



**VAADA**

**Review of the cost of CCCC  
drug and alcohol services**

August 2010

This report contains 21 pages

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## Contents

1	Introduction	1
1.1	Scope of review	1
1.2	Contents of the review report	2
1.3	Disclaimers	2
2	Executive summary	4
3	Costs of CCCC	6
3.1	Funding model	6
3.2	Actual costs - labour	7
3.3	Actual costs – on-costs	9
3.4	Actual costs – other direct and overhead costs	10
3.5	Quantification of short fall	11
4	Episodes of Care and outcomes	14
A	Glossary and participant list	19

# 1 Introduction

The Victorian Alcohol and Drug Association (VAADA) is the peak body for providers of Alcohol and Other Drug (AOD) services in Victoria. One of VAADA's principal roles is to advocate for its members to the Victorian Department of Health (DoH), for whom the AOD organisations provide the majority of their services in Victoria.

VAADA's purpose is to ensure that the issues for people experiencing the harms associated with alcohol and other drug use and the organisations that support them are well represented in policy and program development and public discussion.

AOD providers undertake a wide range of services for the Victorian Government, either directly for the Department of Health or indirectly through a third party brokerage arrangement<sup>1</sup>. One of the Department of Health's funded activity groups is Counselling, Consultancy, and Continuing Care (CCCC).

VAADA, and its member organisations, have been concerned that the level of funding made available to AOD providers under the DoH's current funding model is insufficient to provide a quality service, and that it may not reflect the underlying costs of operating a CCCC service. As a result, VAADA commissioned KPMG to undertake a review of the costs of delivering CCCC services and the adequacy of the DoH funding model under which those services are funded.

This report describes the findings of that review.

## 1.1 Scope of review

The scope of KPMG's review was to conduct a review of the costs of delivering CCCC services (excluding forensic services paid by ACSO-COATS). This review was intended to enable the sector approach the Department of Health regarding the adequacy of funding for these services – accordingly the review report focuses solely on exposing the costs of CCCC and how they will behave under a range of scenarios rather than making any recommendations regarding how that information should be used in ensuing discussions between VAADA and the Department, or by any Agency in structuring its services or costs.

Seven CCCC agencies participated in the review<sup>2</sup> to provide a broad sample of cost and activity information in relation to their direct and indirect costs of providing CCCC services and the operational models that have been adopted to deliver those services. The information collections were undertaken through:

- collection of cost information from the organisations' accounting and financial management systems;
- collection of service volume information from organisations' operational records; and

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<sup>1</sup> Forensic services provided to ACSO-COATS.

<sup>2</sup> Listed in Appendix A

- interviews with key organisational staff, in particular Chief Executive Officers, managers responsible for CCCC, and finance managers.

The review examined the costs of CCCC, Youth CCCC and Extended Hours CCCC<sup>3</sup>. Within this report the three types of CCCC are all described under a single CCCC title in recognition that the observations made for a single type of service will in general apply to the others.

The funding model for Extended Hours CCCC differs from those for Youth CCCC and CCCC in relation to the inclusion of penalties and awards rate payments required for staff working non-standard hours and some small model modification regarding the level of overhead funding. The difference between the two models does not materially impact the conclusions presented below and hence for ease of reading the report primarily confines any discussion to the generic CCCC services with the understanding that any conclusions can be applied in the same manner to the Extended services.

## 1.2 Contents of the review report

The remainder of this report sets out the findings of KPMG's review, structured as follows:

- Section 2 – Executive summary: providing a summary of the review findings and conclusions and hence the principal lines of argument that VAADA may adopt in its ongoing debate with DoH regarding CCCC funding
- Section 3 – Costs of CCCC: that describes the profiles of costs and underlying resource usage patterns observed in the review's participating agencies for their provision of CCCC, and compares those costs to the funding model under which the CCCC's services are funded by DoH.
- Section 5 – Episodes of Care (EoCs) and Outcomes: that examine the findings of the preceding section from the perspective that CCCC is a unit priced service and that funding adequacy is a function of quality as well as underlying cost drivers. Critical to this section and the findings of the entire KPMG review is the definition of EoC on which CCCC are based

## 1.3 Disclaimers

### *Inherent Limitations*

This report has been prepared as outlined in Section 1.1 above. The services provided in connection with this engagement comprise an advisory engagement, which is not subject to assurance or other standards issued by the Australian Auditing and Assurance Standards Board

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<sup>3</sup> Also referred to as After Hours CCCC and Out of Hours CCCC.

and, consequently no opinions or conclusions intended to convey assurance have been expressed.

Sections of this report are based on a qualitative study and the reported results reflect reported experiences and information provided by VAADA and the sample CCCC providers that participated in the review. Any projection of these inputs to the wider AOD sector is subject to the level of bias in the method of sample selection.

KPMG have indicated within this report the sources of the information provided. We have not sought to independently verify those sources unless otherwise noted within the report.

KPMG is under no obligation in any circumstance to update this report, in either oral or written form, for events occurring after the report has been issued in final form.

The findings in this report have been formed on the above basis.

#### *Third Party Reliance*

This report is solely for the purpose set out in Section 1.1 and for the VAADA' information, and is not to be used for any other purpose or distributed to any other party without KPMG's prior written consent.

This report has been prepared at the request of the VAADA in accordance with the terms of KPMG's engagement letter/contract dated 11 January 2010. Other than our responsibility to the VAADA, neither KPMG nor any member or employee of KPMG undertakes responsibility arising in any way from reliance placed by a third party on this report. Any reliance placed is that party's sole responsibility.

## 2 Executive summary

KPMG conducted a review of the costs of delivering CCCC services from a range of AOD service providers and compared the outcomes of that activity to the funding model used by DoH to purchase services.

This section summarises the findings of that review in a series of headline points for VAADA to use in its discussions with DoH regarding the future quanta of funding for CCCC. All of the amounts shown in this section are 2009/10 cost or funding figures, unless otherwise noted.

The KPMG review visited six AOD service providers and also received data from a seventh to form the conclusions presented in this report. The service providers that participated covered a range of health services, community health services, and specialist AOD services. The seven services were located in a range of Metropolitan and non-Metropolitan Regions servicing: inner urban, growth corridor, urban rural fringe, and rural communities.

The findings of the review are as follows:

- The funding provided by DoH for CCCC is based on a unit priced model that once was based on a constructed cost.
- The constructed cost has become compromised by the move to a single flat rate indexation approach since 2007/08. In future years the relevance of the constructed cost is likely to diminish as the funding provided will lose its relationship to underlying costs. This will be due to a single indexation being used that may diverge from the range of cost indexations experienced within CCCC providers. That said, as the single flat rate indexation has only been in place for two years the underlying basis of funding can still be discerned.
- DoH uses a funding model that has three main components on its cost side. These are: labour, on-costs, and operating costs. In each of the three components, the funding model is under providing for the quanta of costs incurred by CCCC service providers.
- Examination of CCCC providers indicates that they are breaking even at best, and in many cases making a deficit over ten percent. This level of deficit is consistent to the potential deficits modelled from an input based cost build up undertaken by KPMG based on actual cost rates incurred. This build up indicated that CCCC providers will just break even to make a deficit of approximately 20 percent depending on their circumstances.
- The short fall in CCCC funding compared to underlying costs arise from each cost component required to deliver CCCC:
  - Labour – the funding model is based on a historic rate for a grade 2 psychologist (HSUA). The 2007/08 rate incorporated in the funding model after indexation is less than that in the current award (see paragraph immediately below) and also is understated due to providers having to make salary adjustments in recognition of qualifications. Also the funding model does not recognise that health services are obliged to utilise

grade 3 psychologists in order that clinical supervision (as required under the industrial agreements) can occur. As a result of the above, the funding model under provides required salary costs by 13.5 per cent for providers using HSUA staff. Non-health CCCC providers manage this short fall by employing staff on cheaper awards (SACS or individual agreements). Where used, this strategy can reduce the salary shortfall to near zero, but does raise issues regarding equitable employment conditions between similar qualified staff across the sector, and also whether the quality of CCCC services being delivered are being compromised.

- The single flat rate indexation used between 2007/08 and 2009/10 (totalling 6.1 per cent) has lagged the annual 3.25 per cent increase in relevant pay awards in the same period (totalling 6.6 per cent).
- The funding model provides for an appropriate rate of salary on-costs. However from a funds perspective, the impact of underfunding of salaries results in on-costs also being underfunded.
- The funding model provides for 14.5 per cent of operating costs in addition to salary and oncost funding. This amount appears significantly less than is warranted given that it is less than actual cost levels incurred by agencies and other benchmark data. At the maximum benchmark range the funding is one third below that warranted.
- In combination, the three cost components appear to be underfunding CCCC providers by up to \$15,894 on the \$87,303 provided for 110 EoCs, This short fall represents 18 per cent of base funding. At the lower end of the expected cost variation scale CCCC providers will just breakeven on their funding – this however is dependent on moving all CCCC staff off the HSUA award, which is not possible for all providers.
- An analysis of the relationship between funding, FTE levels utilised, and EoC targets highlights that the existing CCCC service can achieve EoC targets with 4.1 hours of client facing counselling time per client. This however does expose the organisations to potential financial short falls. The lean nature of CCCC delivery and related funding means that CCCC providers are exposed to, and have to manage the risks associated with, deficit and increasingly complex clients. Both of these may result in service to clients being compromised, and by extension impacts on the level of outcomes achieved (and measured) for the DoH. In addition to this the policy and program requirements surrounding CCCC have also been becoming more complex – these further impact on AOD services, their costs, and their capacity to deliver contemporary CCCC services.

Note: the conclusions made above are based on a limited sample of AOD provider data accessed for this study and hence from a statistical perspective cannot definitively be stated as providing a complete picture of service cost experience for all CCCC service providers. That said, the conclusions presented above when tested with a range of CCCC providers were endorsed as being consistent with the experiences of the sector.

### 3 Costs of CCCC

This section provides a summary of the cost of delivering CCCC services reported by the participating agencies and compares them to the DoH CCCC funding model.

Within this section the cost of CCCC is examined from the context of:

- types of costs incurred and the inputs underlying the costs; and
- the relative volumes of those costs.

In both cases the type of the organisation and the structures they have adopted in the delivery of services, including the CCCC, have a direct impact on the costs incurred, and on the organisations' capacity to report the costs of CCCC services separately.

#### 3.1 Funding model

The DoH funding model is described by the following cost build up<sup>4</sup>:

- One funded FTE position delivering 110 EoCs per annum
- The funding model assumes that the FTE used to deliver the CCCC service is a HSUA4 grade 2 psychologist (HR2-YR3) at a cost of \$61,534 per annum in 2007/08
- The salary costs generate on-costs (WorkCover premiums, provisions for long service leave, provision for 17.5 per cent leave loading, and superannuation guarantee levy) at 14.5 per cent of wage cost
- The CCCC worker is supported by an operating costs equivalent to 15.4 per cent of wages plus on-cost
- Since 2007/08 the rate of funding has been indexed in total at the Victorian Government's NGO price index rate of approximately 3 per cent per annum, where funding for 110 CCCC and Youth CCCC EoCs has increased from \$82,259 per annum in 2007/08 to \$87,303 per annum (or 793.66 per EoC) in 2009/2010.
- Extended Hours CCCC is funded under the same model except with the inclusion of penalty rate costs for after hours, weekends and public holiday staff time and a small variance to the rate overheads are provided for. Extended CCCC funding in 2009/10 was \$992.50 per EoC, a difference of 25 per cent to standard CCCC due almost entirely to the additional (penalty rate driven) cost of labour.

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<sup>4</sup> Per DHS published cost model for CCCC 2007/08.

The following points are noted regarding the DoH funding model:

- The current funding model is based on a historic assessment of the components of costs (both type and quantum) required to deliver CCCC. There is limited evidence that the component of costs and their relative quanta reflects current costs.
- The construction of the unit price does not indicate whether clinical and direct service supervision is incorporated within the allowance for 1 FTE or in the 15.44 per cent operating cost allowance.
- The introduction of the NGO price index, whilst it has simplified the funding model, means that the underlying relationship between actual costs and funding (as identified when the unit price was first developed) will become more tenuous with time – this has already commenced where in the last two years the increase from the NGO price index has lagged the increase in award over the same period (6.1 per cent and 6.6 per cent respectively).
- In a unit pricing model, a unit price is based on an estimation of the typical costs of a range of resource. Natural variations in providers' costs are anticipated to occur – the selection of the cost to use in a funding model (e.g. mean cost, modal cost, median cost, defined percentile cost) is a matter of judgement within the Department establishing the unit cost. The basis of selection for the component cost levels in the CCCC unit cost is not known.

### 3.2 Actual costs - labour

As noted above, the CCCC unit cost is based on 1 FTE grade 2 psychologist HR2-YR3 delivering 110 EoCs. The volume of EoCs delivered is considered in the next section, however in the context of the cost of labour the following points are considered:

- the awards under which the CCCC workers are employed;
- the award levels the employer pays staff at; and
- any degree to which the employer pays at above award in order to maintain a staff base.

In each of the organisations visited as part of the review different combinations of awards were in place, examples include:

- Mixed team of HSUA 4s and HSUA 3s (XX12 – Com Dev Worker)
- Teams on SACS Award employing mixtures of Psychologists, Registered Nurses and Social Workers
- Collective agreement

Consequently, observed salary rates paid in the participating organisations varied significantly, varying from reported rates that included<sup>5</sup>:

- \$98,000 for a staff member under HSUA4 holding both a CCCC counselling role and a program management and clinical supervision role
- \$85,000 to \$77,000 for a staff member under HSUA3
- \$63,000 for staff on SACs; to
- \$63,000 to \$48,000 for staff on collective agreements

In practice only organisations that pay staff outside of the HSUA award have a reasonable chance of achieving the average clinical staff salary cost of approximately \$66,000 that is inherent in the level of funding offered (\$61,534 2007/08 indexed to 2009/10).

During the review activities, KPMG was provided with modelling from a health service that further illustrated this problem. The model recognised that:

- under the psychologist award, grade two psychologists are required to receive clinical supervision from grade three psychologists – and hence that health services are required to maintain teams incorporating psychologists at both grades, despite in theory the model only recognising (and theoretically funding) the lower grade;
- that the actual cost of a grade two psychologist is more than that assumed in the funding model after indexation (approximately \$66,000 per above) where the actual cost for 2009/10 was \$67,700, for grade three psychologist this difference is even greater based on a actual cost of approximately \$81,500; and
- the underfunding shown above is prior to any salary uplift that occurs in recognition of qualification which carries a salary allowance of approximately \$2,000 for a graduate certificate, \$3,000 for a graduate diploma and approximately \$3,500 for a masters.

The net impact on health services, that have no discretion about using the SACS award instead of HSUA, is that average staff costs can be approximately \$75,000 per head, or 13.5 percent above that funded as a result of award conditions alone.

The details in this section do not consider the impact of salary packaging rules as the net cost impact on service providers is minimal. It is however noted that where organisations (e.g. health services) can only offer 17 per cent salary packaging the pressure on them to pay higher wages is increased if they are to compete for staff against agencies that can package to 30 per cent. For

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<sup>5</sup> Note: the amounts shown here are those amounts as being reported as being paid and the award level of staff. The rates paid to actual award rates may differ due to factors such as organisations having to pay above award and incurring additional obligations under the award above the base pay (e.g. payment for qualifications/competencies).

health services this issue may exacerbate the impact of having to use HSUA and create significant issue for the recruitment and retention of staff.

### 3.3 Actual costs – on-costs

The rate of on-costs observed in the participating agencies were commensurate to those provided for within the funding model.

This finding was not surprising given the breakdown of costs within the on-cost adjustment, which comprise:

- Superannuation guarantee levy: 9.0 per cent
- Leave loading: 1.4 per cent (being the up lift costs arising from the 17.5 per cent loading on leave pay)
- WorkCover: 2.3 per cent
- Long service leave: 1.8 per cent
- **Total: 14.5 per cent**

The actual rates of costs incurred were not materially different to those shown above due to:

- the superannuation and leave loading amounts are standard and non-discretionary; and
- the WorkCover amount appears to be consistent with existing industry premium rates, and by its nature is not subject to significant variation across most organisations.

KPMG did not examine the WorkCover history of the participating agencies and hence is not able to comment on the underlying causes of why the observed rates of WorkCover cost (and amounts provided in the funding model) at 2.3 per cent are higher than the general gazetted rate of WorkCover premiums for at for general health services 1.5 per cent.

Reporting of long service leave cost accrual was patchy across the organisations that participated in the review, and those costs observed did vary to the provided rates shown above. This is not surprising given that long service leave tends to be calculated at an organisation level, rather than service level, only once a year. KPMG is not able to comment on whether the long service rate provided for in funding model is correct given that the review did not examine global staff turnover rates in the AOD sector.

Despite the above, the 1.8 per cent rate does appear to be generous given that after ten years any employee would be eligible for 16.5 per cent of their annual salary within long service. A rough calculation of provision rates that incorporates estimates of salary progression and indexation would indicate that the 1.8 per cent allowed will be sufficient for long term long service

liabilities if staff turnover results in no more than 75 per cent of staff reach eight years of employment (the point at which long service leave vests).

Whilst the rates provided in the model appear reasonable it is noted that the funding amount given is calculated on a non-realistic base wage. As seen in the preceding section, the wages provided in the model are generally at or below wage rates paid. As consequence, even though the provision rate is correct, organisations receive insufficient funding under the model to the same relative level as their wage costs are underfunded.

It is further noted that the AOD sector, like many other health and human services sector is examining the merits of portable employee benefits. In the event that portability is introduced the CCCC services would become further underfunded for liabilities incurred.

### 3.4 Actual costs – other direct and overhead costs

The CCCC funding model allows for a 15.4 per cent uplift over the costs of labour to cover ‘operating costs’.

The funding model does not define what operating costs are. For the purpose of this review, it is assumed to be other direct service costs (e.g. consumables and travel) and an organisational overhead (e.g. management, HR, IT costs and infrastructure costs).

In the agencies that participated in the review the rates of cost uplift observed varied between 19 and 36 per cent<sup>6</sup>. These observed rates are consistent with KPMG’s general experience of health and human service costs where direct non-labour costs and overheads are typically between 17 to 23 percent of labour costs

It is noted that:

- none of the sample of providers participating in the review achieve the 15.4 per cent rate inherent in the funding model; and
- the funding model does not distinguish between provider locations – those agencies that showed the largest degree of variation to the funded level were those organisations that provide services from multiple locations and in non-metropolitan areas. For the provision of CCCC services in rural locations this finding has significant implications for their capacity to deliver quality CCCC services under a unit funded model.

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<sup>6</sup> A rate of 63 per cent was noted in one organisation’s accounts, however this rate has been disregarded as it appears anomalous in the context of other information provided, and also in respect to KPMG’s general experience of costs in health and human service organisations. The anomalous figures appear to derive from an unusual level of management recharging – an accounting exercise that may not reflect and underlying reality.

### 3.5 Quantification of short fall

The CCCC funding model appears from each of its components to contribute to a material funding short fall for CCCC providers.

In particular:

- Labour rates can be up to 13.5 percent underfunded
- On-costs have an underfunding that flows from the above
- Operating cost uplift is underprovided by two to eight percent of staff costs.

Table 1 below summaries the financial impact of these, based on the 2009/10 funding rate – where low and high variance is shown to illustrate the range of costs observed in agencies for the three categories. Critically it is noted that in each cost category the costs incurred were never less than the funding provided.

*Table 1: Cost of delivering CCCC services – range of costs incurred and funding by cost category.*

	2007/08 unit cost	2009/10 cost (after NGO indexation assumed applied evenly to all costs)	Low – variance (rate and cost impact)	High – variance (rate and cost impact)
Labour	\$61,534	\$65,307	0.0 per cent \$0	13.5 per cent \$8,816
Oncost @ 14.5%	\$8,922	\$9,469	0.0 per cent \$0	13.5 per cent \$1,278
Operating cost @ 15.4%	\$10,876	\$11,542	1.6 per cent \$180	7.6 per cent \$5,800
<i>Total</i>	\$82,259	\$87,303	\$180 <i>0.2 per cent underfunded</i>	\$15,894 <i>18.2 percent underfunding</i>
<b>Total funding required after adjustment for shortfalls</b>			<b>\$87,483</b>	<b>\$103,197</b>

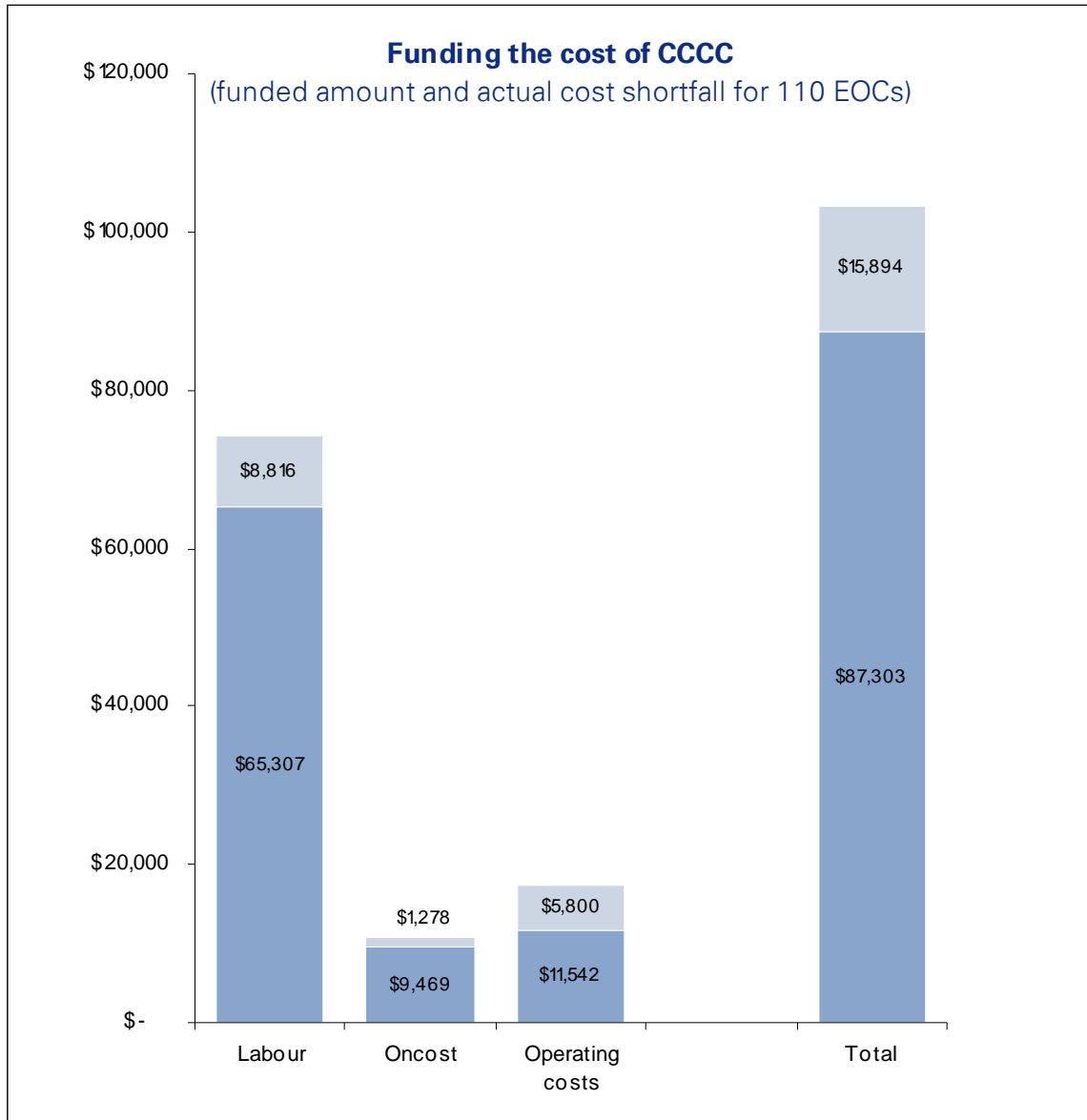
The cost observed in CCCC's services suggest that:

- if an AOD agency staff its CCCC service to the degree implied by the CCCC funding model; and if
- it puts in place appropriate levels of management and organisational support,

that the CCCC service will have a result just between breaking even to making an almost 20 per cent loss on the CCCC activities.

Figure 1 below illustrates the degree of underfunding for CCCC service providers. In the figure, the light blue bars illustrate the maximum level of underfunding encountered by services as shown in the table above under the high variance scenario.

*Figure 1: Funding for CCCC services and maximum potential shortfall to costs per 110 EOCs*



It is noted that the cost variations shown above describe a minimum and maximum variation in costs to funding observed – for the majority of agencies a deficit greater than the minimum, but less than the maximum, will be incurred: i.e. even if an agency has managed its costs within

funding for one category of costs they do not for all three<sup>7</sup>. Following this: the observed rates of deficit incurred in the agencies participating in the review were between 0 per cent and 13 per cent were observed.

The findings are consistent with comments made to KPMG by providers regarding incurring financial stress when delivering their contracted EoCs within an appropriate standard.

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<sup>7</sup> KPMG notes that this may reflect the capacity of organisations to switch costs between categories (e.g. staff at off site location remotely resulting lower labour costs but higher transport and infrastructure costs). KPMG did not investigate cost switching behaviour in agencies as the causes of these decisions frequently include non-service specific reasons, and hence a definitive statement about CCCC alone is not possible.

## 4 Episodes of Care and outcomes

This section sets out a range of observations regarding the impact of EoC and client demand place on organisations and their financial outcomes.

The preceding section modelled the costs of delivering EoCs under the resourcing assumption that is inherent to the funding model, i.e. that one FTE (less any reallocation of time to clinical supervision) delivers 110 EoCs.

As part of the review activities KPMG developed a resource model to investigate the relationship between resource utilisation, the delivery of targeted EoCs, and the relationship between these and financial constraint (as observed in the preceding section where the CCCC funding is examined from an input cost basis).

Three scenarios were examined under the model:

- The base case scenario: which modelled a generally accepted level of activity required to deliver EoCs.
- An increasing complexity model: which modelled the impact of increasing levels of client complexity resulting in greater resource investment to deliver the client outcome (EoC). For modelling purposes only, increasing client complexity was assessed on a 25 per cent increase in counselling time required per client, with no increase in administration time or case management time.
- A financial stress model: which modelled the impact of financial constraint where a service provider losses the capacity to absorb deficits. In the financial constraint model it is assumed that the service has operated at a ten percent funding deficit (i.e. the approximate mid point of the results of the financial analysis presented in the preceding section).

The outcomes of the scenario analyses are presented in Table 2 below. The results of the financial analysis describe a range of outcomes for each scenario that recognise the intimate relationship between:

- EoCs achieved (as distinct to those contracted for);
- average counselling time invested in each client to achieve an EoC; and
- financial outcome for an organisation running an assumed ten percent deficit.

*Table 2: Scenario analysis of relationship between EOCs, client hours and service delivery cost deficit.*

	Base case scenario	Increasing complexity model		Financial stress model	
		EoCs delivered held constant	Deficit held constant	EoCs delivered held constant	Hours of client sessions held constant
Delivered EoCs	110	110	99.2	110	99.0
Average number hours spent in client counselling sessions per successful EoC	4.1 hrs	5.2 hrs	5.2 hrs	3.4 hrs	4.1 hrs
Deficit	10 per cent	19 per cent	10 per cent	0 per cent	0 per cent

The table shown above highlights the relationship between demand, quality of care and financial viability of a service, where:

- a 25 per cent increase in time spent with clients will either reduce the number of EoCs a service can deliver by 9 per cent or increase a deficit by the same amount; and
- reducing an assumed ten percent deficit to zero will reduce the number of EoCs delivered by 9 per cent or the average time spent with a client by 17 per cent.

These findings highlight a number of factors that were described by CCCC providers, but which were not directly relevant to the scope of the costing study:

- The adverse outcomes modelled under each of the scenario analyses assume a fixed definition of an EoC. Service providers did note that the setting of significant treatment goals allows a service to target the achievement of contracted outcomes: i.e. a less complex significant treatment goal can be achieved in a shorter period of time per client, and hence with a lower level of resource investment (characterised by the second column from the right in the table above).

Whether this form of ‘ledger balancing’ is desirable in service quality terms is open to debate – particularly if a service does not use re-episoding.

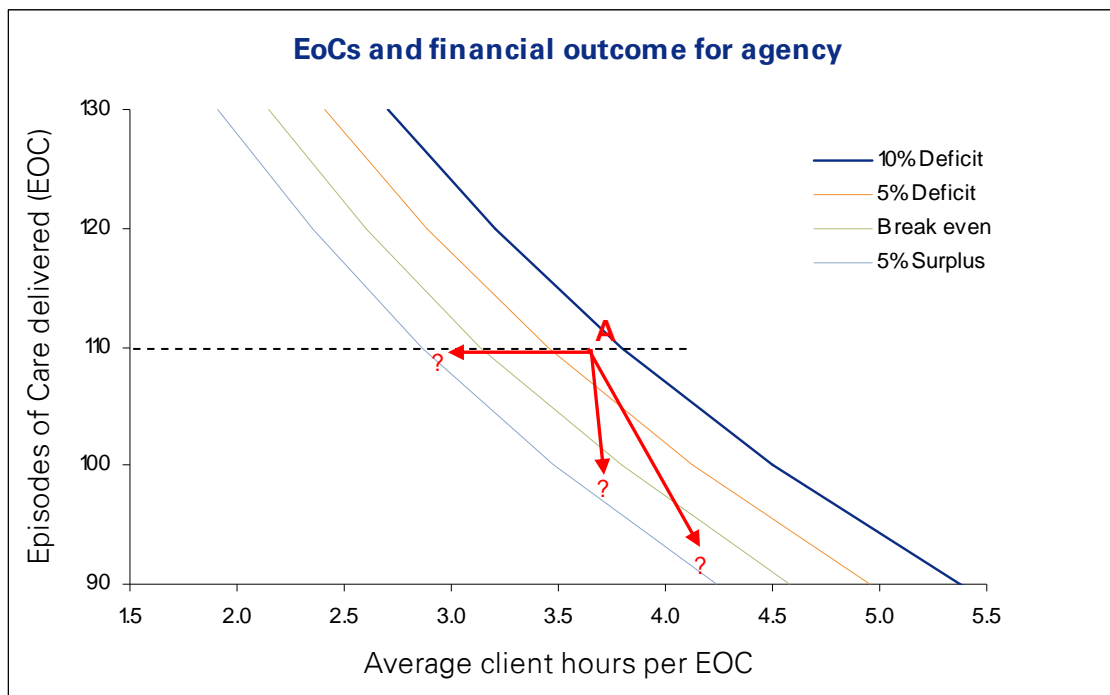
- Increasing complexity of clients’ needs will result in lower target achievement, or poorer financial outcomes for a service. The Forensic service was not within the scope of this

review, however this observation may explain in part why those services that mix Forensic and CCCC services incur higher levels of financial pressure.

This may also provide insight into why non-metropolitan services, which may be the only AOD service in an area incur greater financial pressure as in addition to incurring higher overhead rates) complex clients can less easily be diverted away from the CCCC service to a more appropriate service.

As seen above, the delivery of EoCs (both in terms of number delivered, that may include re-episoding), amount of client time (and therefore potential quality of service and client outcome) and financial outcome (e.g. deficits incurred) are closely linked. Figure 2 below illustrates those relationships using the observed cost / service data described in this report and the model described above.

**Figure 2: EOCs and client hours under varying deficit/surplus levels.**



The diagram illustrates the dilemma confronting an agency that is making the average 10 per cent deficit of CCCC providers to deliver their contracted 110 EoCs (Point A), do they:

- Decrease the hours spent on client facing time per EoC.
- Hold, or increase, the hours spent on client facing time per client to ensure an effective client outcome – and either miss their EoC target, or use re-episoding to achieve a reported

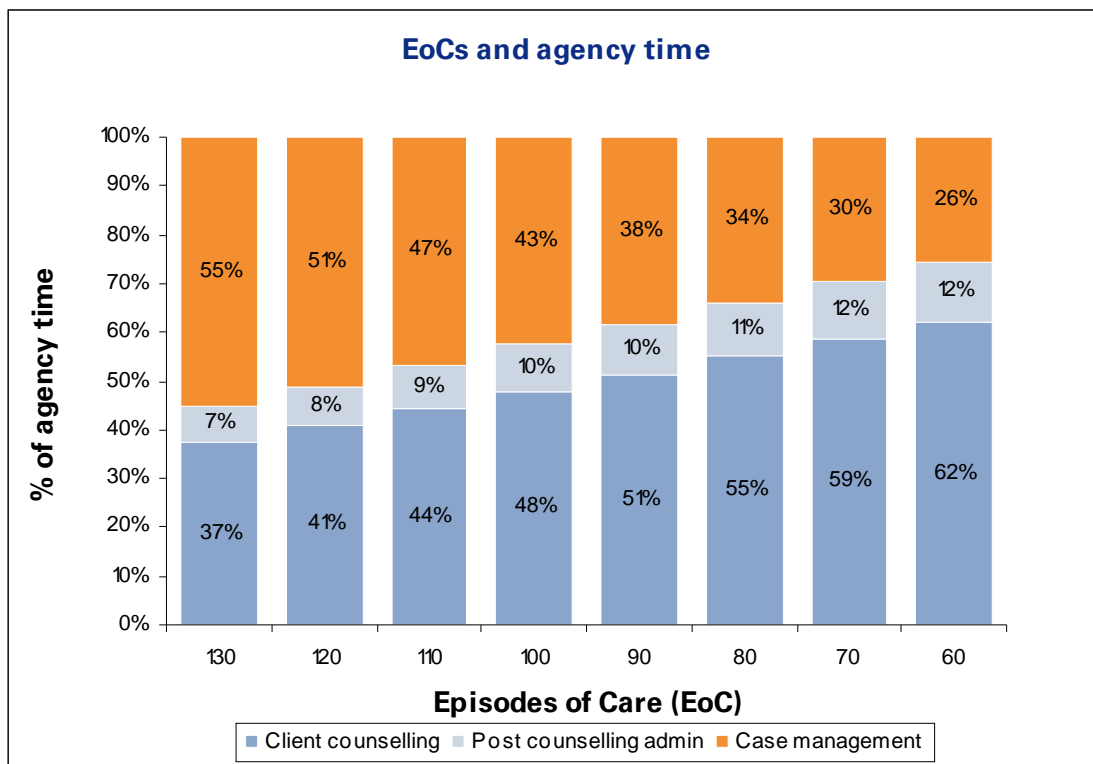
110 EoCs, recognising that this practice can limit the potential of the service to provide CCCC as and when it is required and result in queues for services.

- The diagram also assumes that the organisation ultimately has no choice regarding the options described above as in the long-run no organisation can run on a perpetual deficit.

The scenario modelling did not examine the impact of increasing complexity in the design of the broader AOD service system. In recent years the increasing role of dual diagnosis response to clients has inevitably increased the level of resources a service needs to dedicate to ensure services are coordinated and its own services are delivered in light of new approaches to dealing with CCCC clients. These changes, which always increase demand, rather than reduce demand, apply a further pressure to the resource use and hence financial position of service providers. These changes are not reflected in the CCCC funding model but are likely to continue in the future.

The modelling also illustrated that funding different levels of EoCs impacts on the nature of service being delivered per client. Where the funded EoC count is decreased the percentage of agency resources (or funds) expended directly on clients tends to increase as more time can be spent with a client on a one on one basis. Figure 3 below illustrates this point.

*Figure 3: Modelled application of agency time in response to varying EOC targets.*



The insights provided by the table above do not relate directly to the adequacy of the existing funding for CCCC but is relevant to any future debate regarding balancing changes to agency funding for a target of 110 EoCs, or addressing the underfunding issue through adjustment to EoC target numbers (under a fixed or also changing funding base).

## A Glossary and participant list

ACSO	Australian Community Support Organisation
AOD	Alcohol and Other Drug
CCCC	Counselling, Consultancy, and Continuing Care
COATS	Community Offender Advice and Treatment Service
DoH	Department of Health (Victorian)
EACH	◀ Eastern Access Community Health (as part of Monash link)
EoC	Episode of Care
HSU(A)	Health Services Union Award
ISIS	◀ ISIS Primary Care
LCHS	◀ Latrobe Community Health Service
MH	◀ Moreland Hall
PH	◀ Peninsula Health
SACS	Social and Community Services (award)
SEADS	◀ South East Alcohol and Drug Service (part of Southern Health)
VAADA	Victorian Alcohol and Drug Association
WRAD	◀ Western Region Alcohol and Drug Centre

Note: “◀” indicates the organisations that provided data to this CCCC review