversion and criminal justice drug treatment: mechanism of emancipation or social control?. *Drug and Alcohol Review*, 25, 377-385

Cohen, S. (1985). *Visions of Social Control*. Polity Press: Cambridge

Department of Human Services (2008a) *Shaping the Future: The Victorian Alcohol and Other Drug Quality Framework*, DHS: Melbourne

Department of Human Services (2008b) *A new blueprint for alcohol and other drug treatment services*, DHS: Melbourne

Department of Human Services (2009) *Discussion Paper on the Forensic Drug Treatment System*, DHS: Melbourne

Hughes, C. & Ritter, A. (2008). *A Summary of Diversion Programs for Drug and Drug-Related Offenders in Australia*. DPMP Monograph 16. National Drug Research Centre: Sydney

Hussain, Q. & Cowie, M (2005). *Alcohol and other Drug Treatment within the Context of the Criminal Justice System: A review of the literature*, Caraniche: Melbourne

Kavanagh, D. J., Spence, S. H., Wilson, J., & Crow, N. (2002). Achieving effective supervision. Drug and Alcohol Review, 21, pp.247-252

McMahon, M L (2006). Support and supervision: A lifelong learning process. In H. L. Reid and J. Westergaard (Ed.), Providing Support and Supervision: An Introduction for Professionals Working with Young People, pp.124-135. Routledge: UK