Regional voices: The impact of alcohol and other drug sector reform in Victoria

Final Report

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Note. To avoid confusion in the report, the term 'agency / agencies' has been used to denote an organisational boundary while 'service' means a specific support or treatment intervention provided within an agency.

Executive Summary

Major reform was implemented in Victoria's alcohol and other drug (AOD) treatment system on September 1, 2014. This study documents service provider perspectives on benefits of the reform and major issues that have arisen, one year on. Forums were held in eight locations around the state and a total of 131 people took part. A nominal group technique was used to identify priority issues and data were analysed thematically to explore issues that were prioritised at more than one forum.

Reform benefits

When asked to reflect on benefits arising from the reform, the most common initial response from participants was silence. The response was particularly negative at rural forums, where significant changes had typically been experienced. Hence the discussion quickly moved on to challenges. In metropolitan forums, some participants described specific improvements to service operations while acknowledging that both the process of change and shortcomings of the reform itself had been challenging.

However a number of benefits were identified from the analysis of participant responses. The introduction of standardised assessments was generally regarded favourably. Some benefits had been realised in specific services or consortia, namely relationship building and structures for clinical governance. Other benefits identified by participants showed promise however their potential had not been realised at the time of the consultations. These areas with potential benefits include: a stated commitment to continuity of care; the care and recovery co-ordination model; and investing in local planning.

Reform issues

The priority issues identified in each forum were thematically analysed, which led to the identification of eight items (areas of concern). These items were: intake and assessment; treatment types and restrictions; professional relationships; workforce impacts; funding and drug treatment activity units (DTAUs); administration and bureaucracy; client voice; and evaluation. The first six of these items, which were prioritised at more than one forum, have been described in detail.

Intake and assessment was identified as a priority issue at every forum. The concerns raised were about the process at initial contact and the multiple steps needed to get to treatment. There were particular concerns for complex clients and in rural areas.

Forum participants felt that the five **treatment types**[1] and associated **restrictions** placed limitations on practice flexibility and service responsiveness (e.g., with limited

[1] The five treatment types are counseling, withdrawal, care and recovery co-ordination, residential rehabilitation, and maintenance pharmacotherapy. The first round of recommissioning was concerned

scope for integrated support, requiring a distinction between Standard and Complex Counselling). In combination with the constraints of funding targets and unit costing, this has meant that not all work can be reported. They also identified a number of gaps in the system that include treatment types, modes of service delivery, and services for specific groups.

The process of change has disrupted **professional relationships** and in some locations this is an ongoing problem. Negative **workforce impacts** include *"stress for staff"* from the ongoing uncertainty regarding sector changes and *"an exodus of skilled workers"* during the change period.

Forum participants reported that **funding and DTAUs** do not match the work involved. The funding is not sufficient and the treatment definitions are too narrow – so that some activities cannot be counted (e.g., not allowing for *"any work outside of direct clinical work")*.

Sector reform has resulted in **increased administration and bureaucracy**. This is particularly the case for recording and reporting systems, including 'doubling up' - because of the separation of Intake and Assessment (I&A) from AOD treatment services and because multiple reporting systems are being used.

Directions

Suggestions have been made based on the study findings. However, these findings need to be compared with findings from the analysis of other data, for example on client characteristics, throughput, and attrition following the reform. The recently completed review of Victoria's AOD services (the 'Aspex report') will be useful in this respect.

The table below includes suggestions for sector development based on the priority issues that have been described.

with non-residential treatments and with intake and assessment, so residential withdrawal and rehabilitation were not addressed. The pharmacotherapy system was recommissioned through a separate process.

Priority issues and allied suggestions for change

1. Intake and assessment

- All outpatient AOD agencies should have capacity to provide Intake and Assessment (I&A), to enable system access and support a timely process for entry to treatment.
- All agencies providing I&A should provide at least one outpatient treatment type so there is scope to build on the initial engagement with clients and to streamline treatment entry.
- The process for determining people's eligibility to treatment based on the screen and the tiered framework needs review to ensure neither approach is a barrier to engaging with those seeking help for an AOD problem.
- Complex clients are the primary target of specialist AOD services and their access to treatment should be facilitated by funding and accountability arrangements that support engagement, including flexible modes of service delivery. This will include outreach, particularly in rural areas, and require service targets that account for the time required to engage, retain and support complex clients to make treatment progress.
- Regional and rural AOD services / systems are shaped by local conditions and need a tailored approach to planning that includes recognition of variations in treatment modalities to account for the network of services available and the geographic and social conditions involved.

2. Treatment types and restrictions

- The reform reduced service types to evidence-based treatment modalities and included scope for agencies to develop their own service models. However, it has been difficult for adequate models to be developed based on the limited DTAU funding available and the service targets. This is particularly the case for 'Standard' Counselling courses of treatment and Care and Recovery Coordination. The DTAU funding needs review to ensure that all treatments are viable. The evidence-based treatment modalities need attention to ensure that non-clinical, but fundamental, elements of engaging and supporting clients are acknowledged (and thus funded).
- Brief intervention has a strong evidence-base and it should be included as an outpatient treatment modality.
- Family support should be acknowledged as a legitimate service activity and adequately remunerated.
- Youth services need tailored models to address engagement and retention challenges that are important for this cohort.
- CRC services have experienced difficulties because of a mismatch between expectations and funding and due to the inclusion of AOD Supported Accommodation. The CRC model and funding needs review. AOD Supported Accommodation should be addressed separately, with consideration of the actual needs of the client group and the associated level of support that is required.
- Finally, harm reduction has been excluded in the reform although it is evidence-based and improves people's health and well-being, while offering a pathway into treatment for some. The decision to exclude harm reduction from AOD treatment is likely to be impacted by the limited funding available and the importance of maintaining the specialist nature of the system. Harm reduction should be recognised and funded in its own right.

3. Professional relationships

- Trust and cooperation are important for a strong and sustainable community

sector and they will be facilitated by clarity about future funding arrangements and strong lines of communication with the sector.
4. Workforce impacts • The reform has disrupted professional relationships between AOD agencies and between AOD agencies and referral organisations. Workforce development strategies should support collaborations, partnerships and linkage development. Strategies for agency coordination may also be beneficial.
5. Funding and DTAUs • The DTAU funding amounts are largely regarded as inadequate and restrictive. Service specifications need to incorporate non-clinical elements of treatment courses and the funding formula needs review.
6. Administration and bureaucracy • Multiple reporting systems are in use, which is contra to the intent of the reform and difficult for agencies. A standard reporting system that is about service activities (outputs and client characteristics) is required. • Separate from this, outcome measurement would be valuable to allow the demonstration of treatment effectiveness using agreed goals. Short term goals would address distinct service encounters (e.g., engagement, retention, referral) while longer-term goals would address client progress – possibly across multiple courses of treatment and agencies - (e.g, behaviour change, social reintegration). • Outcome measurement is not about purchasing accountability but about demonstrating system effectiveness and this information would provide a valuable foundation for sector planning and development.

The reform of Victoria's AOD treatment sector was a bold initiative that followed a long period of major policy inaction. The protracted nature of the change process and the uncertainty this created for agencies meant that the conditions for change were far from ideal. Added to this is the reality that introducing a separate catchment-based Intake and Assessment function in a no-growth environment effectively reduced the budget for treatment services that don't also offer assessment. This situation is pronounced in rural Victoria. A further complication is the gap between demand for treatment and the availability of places, which puts pressure on government and on services, as well as those seeking an immediate and meaningful response when they approach an AOD service. Collectively, these issues highlight the complex and challenging nature of planning and implementation in this area and the need for collaborative processes that emphasise strong relationships between policy and practice stakeholders. This has significant implications for the design and resourcing of future planning and sector development activities.

Addressing the issues identified in this report is critical to support the sustainability and further development of Victoria's AOD sector. The first step is to consider our findings in conjunction with those from the Aspex report. We then recommend developing a working group that combines expertise from policy, practice, and academic realms to enable a sound understanding of the issues, constraints, and

lessons learned from other planning and reform encounters. A rapid assessment process may be warranted to gather information and engage in intensive planning and subsequent change in a timely manner. Attention to implementation planning and monitoring the changes made will be essential. Planning will need to account for the partially reformed sector by explaining the relationship between these services and services that have not been subject to reform.

1. Introduction

Background

Major reform was implemented in Victoria's alcohol and other drug (AOD) treatment system on September 2014; arising from an environment of change heralded since the 2011 Victorian Auditor-General's report on the state's approach to managing specialist AOD services. With the first stage of the recommissioning process now complete, agencies operate within a structure that includes a new approach to funding along with consolidated treatment types and centralised pathways for intake and assessment[2]. The second stage of recommissioning that was planned by the previous government (focusing on residential and youth specific services) has not eventuated.

Given that the recommissioned services have been in operation for 12 months, it is timely to gather information on what the reform changes mean 'on the ground'; how agencies have responded; and what has been learnt. This information will be useful in future efforts to support and strengthen the system. This is the focus of the current study.

Aims and objectives

This project is about sector perspectives on reform impacts. The primary aim was to "build relationships, and determine local needs and canvas views on how VAADA can best support agencies to deliver effective services". VAADA identified five objectives:

- Further the relationship building between VAADA and service providers
- Demonstrate a commitment to face-to-face consultation on key issues in the recommissioned system
- Develop an up to date body of knowledge about the broad AOD issues impacting providers and service users
- Identify current challenges in the delivery of services and opportunities for advancing strategies to overcome these
- Determine sector views on strategies to enhance the system given 'stage two recommissioning' will not proceed as initially planned

Method

Data collection involved a group forum in each health region of Victoria (8 in total, lasting around five hours each). VAADA promoted the forums via VAADA Enews (a free email information list) in addition to sending an electronic invitation to all publicly funded AOD services in Victoria. Participants registered their interest in being involved and nominated a forum based on geographic location. A total of 131

[2] A separate project, entitled *The processes of reform in Victoria's alcohol and other drug sector, 2011-2014,* focused on the background to reform and the processes involved. The report is available from VAADA (www.vaada.org.au) and from Lynda Berends (https://chasr.acu.edu.au).

people participated in the forums. An average of 16 people took part in each forum, and the range was from 11 to 20.

A nominal group technique (George & Cowan, 1999; Stewart & Shamdasani, 2004) was used at the forums. This technique is useful when some group members are much more vocal than others, when the area under discussion is broad and complex, and when issues are controversial or involve different perspectives. This approach allowed us to scope general issues at a regional level; focus on the most critical issues as identified by participants; and explore possible solutions / remediating strategies for one or more of these issues.

Each forum commenced with a general discussion on benefits and issues arising from the reform. Next, groups of participants (numbering around 4 to 6) identified key issues and ranked the top issues from 1 to 4. Findings from these groups were combined to arrive at a list of four issues, ranked by priority, which were the agreed top four issues at forum level. The first item on this list became the focus of a problem-solving discussion at the forum, to identify strategies that may address or minimise the challenges involved (there was insufficient time to discuss remaining issues). Notes were taken and transcribed for analysis.

This study was subject to review by the university's ethics committee and approval was obtained in August 2015. A six-month timeframe was involved, from ethics submission to project finalisation.

Further information on the method is included as an attachment to this report.

Analysis and reporting

After the forums were completed, the data were analysed thematically to show the benefits identified and the issues that were raised and prioritised. The benefits and issues have been given labels to show their main focus (e.g., 'standardised assessment', 'professional relationships'). The issues have been matched to forum location, to identify the most common priorities across the forums and those highlighted at particular locations.

Throughout this report, extensive quotes have been used to 'give voice' to participants. These quotes are labelled to show the forum location and number (e.g. M3 = Metropolitan forum number 3).

While the findings in this report are representative of the views expressed at the forums, the extent to which participants were representative of all local providers varied by location. At four forums, all major AOD providers were represented (Box Hill, Dandenong, Benalla, Traralgon) and at four forums some major providers were not represented (Ballarat, Colac, Preston, Swan Hill).

In addition, the Victorian Department of Health and Human Services (VDHHS) has not been represented in the study as our focus was exclusively on the perspectives of service providers who attended forums. It would be valuable to hear from the

VDHHS and to learn from output and outcome data on client throughput and treatment progress following the reform.

It is also important to note that we have not attempted to outline how the 'ideal' AOD sector could be configured or funded; rather we have focused on the issues that forum participants raised. The project findings should be interpreted in the context of the significant changes that have taken place in the sector and the efforts made to stabilise and adjust as a result of these changes.

Dissemination

The project report will be publicly available from the VAADA and CHaSR websites. One or more conference presentations may also be delivered. The report authors plan to develop one or more manuscripts for peer-reviewed journals.

2. Benefits

Introduction

At the beginning of each forum, participants were asked to reflect on the benefits of the reform. The most common initial response to this question was silence. Participants emphasised that it has been a challenging period, partly because of the process of change and the uncertainty regarding outcomes for services and the sector at large and partly because of the changes that have occurred.

The response to this question about benefits was particularly negative at rural forums, where discussion quickly moved on to challenges. At two rural forums no benefits at all were identified (R4, R5). In the remaining three rural forums some participants felt they were making progress despite operating in difficult circumstances. For example, participants noted that, it is *"starting to get to the point where everything is settling down"* (R1), there are *"opportunities for deeper relationships (but lots of repair work required)"* (R3), and the *"referral process is more streamlined"* (R2). As reflected in these comments, the 'benefits' were generally about services' efforts to move forward rather than actual improvements to service configuration or client access.

The situation was different in metropolitan forums, where some participants described specific improvements to service operations while acknowledging that both the process of change and shortcomings of the reform itself have been challenging.

The data on benefits were categorised into six themes, which are summarised in brief below and then described:

- Relationship building ~ in areas where new service constellations have been a product of recommissioning
- Continuity of care ~ praise for the intention to improve continuity of care in the sector, although improvements have generally not been realised
- Standardised assessments ~ support for having a standardised approach so that client information can be shared across treatments
- Clinical governance ~ an opportunity to improve internal operations in tandem with recommissioning
- The principle behind Care and Recovery Coordination ~ support for the intention of the model but not for how it has been operationalised
- Catchment-based planning ~ support for having dedicated resources for planning; a recognition of the potential benefit from this investment

These benefits were not identified in all forums. Further, when a benefit was identified not all participants at the forum were in agreement. Instead, the benefits had been realised by some organisations / consortia. Our intention in describing the benefits associated with recommissioning is not to downplay the significance or impact of reported challenges, but to acknowledge instances of positive change.

Relationship building

Relationship development has occurred at different levels; within consortia, extending to local hospitals, and including other sectors. Participants explained that: *"we've had some great conversations and developed some great partnerships"* (M2); *"[a benefit is] services coming together, talking and building relationships"* (M3); with an *"amazing amount of shared knowledge"* from people and agencies working collaboratively (M1). It was also noted that, *"we have a large consortium and reform has forced agencies to collaborate"* (M2).

Continuity of care

One aim of the reform, to support client flow through the sector, was well regarded. In one metropolitan forum it was noted that, *"the intent of the reform in addressing the compartmentalisation within AOD is positive"* (M1), while participants in another metropolitan forum reported that their service provision had improved:

> *For some clients, many services are more accessible – you can get something local to you much more easily as we have made an effort to spread ourselves geographically – more accessible (M3).*

Consortium members at one rural forum felt that there is now scope to undertake extensive treatment planning that sometimes involves multiple providers. This is followed by a measured and specialist orientation to treatment and support provision that is tailored to client need. This model was described as follows:

> *Clients are comprehensively assessed and then services branch out appropriately. Psychosocial factors are taken into account and treatment planning is consistent throughout the journey (R3).*

Similarly, participants from a metropolitan consortium described a considered approach to treatment planning and care coordination. Participants explained that the improvement in service operations has meant, *"agencies come together in terms of ITPs [individual treatment plans] and client management – that is a huge positive"* (M2).

Standardised assessments

Participants at most forums believed there were benefits from having a standard assessment tool. At one metropolitan forum it was explained that having the common assessment tool has meant, *"we are all speaking the same language now"* (M1). Participants from other forums expressed similar views:

> *[The] assessment process was fragmented before the reform […] The new tool is an excellent tool with lots of appropriate appendices. It incorporates ABIs [acquired brain injury], gambling, dual diagnosis etc (R2).*

> *The assessment tool is a positive– there is now consistency and [the process] ensures assessments are completed (M3).*

Improved clinical governance

The onset of major change through recommissioning has prompted some agencies to modify and improve their clinical practice. In one metropolitan location, regular clinical reviews involve multiple providers, including those from other sectors at times. As such, there is an opportunity for professionals to learn from each other and to develop targeted care pathways. This development was described as follows:

> *Clinical review process – a process for formally presenting and reviewing AOD assessments and discussing the client's preliminary treatment plan and pathway (M3).*

At another metropolitan forum it was reported that clinical supervision is now in place and there has been a useful separation between management duties and clinical practice:

> *Improved clinical governance, firmer guidelines around clinical work…the quality has improved (M2).*

The principle behind Care and Recovery Co-ordination

Participants were supportive of the intention behind the Care and Recovery Co-ordination (CRC) service type; to provide extensive and long-term care for the most complex clients and enable treatment progress, an approach which was described as "*fantastic and really important*" (M3). The potential benefits of the role were raised, for example: "*particularly while waiting for detox and rehab – it has potential and is evolving*" (M1). Similarly, in one rural location it was noted that CRC is a "*handy point of referral – intake and assessment can refer to CRC workers while they're on waiting lists for rehab*" (R4).

However, there was some confusion about the CRC role. Participant discussions suggest that the role is being configured according to local service needs (and gaps) and influenced by past ways of operating. The situation is further complicated by the perceived inadequacy of the funding for CRC and the allocation of AOD Supported Accommodation[3] beds to the service. This area needs attention, to support the integrity of the CRC model and to adequately configure and cost AOD Supported Accommodation.

Catchment-based planning

While it was generally acknowledged that catchment based planning is in development (with plans due for delivery shortly after the forums), the intention of this resource was well regarded. For example, participants at two metropolitan forums said that, "*catchment based planning is a standout, particularly in its potential*" (M1) and, "*catchment based planning is a positive*" (M2).

[3] AOD Supported Accommodation is sometimes termed 'AOD transitional housing' however, we have used the historically relevant term as it was used in the forums.

Key points

- The process of reform has been very challenging and limited benefits were identified
- Participants in rural forums generally focused on challenges
- Some metropolitan agencies and consortia have implemented improvements, particularly in their approaches to treatment planning
- Benefits identified were in the areas of: relationship building; the aim to improve continuity of care; standardised assessments; improved approaches to clinical governance; the intention behind Care and Recovery Coordination, and the potential of the catchment-based planning resource

3. Major issues following reform

Introduction

As noted previously, in each forum the participants were asked to agree on the top four issues associated with the reform. Across all eight forums, this meant a possible total of 32 issues. However, some of the issues were similar and through thematic analysis it was possible to arrive at a set of eight priority items:

- Intake and Assessment (I&A)
- Treatment types and restrictions
- Professional relationships
- Workforce impacts
- Funding and Drug Treatment Activity Units (DTAUs)
- Administration and bureaucracy
- Client voice
- Evaluation

A brief note on the reduction from 32 to eight priority issues

There is some overlap between these issues, for example 'professional relationships' and 'workforce impacts'. This is inevitable given the breadth and depth of the areas involved. In addition, as the priority lists were analysed and thematically based categories were developed there was scope for each forum to be represented by fewer or more than four of the eight items (although they may have originally identified four items). For example, at one forum the top four priorities included 'DTAUs are hard to understand and unrealistic' and 'resources and funding does not match demand'. We have combined these issues into a single item that is labeled 'funding and DTAUs'. At another forum, 'pathways and networks' was listed as a priority issue, whereas we have separated these topics into two areas; 'intake and assessment' and 'professional relationships'.

Table 1 shows the items that were represented in each forum's list of 'top 4' priority issues.

Table 1. Priority issues by forum location

ISSUE	FORUM CODE*							
	R1	R2	R3	R4	R5	M1	M2	M3
Intake and assessment								
Treatment types and restrictions								
Professional relationships								
Workforce impacts								
Funding and DTAUs								
Administration, bureaucracy								
Client voice								
Evaluation								

*R=rural. M=metropolitan.

There is substantial depth in each of these items. For pragmatic reasons, we have selected the six items prioritised at more than one forum for detailed description (i.e., not including 'client voice' and 'evaluation').

3.1 Intake and assessment

The model

Intake and Assessment services (I&As) are central to the reform. Catchment based I&As are designed to be the 'front-end' of the system at local level; to be available for and undertake specialist assessments and to facilitate timely access for those most in need of treatment. According to Departmental policy, their role encompasses youth, adult, residential and non-residential, state and commonwealth-funded AOD services (see VDHHS April 2015). These I&As are funded to:

- Be responsive to all clients and their families
- Identify the clinical treatment and support needs of people with AOD concerns and the associated support needs of their family
- Deliver timely, high quality, culturally safe alcohol and drug screening and assessment for people seeking AOD treatment
- Provide brief interventions on an opportunistic basis
- Develop initial treatment plans
- Be based in locations that are easy to access, operate during business hours, and demonstrate capacity for after-hours responsiveness

- Ensure support and engagement strategies are in place for those waiting to enter treatment (VDHHS, April 2015, pp. 12-13)

Departmental policy states that the I&As are also required to work with the statewide intake service, the bed vacancy register, and with the Australian Community Support Organisation (ACSO)[4].

The issue

As shown in Table 1, intake and assessment was identified as a priority issue at every forum. The concerns raised were about the initial process of engagement and the complex process preceding treatment.

Specifically, forum participants reported that the system was more difficult to access and the referral pathway from catchment-based I&A to treatment was problematic when multiple agencies were involved. The structures introduced by the reform translate into multiple steps for treatment entry. This is of particular concern for complex clients and participants reported that there are fewer of these clients in treatment post reform. These structures also limit services' capacity to provide an immediate and meaningful response to those seeking treatment. Participants described problems arising from separating assessment from other treatments and the usefulness of a separate screen was also questioned.

After our initial analysis of the data on intake and assessment, it was apparent that some concerns were particular to rural locations. As a consequence, we have included a separate subsection on rural Victoria.

Accessing the system is more difficult

At some locations, forum participants commented that the initial step in help-seeking for an AOD problem has become more difficult as a result of the centralised intake and assessment structures; both statewide and at catchment level. Participants felt that the "*no wrong door has become every door is closed*" (M1); the "*no wrong door policy [is] gone*" (R1). They said:

> *[There is a] lack of support for clients accessing intake/assessment (R1).*
>
> *Clients are waiting for a long while on the telephone e.g., 37 minutes just for the first intake point (M2).*
>
> *Phone assessment brings a bit more of a tech savvy cohort – you need both routes into treatment to effectively service the region (R5).*

Particular issues associated with referring young people into the system are discussed later in the report, in the section on treatment types and restrictions.

[4] For a comprehensive description of the catchment based I&A please refer to the *Catchment based intake and assessment guide – April 2015 – v02 (VDHHS April 2015).*

Referral pathways

At some locations, there was discussion about the lack of referrals from the catchment-based I&As to AOD treatment services. In R5, transitional issues were at play in that new catchment I&As had to be established and there were problems with staff recruitment and the capacity to provide a response across the geographic area throughout business hours. However, when participants were asked if the impacts of transition had been resolved it was apparent that the situation has not improved. Participants said:

> *[The referral numbers] worsened in the last quarter – we aren't dealing with them [the client] at the point of initial access – we don't know about numbers calling; those who have assessment then don't follow through and drop out (R5).*

They explained that referral workers in related sectors (e.g., other community programs) and health care providers including GPs are finding it too hard to refer clients into the new system. They noted that, "*as a service provider, you try once or twice, then you give up*" (R5).

Competition for referrals has been introduced in some locations by having multiple I&As and I&As that are separate from some treatment services in the catchment. As a consequence, a treatment agency may be reliant on a separate I&A agency for referrals. This sets up a dependent situation between agencies that have and may continue to compete with each other for government funding – and if agencies don't meet their targets their ongoing viability and competitiveness is undermined. In one example from a metropolitan forum it was explained that:

> *The Intake and Assessment provider in the catchment has the responsibility to give 50% of the referrals to the partner of [the] catchment consortium – so there sets up a responsibility to either support success or failure (M1).*

In another example, from a rural forum, treatment services explained that:

> *[We are] dependent upon [the] Intake and Assessment service for [our] workload (R3).*

The situation is complicated. While there may not be any intention to penalise services by not providing referrals, there are norms around client and clinician preference as well as practicalities regarding the ease of moving from assessment to treatment. For example, referrals may stay 'in-house' because of client preference - to stay with the agency where they had their assessment and engaged with a clinician. In addition, the I&A clinician may also choose to refer internally as she/he is more familiar with the services and clinicians at her/his own agency. These practices may also involve outposted I&A clinicians, who find it simpler to refer to their host agency rather than elsewhere.

There are multiple steps to enter treatment

In the reformed system, accessing treatment involves 4-5 steps: a) screen, b) assessment, c) referral to treatment, d) (possible) wait to enter treatment, and e) treatment entry. There may also be a circuitous route to treatment, depending on the source and destination of the original referral (e.g., from a GP to an AOD treatment service, to an I&A, back to the AOD treatment service).

It was explained that the "*convoluted intake process is a barrier to service*", where there is "*a whole bunch of services unable to do their own intake and assessment, e.g., referring people out to have them referred back for treatment*" (M1). The situation was described as follows at one rural forum:

> *[There are] multiple pathways and increased steps to enter treatment. E.g., doctors refer to [a] service, who refer to intake, who refer to [a] service, then wait for treatment etc – [this is] fine for clients with good support, but not okay for complex clients with a lack of support (R2).*

In another rural forum participants said:

> *[The] service that is a pilot of Services Connect reports losing a lot of clients who are referred out to be referred back in (R5).*[5]

The complexities of identifying that someone has an AOD problem and then encouraging that person to engage in treatment have been compounded, as described in this rural forum:

> *Potential clients aren't always open and honest about their substance use. They often seek generalist services and are then referred to AOD. [But] generalist services can't refer straight into AOD without going back out through the I&A service (R4).*

In simple terms, limiting assessment to particular services has created additional steps to reach treatment. This has resulted in barriers for clients and for those referring into services as well as AOD specialist services that are funded to provide treatment.

Complex clients

Many participants spoke about the loss of complex clients from the sector post the reform and they felt this is likely to be a result of the structural changes that have occurred.

For example, they said:

[5] The VDHHS (April 2015) explained that, "some AOD clients presenting at specialist AOD services may be referred from or in receipt of case management support and care coordination from Services Connect Key Workers or Partners in Recovery workers. With the client's consent, catchment based intake and assessment services will be required to clarify the level of support provided to the client by other services."

Complex clients [are] not getting through (R2).

We are missing the cohort of clients that was our 'bread and butter' – the more complex clients (R5).

Tier 5 plus – they are not going to ring and sit through a screen. If they come to us, we work hard to support them though but some [are] not reaching the front door (M3).

The previous point about the multiple steps to treatment is borne out in these comments and in participants' reflections about what is required to navigate the system. They said:

Higher cognitive functioning clients are making it through intake and assessment and into services. Services are wondering where the more complex clients are ending up. Those clients who are able to navigate their way through the system are doing so, but those who are too complex or in crisis appear to be dropping off (R4).

The intake and assessment structures, which require stability and (in some cases) capacity to use a telephone service, and to cope with a delay between screening and assessment and treatment entry, appear to have changed the client group – away from those with the highest severity of need and toward those in need of treatment and with capacity to engage with and manage the intake and assessment processes involved. This is clearly contra to the intention of the model. At one metropolitan forum participants explained that:

I think the model is more of a mainstream model. It will work for a certain group of people but for those with more complex needs, or CALD or ATSI I don't think it will work. I don't think that it is for the whole sector [client group] (M2).

Participants in metropolitan forums who are from agencies that provide residential services explained that the delay between initial contact and treatment entry effectively discriminates against their client group, which is arguably the most severe in the treatment population. For example, participants said that:

No matter how comprehensive the assessment, or how good the engagement at point of assessment, by the time we are ready to engage as a resi [residential] service, the person has dropped away (M2).

This view was also expressed in relation to withdrawal for another client group regarded as complex:

For that group of people who are long-term heroin users – they are not going to get into any detox (M3).

Further, participants reported that within the reformed treatment types and funding amounts they are not able to use strategies that facilitate engaging people in complex circumstances who need treatment. These strategies include assertive outreach and outposting at a support service (e.g., housing). This issue is discussed further in the sections on treatment types and restrictions and on DTAUs.

The separation of assessment from other treatment

Some forum participants felt that separating assessment from other treatment modalities is a mistake, as assessment is a "*rapport building opportunity*" (M1). Others commented that, "*having a centralised point of intake is valuable, but the assessment function should sit with treatment agencies*" (R2). It is "*in assessment where you engaged, developed a rapport and built a relationship. That has fundamentally been taken away and we spend a lot of time chasing referrals*" (M2).

The lapse between assessment and treatment has particular consequences for clients. At one rural forum it was noted that, "*it [assessment] can open up too many issues and wounds for people, who are then left with that until treatment is available*" (R5).

The model was criticised more broadly in relation to the need for support when clients are waiting to enter treatment. For example:

> *The I&A service has had to reassess their systems constantly to respond to client need, particularly regarding complex clients who are on waiting lists without support (R1).*

Some participants explained that assessments are meant to take 1.5 hours to match the funding provided and meet service targets. However this puts pressure on clinicians and clients, particularly given the potential gap between assessment and treatment entry. For example, in one location it was explained that:

> *[We] need more time [at assessment] with complex clients (M3).*

The quality, completeness, and accuracy of the assessments were brought into question at some forums. There were circumstances where treatment plans were not developed, or where the plans were perceived to be more like a "*single snapshot*" rather than a "*core plan*" (R3). Further, participants identified instances where the "*client presents differently to treatment*" than the I&A and that "*AOD treatment staff do not have capacity to follow up with the I&A service regarding incorrect data/mistakes*" (R2).

It is important to note that having centralised I&A within treatment agencies / consortia was not regarded so problematically (e.g., M1 and M3 consortia, R4 outposted I&A). In one consortium, which provides I&A along with other treatments, a tailored model has been developed that includes a clinical review process to establish a treatment plan and pathway. This involves:

> *A process for formally presenting and reviewing AOD assessments and discussing the client's preliminary treatment plan & pathway. This process ensures a range of clinicians have input into the development of a case plan. Attended by clinicians from various roles and skill-sets and experience (not just assessors but might include non-resi nursing staff) and is overseen by the Clinical Consultant role. It ensures the client's assessment and plan is reviewed by various clinicians rather than just one assessor. Sometimes other service providers attend and may walk away with a client (M3).*

It was explained that, "it [clinical planning and review] is not a product of the reform per se, it happened previously but only in some catchments" (M3). This example is consistent with an earlier perspective about the potential benefits from having a central point for intake and assessment but not if it is separate from treatment providers.

At another agency, which provides many different treatment types but *not* I&A, it was suggested that:

> *Maybe this will be the great hope – someone sits down and does an assessment and that follows them… but clients are not experiencing that. They are being told to go through various processes. With the old system the benefit was you [AOD treatment staff] engaged, you were known to the client" (M2).*

For residential withdrawal and residential rehabilitation, the medical module of the assessment needs to be completed prior to admission. This generally falls to the residential service rather than the I&A service. In some instances 'work arounds' have been introduced, for example where a residential withdrawal worker goes to an I&A service to complete the assessment or where an I&A worker goes to a hospital to complete an assessment involving a patient already medically assessed as having AOD problems. However these modifications to the I&A model may not be the best use of resources or the most obvious and effective way of providing adequate assessments.

The screening and assessment tools and their administration

It is difficult to separate concerns about the intake process from commentary about the standardised screen. One issue that combines these concerns is about the impact of administering a formal screen at first point of contact with the potential client. This was widely regarded as problematic because it is not welcoming - and because the formal screen is not necessary.

At one forum, it was noted that the screening process is *"unwelcoming, disengaging"* and that the tool *"is a non-welcoming way we welcome people to the system"* (M1). At another forum it was explained that, *"I question the validity of an eligibility screen. I think it could be done away with – most people calling are wanting help"* (M2). Forum participants were clear that an adequate screen would

involve 'three or four simple questions' that would be followed by arrangements for an actual assessment.

As noted previously, having a standardised assessment tool was regarded positively but having to administer this formal process at the first point of meaningful engagement and get through the assessment in a single session was seen as a problem. For example, participants noted that the assessment modules *"were designed for treatment providers to use over 3 or 4 sessions, but the I&A service assessors have to fill the information out in 1 sitting"* (R2).

The tiered model on severity of need

Using the tiered model on severity of need to determine treatment eligibility was seen as inappropriate to the sector, in terms of limiting engagement when people seek help and denying the opportunity for intervention before people's risky alcohol and other drug use becomes entrenched. There was also concern about (mis)using what is essentially a system planning tool as a way to categorise and triage potential clients. At one forum it was explained that:

> *The concept of the tiers is problematic. In practice, people who contact AOD have clear problems and need AOD treatment. Not many people contact AOD when they don't have an AOD issue (M1).*

Similarly, participants at another metropolitan forum (M3) felt that the tiers should not be used as a way to make decisions about directing people toward / away from treatment.

Rurality

Centralised intake and assessment appears to be a poor fit with the realities of service provision in rural areas. This concerns both statewide screening and catchment-based I&As. At state level, intake clinicians do not necessarily understand the distances between services (and telephone assessments may not be appropriate). At catchment level, it may be difficult to provide an accessible I&A service across the geographic expanse involved, and participants raised concerns about workforce capacity and service viability. Further, it was felt that clients and communities have strong expectations of AOD services and do not appreciate that these services may no longer be available because of structural change.

Another point of variation for rural areas is the level of service integration and networking that has been established in some locations, which means that health and social services operate in a complementary manner. This approach is a good way of accounting for the limited services available across health and community welfare portfolios, however it appears that this integration has been compromised as a result of sector reform. These issues are explained below.

Integrated models of care

Where AOD services operate in regional community health settings, integrated models of delivery may be in place. At one forum, it was explained that having catchment-based AOD intake and assessment has dismantled the integrated model that had been developed over many years:

> *We had an integrated model, we had a one-stop shop. All the integrated services have been taken away (R5).*

Participants at this forum described the components and workings of their model:

> *In the community health organisation there is a suite of services – family, generalist counselling, maternal child health nurse, housing…prior to recommissioning, a lot of clients were joint clients of those services. We could coordinate their needs, including AOD, especially the timing of AOD in relation to addressing other issues. Since recommissioning, the CHS has not received one referral from an I&A provider to any of those other services. There has been a real lack of partnership and working together in an integrated way (R5).*

Rural outreach

Outreach has also been a feature of service delivery in a number of rural locations. In one location, the CHS had established a regular presence in remote towns prior to recommissioning that enabled treatment access by a small number of complex clients with long-standing concerns. It was explained that these clients are no longer in the system:

> *AOD treatment services are no longer getting referrals and clients from outlying areas – [town a], [town b]…not getting referrals from rural and remote areas. Services believe this is a system issue, not about a sudden change in service user demand (R5).*

Service viability

The reform has meant substantial changes to the workforce in rural areas. This includes recruitment to establish I&A services and staff reductions in some treatment agencies. Participants identified a number of difficulties:

At one forum, it was noted that "*the reforms have spread workers very thinly*" and that the "*main service provider in* [regional centre] *went from three counsellors down to one*" (R1), which threatens the viability of the service. At another forum, it was explained that "*small agencies are disadvantaged in regional areas by DTAUs and the reporting process – [we] don't have the capacity to commit time and money required for reporting*" (R3).

In another forum, an I&A service described the challenges of having dedicated staff to cover a large area:

> *Staffing [the catchment I&A] is a big issue. [We have] one staff member covering the large geographic region of [part of the catchment]… Monday at the hospital in (a central area); Tuesday in [the East]; Wednesday in [the South East]…overnight stays are needed for trying to cover region (R5).*

Similarly, it was explained that the working hours of I&A staff do not necessarily match client needs, "the *I&A worker may work 9:30am until 2:30pm, where clients aren't generally available for assessments until later in the afternoon*" (R4).

Small towns and communities

Concerns were also expressed about community expectations and patterns of behaviour that do not sit well with the compartmentalisation of treatment across organisational boundaries. This includes both client expectations and the ways that services work with one another. The range of issues is illustrated by these comments from rural forums:

> *In a small town, clients may use one service and then expect to use the same service again next time. They're now being sent elsewhere for I&A (R3).*

> *Lots of very unwell people are walking around in the community who may have accessed treatment previously by walking in the door but don't access it now (R1).*

> *Clients used to be able to walk in and receive services on the day. Now, due to the centralised I&A service having to undertake assessments, clients have to wait (R4).*

> *The smaller the community, the harder it is for the person to get over the barriers to access (R5).*

Referral pathways and service networks

The need for catchment-based I&As was questioned as there are limited services in rural areas and service visibility is not an issue. For example:

> *In rural locations, there's generally one town with one service provider, so there's no need for centralised intake and assessment to match clients with appropriate services (R4).*

> *Hospitals don't want to refer clients out of their service, only to be referred back in (R3).*

Further, staff networks are important for enabling client access to other agencies:

> *AOD workers in smaller agencies in rural settings have to be skilled in multiple areas and build relationships with multiple agencies on behalf of their clients (R3).*

The I&A service has promoted the new system to GPs. It's a long, difficult process (R4).

Sector changes have not been well communicated and other agencies may not be aware of what is available:

We, as a sector, have to do some very strong education about what treatment is available and what sits behind the central intake service (R5).

However, treatment services are not funded to educate other providers.

Key points

- Catchment-based intake and assessment was identified as a major issue in all locations
- Accessing the system is more difficult
- Referral pathways from I&As to treatment services are problematic when multiple agencies are involved
- There are multiple steps to enter treatment
- Fewer complex clients are getting through to treatment
- The reconfiguration of the sector has created a dependent relationship whereby some treatment agencies are reliant on other (competing) organisations for referrals
- Separating assessment from treatment is difficult for clients, causes attrition and limits the quality and appropriateness of assessments and individual treatment plans
- Where I&A sits within an organisation or consortium the situation is not as problematic and some agencies have developed improved clinical models
- Catchment-based intake and assessment is a poor fit with the realities of service provision in rural areas
- Catchment-based I&As are not feasible for rural areas. It is difficult for catchment-based I&A staff to have sufficient awareness of the services available and the distances involved
- Rural outreach is not possible although this has extended reach in the past
- Integrated models of care in rural areas have been dismantled and treatment service viability is under question in some locations
- Some I&A services in rural areas have found it difficult to recruit staff and establish services because of a workforce shortage and the distances involved to provide I&A across multiple locations

3.2 Treatment types and restrictions

As noted previously, sector reform included the consolidation of services to several major treatment modalities and support functions (intake and assessment, counselling, care and recovery coordination, withdrawal, residential rehabilitation). Stage one of recommissioning focused on general / adult outpatient treatment types and I&A.

The treatment modalities are evidence based and they have been described in clinical terms and costed using the DTAU funding model. The reduction of service types is a substantial change from the more than 20 types that existed prior to

reform. Significantly, there has been a reconfiguration of the Counselling, Consultancy, and Continuing Care service type to focus more on individual / group counselling along with the introduction of 'simple' and 'complex' counselling courses of treatment. In addition, while stage one of the reform did not include youth services, the new service specifications expand the target client group for general / adult services to include clients aged 16 years and above. These radical changes, the associated costing model, and the separation of assessment from treatment appear to have restricted providers' capacity to deliver services using approaches to service delivery that they consider important.

Concerns over the treatment types and associated restrictions were identified as a priority in five of eight forums (both metropolitan and regional – see Table 1). In this section, we have described participant views on the reduction of service types, the treatment gaps that exist (particularly early and brief intervention) and the omission of particular approaches to service delivery (e.g., involving assertive outreach). We have also documented participant perspectives on optimal approaches to provide for some population groups (youth and family/significant others)[6]. We elaborate on these points below.

Perceived inflexibility of treatment types

Participants explained that their clients have complex needs and require flexible and tailored service provision that focuses strongly on engagement. They said that the revised treatment types mean it has become more difficult to engage with high needs clients and to provide flexible, responsive and tailored services. It was explained that, "*this population of service users don't always 'fit in the box'*" (R1) and that working in the reformed system is sometimes like "*putting square pegs into round holes*" (R3).

The unit-costing model added to these concerns as participants felt it was not always possible to record work in terms of DTAUs, which effectively means it is unfunded. It was noted that the system now relies on "*clinical good will*" (M3) to carry out work that is not covered by the service types.

Participants commented that complexities have arisen because the system has been only 'partially reformed'. This has meant the development of multiple pathways for treatment entry and different conditions for client groups, rather than a streamlined approach.

At several forums, participants raised concerns about the standard and complex counselling models:

> *The standard and complex prescribed sessions creates an artificial construct and reduces clinical judgement – an inflexible process (M1).*

[6] At the final forum for the project, it was noted that the VDHHS had circulated a document with activity lines for additional interventions (namely Bridging Support, Single Sessions, Brief Interventions, Family Counselling).

The distinction between standard and complex is somewhat artificial (M2).

The gap between complex services and standard services is too big. The episodes of care model was more client-centred and flexible and less artificial (R3).

Sector gaps; providing support for clients in-between and following services

Many participants identified a 'gap' in the sector's capacity to support clients on waitlists before commencing treatment – which was described as being 'in-between services'. For example, a client may require a transitional service while they are waiting for admission to a residential unit. This was sometimes called a 'holding service' that may include a regular phone call involving brief counselling or early casework. If treatment services undertake these activities there is no way to record the work as a DTAU.

This service gap was reported as impacting client retention, particularly in the early stages. It was explained that there is "*nowhere to refer clients*" and this results in "*significant drop off*" after assessment (R3). I&A participants noted that many clients require continuous support and in some locations they have begun providing 'bridging support' for those on wait lists. However, some participants saw this as problematic given the I&As are not intended to provide treatment. Inevitably, clients that have ongoing contact with a clinician will begin to form a therapeutic relationship. Then, when a treatment place becomes available they will have to sever contact with the clinician and start again.

It appeared that very few services were able to provide aftercare (i.e., support following a residential stay), which is a longstanding issue for the sector. Participants from one metropolitan consortium reported that they provide unfunded aftercare. They continue to provide this support because "*aftercare is crucial to outcomes for clients*" (M2) and because they have sufficient organisational capacity to manage the costs involved.

Treatment types

Although the service landscape was varied, it was identified across forums that clients either experience barriers or have no access to two treatment types; brief and early intervention.

Brief intervention

Participants were concerned that, post recommissioning, there has been a lack of brief intervention[7]:

The opportunistic, brief intervention stuff is gone (M3).

This was a strongly valued intervention type, and participants stressed its efficacy:

[7] Brief intervention was not part of the service framework pre-commissioning.

Brief interventions are very effective and so is family support and they are the two things that can't be offered anymore (R5).

Participants also had concerns about brief intervention being part of the I&A, as this blurs the distinction between assessment and 'other treatments' and may jeopardise the funding and legitimacy of treatment services. It was noted that I&A staff in some catchments had received training so they can begin to provide brief intervention and this potentially undermines treatment services. For example, participants explained that:

When the I&A service provides brief treatment and clients don't make it to treatment services as a result, it affects the funding of those services (R1).

It is worth noting that the VDHHS (April 2015) description of I&A includes brief intervention.

Early intervention

At almost all forums, some participants spoke about a service gap for those who are not deemed 'eligible' for specialist AOD treatment according to the new screening process for intake (that is, people deemed Tier 1 or Tier 2). In particular, participants believed that opportunities have been missed for early intervention:

The system is targeting a specific group of AOD clients and leaving a lot of people out who have the potential to become high-risk clients (R1).

No funding for early intervention, e.g., education, low risk management (R4).

Participants from one agency reported having undertaken consultations with meth/amphetamine users and they emphasised the importance of early intervention for this cohort, stating that these individuals "*needed intervention at the point where they were partying*" (M2) rather than waiting for serious drug-related problems to develop. Participants emphasised that the new system should not have been set up to 'screen out' individuals, but should cater to the needs of all those who seek treatment.

We are losing early intervention – we have never had exclusion criteria before e.g., technically early intervention gets screened out or people who are early relapse or risk of relapse (M1).

No longer do we work with pre-contemplative or contemplative clients unless they are forensic (M2).

It was noted that the new system is configured so that there is increased reliance on GP networks and the private health system (e.g. psychologists, psychiatrists) to 'pick up' clients with low level needs. However, participants expressed a lack of confidence in this approach – both in terms of client access and the provision of an adequate response. For example, in one rural forum it was noted that:

GPs are not providing adequate early intervention strategies (R4).

Approaches to service delivery: assertive engagement and outreach

At multiple forums, participants reported that services were no longer funded to assertively engage clients and to provide outreach services. As a result, clients who do not typically approach services are no longer accessing treatment.

As noted previously, this was a particular concern in rural Victoria. Participants from one rural area reported:

> *Counsellors no longer have capacity to conduct outreach…Ongoing, assertive engagement isn't funded but it should be (R1).*

A similar view was expressed in another rural forum, where it was explained that, "*outreach is a necessary part of the model in this area*" (R5). Participants at this forum explained that the lack of outreach has reduced the visibility of their service, impacting on clients because poor visibility weakens partnerships with other services:

> *A lot of work was done previously via outreach – this gave the services a face and a lot of work was done reaching out to health and community services and the community in general, building relationships and trust. E.g., GP clinics in the region had very good relationships with [the] local AOD service due to [the] non-resi nursing role being the 'face' of AOD. Many referrals were received that way. Post reform, referrals to non-resi have been very slow and 'repeat' clients seem to have disappeared (R5).*

The need for outreach was also raised in a metropolitan forum, in reference to having a focus on harm reduction and to enhance the accessibility of treatment for complex clients. Participants at this forum explained that:

> *I think the reform has targeted the middle of the bell curve – highly marginalised, young, complex, homeless – it doesn't fit. We used to have outreach services that used to engage with people in their environments (M3).*

Specific client groups

Many participants spoke about their limited capacity to work with family members / significant others - although this was originally a goal of the reform. Further, the 'partially' reformed system has negatively impacted services for young people.

Participants across both metropolitan and regional forums spoke about how the current funding model does not account for working with families. For example:

> *A number of people call intake and assessment services to talk about their children etc and providers aren't funded to deal with them (R1).*

The second stage of system reform was to encompass changes to youth services, however the second stage has not occurred. Participants reported that stage one of the reform has impacted young clients because access is more complicated and there is an understanding that general / adult services are equipped to provide for younger clients, although this may not be the case.

In one forum it was explained that young people are now screened by staff who are trained to work with adults (as clients call a central number) and therefore they may not receive a 'youth-appropriate' service at the point of initial engagement (M1). Participants from other forums also identified the inadequacy of the standard I&A model:

> *Young people – [the] 16-21 age group has been included in adult system but we know young people don't engage in the same way as adults (M3).*
>
> *Young clients aren't always prepared to call the intake number or wait on the phone (R2).*

Some participants felt that while young clients may not be AOD dependent they still require a service (R3), a concern that overlaps with the earlier point about early intervention. This is a potential issue in a system where the trigger for access is AOD dependency. Further, the partial recommissioning has been confusing for providers such as GPs (as noted elsewhere). Staff in one rural location spoke of GPs being confused about "which phone number" (R2) to use when seeking to refer a young person. There was a similar view expressed in another rural forum:

> *GPs etc [i.e., other primary care staff] are confused about the entry points and whether they apply to youth (R1).*

AOD Supported Accommodation

It was noted that the complexities of AOD Supported Accommodation were not addressed in stage one of the reform, with the ultimate decision being that the CRC would be responsible for this service. The majority of forum participants felt that this arrangement was problematic. At one metropolitan forum a provider described the ongoing problems in attempting to deal with the AOD Supported Accommodation properties. Participants at another forum commented that "*it was an after-thought in terms of system design*" to link AOD Supported Accommodation to the CRC and that "*agencies have inherited clients and beds that are part of a different system*" (M2).

Some participants reported not having the necessary resources to integrate AOD Supported Accommodation into their service. This was the case in some regional areas, where it was reported that AOD Supported Accommodation was not currently being provided – even though housing had been allocated.

Further, in areas where AOD Supported Accommodation was provided the CRC role was sometimes subsumed. For example, participants at one metropolitan forum explained that, "*care and recovery workers are overwhelmed having to take on supported accommodation clients*" (M3). At another metropolitan forum participants said, "*the CRC role gets swallowed up by supported accom – 'Pac Man' like*" (M2).

Key points

- The restriction of treatment types, combined with the unit costing model reduces clinician flexibility and responsiveness
- Gaps in the system include support services when clients are waiting to get into treatment, a lack of early and brief intervention, restrictions on assertive engagement and outreach, and concerns about services for young people and work involving families
- AOD Supported Accommodation needs attention to ensure the viability of the model

3.3 Professional relationships

At five forums, concern about professional relationships was identified as a priority issue. Participants most commonly raised the following points: disruption to relationships; communications involving I&A; and a lack of VDHHS leadership to communicate with other systems (and within AOD) regarding new arrangements. These areas are described below.

Disruption to professional relationships

In one rural forum, participants described a "*disruption to professional relationships*" (R2) that has arisen from the change process and the shift in resources and roles. They explained that this has impacted very strongly on referral processes - both in and out of AOD services. For example:

> *Reforms have adversely affected numerous networks that existed. The connection between services has disintegrated quite markedly (M3).*
>
> *A lot of work was done previously via outreach – this gave the services a face and a lot of work was done reaching out to health and community services and the community in general, building relationships and trust….Many referrals were received that way (R5).*

Participants explained that while professional relationships were not perfect before the reform, they were generally able to overcome the challenges involved; "*we made it work*" (R5). However in the reformed system the situation has deteriorated.

There was a level of anxiety about funding and an acknowledgement that this has put considerable strain on the relationships between services – particularly in rural areas. For example:

Consortia equal a loss of funding and fragment[ed] sector relationships (R1).

[There are] resilient relationships and good will amongst the sector however, [there is] anxiety about money (R3).

As described previously, the dependent relationship - whereby a treatment agency relies on referrals from the I&A in a separate organisation is an ongoing issue. This is true for many parts of rural Victoria and for metropolitan treatment agencies that do not provide I&A.

Intake and assessment

Participants from a range of locations and agencies identified challenges associated with having a new service in the sector (I&A) and the need for communication networks and agreed ways of operating to be established. In some locations, there was an interest in developing protocols for communicating with I&As.

One challenge to professional relationships in rural areas involved errors or omissions in assessments and a lack of process to communicate about the quality of assessments. While some I&A participants felt that treatment services should let them know of any problems, participants from treatment services felt they did not have sufficient capacity – especially in the context of reduced funding and staff. For example:

[We] need to consider workload / capacity of AOD staff. Do they have time to call the I&A? (R2)

These challenges were described as particularly important for rural Victoria. A participant with knowledge of rural services suggested that:

In metro, there were winners and losers but we knew each other and had relationships [whereas] in some regional areas – [the] new I&A provider came in and didn't have those relationships (M3).

Attempts to address this issue were also identified, for example it was explained that, "*the I&A service is trying to work with what they've got and build relationships as best they can*" (R1).

Leadership from VDHHS

Some participants expressed an interest in the development of better lines of communication between the Department and services, and for the Department to take a role in communicating sector changes to other systems. At rural forums, participants identified a need for "*communication and promotion by VDHHS outside AOD*" (R2) and expressed some disappointment at the Department's limited contribution. They said, "*it's a shame that we are 12 months down the track and there has not been some sort of cohesive leadership from the Department*" *(R5).*

Further, at a metropolitan forum there was a call for *"relationships between different areas (mental health, dual diagnosis)"* to be clarified (M3).

Key points

- Professional relationships have been disrupted as a result of the change process
- The introduction of a new provider (I&A) requires strategies to establish good communication and protocols
- Leadership from the VDHHS should include attention to good lines of communication with AOD services and referral agencies

3.4 Workforce impacts

Negative impacts on the workforce were identified as a priority issue at four forums (R1, R5, M1, M3). Forum participants discussed several areas:

- The impacts of uncertainty and change on the AOD workforce
- Perceived 'de-skilling' of the AOD workforce
- The impact of separating I&A from treatment
- Staff qualifications and professional development

These areas are explored below.

The impacts of uncertainty and change

In many forums, staff fatigue, stress, and burnout were raised as significant issues that threatened the stability of the workforce. To some extent, this was about the protracted and uncertain nature of the recommissioning process, as explained at one forum:

> *We should not discount the amount of harm that the uncertainty of recommissioning has had on staff. It was emotionally really difficult. It took a toll and we are still feeling it now (R5).*

The redistribution of funds and new service specifications and targets were perceived as placing ongoing pressure on staff:

> *We are asking people to do more with less. There has been layer upon layer of stress for staff and there are some incredibly passionate and dedicated people in this sector who have just kept working and done whatever is needed (M2).*

Forum participants in some rural areas were concerned about staff wellbeing, retention, and their capacity to attract new workers. The Aspex review was seen as pivotally important for the future of services. It was explained that:

> *We are all waiting to see what comes out of the Minister's Review because if nothing happens then a lot of people [staff] will leave (R5).*

Perceived 'de-skilling' of the AOD workforce

In the majority of forums participants described a loss of experienced staff from the AOD sector during the process of reform, involving an "exodus of skilled workers" (M1) and a "loss of qualified staff" (M3). Poor staff morale is an ongoing concern in parts of rural Victoria, with participants suggesting that:

> *Staff are unhappy and want to leave the sector, [they are] unhappy with the reforms and the new system (R5).*
>
> *Workers who do have the experience are leaving the sector due to burn out (R1).*

Some forum participants reported that they lost staff due to reduced funding for treatment and uncertainty about long-term funding arrangements. In one metropolitan forum it was reported that an agency lost three key workers because of funding changes and in a rural forum an organisation reported losing four equivalent full time positions.

In most areas it was reported that staff recruitment had been slow. This was reportedly a greater challenge in regional areas:

> *Recruitment in the region has always been a challenge, but it has worsened since recommissioning (R5).*

Participants in multiple forums mentioned numerous implications of the loss of experienced staff from the AOD sector, including less access to quality supervision and clinical supervision and loss of management experience.

Impact of separating I&A from treatment

Another issue related to de-skilling was the impact of separating the workforce into two groups: I&A and treatment. Participants noted that staff were becoming de-skilled in the critical area of providing assessments, commenting that "*we are de-skilling clinicians*" (M1). At another location, participants argued that assessment is one of the "*highly skilled parts of the system*" (M3). Accordingly, they felt it was important to have specialist AOD staff undertaking assessments.

Participants felt that treatment providers have reduced capacity to use their judgement in deciding on treatment pathways for their clients – they have lost clinical autonomy. This was seen as a result of having a separate staff member (often outside the agency) undertaking assessment. More generally, some forum participants believed that the system was overly rigid and dictatorial, in terms of "*how they can and can't operate*" (M3).

Staff qualifications and professional development

Participants in the majority of forums expressed substantial concern about workforce sustainability and the lack of professional development opportunities post reform. In

particular, there has been no opportunity to upskill and participate in training. More specifically, some participants mentioned that there had been no up-skilling in youth AOD issues or providing youth-specialist responses following the expansion of services to include younger clients (16 years and older):

> *We cannot say the Department has invested in [the] sector's workforce. On 1 September [we] went from an adult system to a 16 years plus system and twelve months on we have not had any investment in the workforce needs in the area (M3).*
>
> *No particular development to up-skill workforce for 16 plus age group (M1).*

Participants in many forums felt that the minimum qualification for the workforce (Certificate IV) was inadequate, although there were mixed views on this issue. Some participants believed that Certificate IV was sufficient, particularly when staff were experienced. Others spoke about how the de-funding of Certificate IV and graduate programs meant there was little opportunity for staff training and development. Participants in all forums wanted qualified professional staff; however, they acknowledged that salaries awarded in the sector do not necessarily attract individuals with university level qualifications. For example, at one metropolitan forum it was noted that, "*it's a very difficult and complex job we do but we are funded at Cert IV level*" (M1).

Participants also described how career pathways in the AOD system were "*unclear*" (R2) and this has decreased the likelihood of attracting quality staff to the sector.

Key points

- Staff wellbeing has been negatively impacted by the nature of the sector reform process
- There has been an exodus of skilled workers and it has become more difficult to recruit staff in rural areas
- Separating I&A from treatment is not helpful as assessment is a highly skilled activity and all clinicians should have experience in this area

3.5 Funding and Drug Treatment Activity Units (DTAUs)

Funding and DTAUs were raised as a 'top four' issue at three of eight forums (M1, R2, R5) and discussed by groups in all forums. Participants discussed the following aspects of this issue:

- DTAU funding amounts are unrealistic and treatment definitions are too narrow
- There is confusion about how to translate DTAU funding amounts into models for service delivery
- The cost of maintaining consortia
- The interdependence of agencies

These issues are discussed below. The reader will note some overlap with previous sections. The focus in this section is on data specific to DTAUs and financial resources.

DTAU amounts are unrealistic and treatment definitions too narrow

Participants in all forums indicated that the funding for DTAUs was insufficient and, in combination with the narrowly defined treatment types, it has been difficult to maintain the quality of their work and to meet funding targets. Participants said:

> *DTAUs are unrealistic: even if you are operating at capacity the DTAUs make it difficult to reach targets and do good clinical work. [We] need [a] reduction in number or [an] increase in [the] value of DTAUs (M2).*

It was also noted that DTAUs do not cover the 'gaps' in client work that exist outside specific treatments and the 'non-clinical' work that is part of the worker's role. Participants said:

> *Any work outside of direct clinical work is not accounted for. Why can't we claim for anything outside of direct services (M1).*

This point is relevant to support work that may lead to a clinical encounter or result in a different course of action for potential clients (and their families). For example, a participant at a metropolitan forum described a situation where she spent six hours with an individual in crisis, contacting a mental health crisis team and the police and completing associated paperwork, but then being unsure of how to record this work. She made a decision to provide the work based on the individual's need, while recognising that this penalised the service financially as a day's work was effectively 'lost'.

Participants also commented that the system does not account for clients who do not take up appointments, which is a common occurrence.

The continuing anxiety about funding was evident in participant discussions about DTAUs and the risk of future cuts to services if DTAU targets are not achieved. Participants explained that:

> *Money will be lost if DTAUs [are] not met and this is putting pressure on agencies (M1).*

Confusion about DTAUs

It was common for participants across forums to describe DTAUs as confusing and complex. It was mentioned that they are *"hard to understand", "hard to count", "inflexible"* and that they do not take agency variations into account (M1).

Participants in many forums mentioned that they would like clearer communication and guidelines about DTAUs from VDHHS, consistent with the point raised previously about seeking leadership. For example, they said:

[We] are unsure about [the] basis of targets [for] DTAUs – no communication from Department (M3).

[There have been] mixed messages from the Department about targets and moving money… No clear guidelines & no clear direction from the Department - for example, 'this buys this' (M1).

[The] complexity of DTAUs has caused some problems (R1).

It was clear that agencies had grappled with learning and adapting to a new funding approach, which was described in one forum as "*a business model*" (M1). Some agencies, particularly those in rural areas and with limited staffing, spoke about having limited administrative and reporting capacity to respond to changes in the funding formula.

Cost of maintaining consortia

Participants were concerned that DTAUs do not account for the extra costs associated with maintaining quality services involving multiple collaborators:

We didn't factor in as a cost the work required to work in consortia – build relationships (M2).

In addition to meetings and administrative costs, participants noted that funding was not available for management and workforce development, including planning, evaluation, and staff training. Though important, these areas were not as strongly emphasised as activities related to direct service provision - perhaps because of the importance placed on client care and possibly because the effects are likely to be fully realised only over time.

Interdependence of services

Across all forums participants emphasised that the process of reform was a stressful experience because of the redistribution of funding and the loss of funding in some agencies. Participants described being in competition with other services and simultaneously in dependent relationships with them as they grappled to form partnerships. The uncertainty of the funding environment meant that agencies were unsure if they could completely trust or rely on other each other – given that they were not sure if they would be competing for funds again in the future.

Participants in some forums described a dynamic whereby services who were competitors in funding bids during the reform process are now reliant on one another for client referrals. For example:

A decrease in referrals may result in a decrease in the funding base and agencies feel powerless – the accountability sits with the intake provider (R5).

They described how, coupled with uncertainty about job security, this was a difficult environment for staff in the sector.

Key points

- DTAU funding is insufficient and there is no allowance for non-clinical work or for the time needed to maintain good relations with consortia partners
- Contractual changes have resulted in some organisations being dependent on competing agencies for referrals

3.6 Administration and bureaucracy

The issue labelled 'administration and bureaucracy' is about changes in administrative requirements following system reform. This issue was identified as a forum wide priority in three locations and discussed by a number of groups in both metropolitan and regional forums.

Participants commented that the reform has resulted in additional administrative demands, for example:

> *Extra admin requirements – ADIS – Penelope – DTAU formulas (R1).*
>
> *Doubling up of admin – intake and assessment v treatment….No common database….Doubling of 'systems' across consortiums (M1).*
>
> *Greater emphasis on notes, admin and risk – pushing AOD into medical (M2).*

These issues were accentuated in rural areas, where some services have lost staff and where multiple databases may be in use because of the integrated nature of service delivery. For example, in one rural forum it was noted that "*[we] don't have the capacity to commit time and money required for reporting*" (R3). At another location the situation was described as burdensome because, "*multiple reporting systems are in operation; doubling & sometimes trebling the workload*" (R5).

There was an identified need for a common database and a mechanism for services to share client information across locations. As noted at one metropolitan forum, "*there is no statewide or catchment wide database that we can properly track a person through from assessment to non-resi, counselling, etc, etc*" (M3).

The situation is further complicated by the partially reformed system, which does not include residential services. It was explained that:

> *The big issue is the interface between commissioned and non-commissioned services, particularly residential services. There is lots of grey around responsibilities and it translates into confusion for clients (M2).*

Key points

- Administration and bureaucracy has increased
- There are multiple recording and reporting systems
- There is confusion around the interface between recommissioned and non-recommissioned services

4. Directions

This section is about directions to address the issues that have been described in this report, based on the perspectives put forward by forum participants. Given the study limitations, these suggestions need ratification through the examination of other research – particularly on client characteristics (severity of need), throughput and attrition and with input from practitioners on the realities of service provision in community settings. We appreciate that the Aspex report has recently been released and it should be a valuable resource to inform planning for system development. In addition, the national review of AOD treatment services (Ritter et al. 2014) includes information on system planning, purchasing, and accountability that is relevant to the areas covered in this report.

The over-riding message from our work has been the need for urgent attention to address negative consequences of the reform. The most critical element in any assessment of system development is actually whether the client's experience of accessing and receiving treatment is positive and successful, from the first point of contact onward. We suggest that a structured approach to obtaining client input is required to add to perspectives obtained from this project and other sources of information identified above.

The final part of this section is a brief reflection on *how* to move forward, with recognition that major change is difficult and that positive working relationships are important to the successful identification and implementation of the changes sought.

4.1 Issues and suggestions

This project has focused on major issues arising from the reform that have been prioritised as in need of attention. The table below provides a brief description of suggestions to address these issues.

Table 2. Major issues arising from the reform and allied suggestions

Priority issues and allied suggestions for change
1. Intake and assessment • All contracted AOD agencies should have capacity to provide intake and assessment, to enable system access and support a timely process for treatment entry. • All I&A agencies should provide at least one outpatient treatment type so there is scope to build on the initial engagement with clients and to streamline treatment entry. • The process for determining people's eligibility to treatment based on the screen and the tiered framework needs review to ensure neither approach is a barrier to providing a meaningful response to those seeking help for an AOD problem. • Complex clients are the primary target of specialist AOD services and their access to treatment should be facilitated by funding and accountability

arrangements that support engagement, including flexible modes of service delivery. This will include outreach, particularly in rural areas, and require service targets that account for the time required to engage, retain and support complex clients to make treatment progress.
- Regional and rural AOD services / systems are shaped by local conditions and need a tailored approach to planning that includes recognition of variations in treatment modalities to account for the network of services available and the geographic and social conditions involved.

2. Treatment types and restrictions

- The reform involved reducing service types to evidence-based treatment modalities and included scope for agencies to develop their own service models. However, it has been difficult for adequate models to be developed based on the limited DTAU funding available and the service targets put forward. This is particularly the case for 'Standard' Counselling courses of treatment and Care and Recovery Coordination. The DTAU funding amounts need review to ensure all treatments are viable. The evidence-based treatment modalities need attention to ensure that non-clinical, but fundamental, elements of engaging and supporting clients are acknowledged (and thus funded).
- Brief intervention has a strong evidence-base and it should be included as an outpatient treatment modality.
- Family support should be acknowledged as a legitimate service activity and adequately remunerated.
- Youth services need tailored models to address engagement and retention challenges that are important for this cohort.
- CRC services have experienced difficulties because of a mismatch between expectations and funding and due to the inclusion of AOD Supported Accommodation. The CRC model and funding needs review. AOD Supported Accommodation should be addressed separately, with consideration of the actual needs of the client group and the associated level of support that is required.
- Finally, harm reduction has been excluded in the reform although it is evidence-based and improves people's health and well-being, while offering a pathway into treatment for some. The decision to exclude harm reduction from AOD treatment is likely to be impacted by the limited funding available and the importance of maintaining the specialist nature of the system. Harm reduction should be recognised and funded in its own right.

3. Professional relationships

- Trust and cooperation are important for a strong and sustainable community sector and they will be facilitated by clarity about future funding arrangements and strong lines of communication with the sector.

4. Workforce impacts

- The reform has disrupted professional relationships between AOD agencies and between AOD agencies and referral organisations. Workforce development strategies should support collaborations, partnerships and linkage development. Strategies for agency coordination may also be beneficial.

5. Funding and DTAUs

- The DTAU funding amounts are largely regarded as inadequate and restrictive. Service specifications need to incorporate non-clinical elements of treatment courses and the funding formula needs review.

6. Administration and bureaucracy
- Multiple reporting systems are in use, which is contra to the intent of the reform and difficult for agencies. A standard reporting system that is about service activities (outputs and client characteristics) is required.
- Separate from this, outcome measurement would be valuable to allow the demonstration of treatment effectiveness using agreed goals. Short term goals would address distinct service encounters (e.g., engagement, retention, referral) while longer-term goals would address client progress – possibly across multiple courses of treatment and agencies (e.g, behaviour change, social reintegration).
- Outcome measurement is not about purchasing but about demonstrating system effectiveness and this information would provide a valuable foundation for sector planning and development.

4.2 Processes for change

The reform of Victoria's AOD treatment sector was a bold initiative that followed a long period of major policy inaction. There was extensive preparation and planning to inform the proposed changes, including working groups and review projects. In contrast, there was limited time between the finalisation of approved providers and the planned date for the reformed system to commence (Berends & Ritter 2014). The protracted nature of the change process and the uncertainty this created for services, along with inadequate communication, the open tender approach and the multiple steps in decision-making around recommissioning have meant that the conditions for change were far from ideal (see Berends & Ritter, 2014 for details).

Added to this is the reality that introducing a separate catchment-based intake and assessment function in a no-growth environment has effectively reduced the budget for treatment services – particularly those that do not offer I&A. The situation is pronounced in rural Victoria, and there is the added complexity of few services, limited workforce availability, and long-standing ways of operating both within AOD and in community health.

A further complication is the difference between demand for treatment and the availability of places. Recent work at national level has estimated that demand for AOD treatment is significantly higher than treatment availability (see Ritter, et al. 2015, Chapter 8) and this places pressure on government and services, as well as those seeking an immediate and meaningful response when they approach an AOD service. These issues are difficult to reconcile.

Academic scholars have suggested that a neo-liberal approach to administering public services does not work well when complex social challenges are involved (O'Flynn, 2009; Stenius, 2011). Instead, a 'public value management' approach, with its emphasis on strong relationships between policy and practice stakeholders, trust through quality services, and collective (public) preferences (O'Flynn, 2007) provides

a stronger foundation for positive change[8]. However, this process is resource intensive and involves active cooperation and shared problem-solving to deal with difficult decisions about resource allocation and related areas. This is a substantial commitment that requires appropriate resourcing.

Addressing the issues identified in this report is critical. The first step is to consider our findings in concert with those from the Aspex report and other relevant sources of information. Next, a working group should be developed that combines expertise from policy, practice, and academic realms to enable a sound understanding of the issues and constraints involved and to problem-solve collaboratively. This may include sub-groups for particular service types and locations, to support the development of appropriate strategies. Attention to implementation planning and monitoring the changes made will be essential. Finally, planning will need to account for the partially reformed sector by explaining the relationship between these services and services that have not been subject to reform.

[8] The reform process in Western Australia provides a useful illustration of a collaborative governance approach to system change (see Berends et al. 2015)

5. Summary

The project

Major reform was implemented in Victoria's AOD treatment system on September 1, 2014 and this study documents service provider perspectives on benefits of the reform and major issues that have arisen, one year on. Forums were held in eight locations around the state and a total of 131 people took part. A nominal group technique was used and data were analysed thematically.

Benefits

When asked to reflect on benefits arising from the reform, the most common initial response from participants was silence. The response was particularly negative at rural forums, where the discussion quickly moved on to challenges.

In metropolitan forums, some participants describe specific improvements to service operations while acknowledging that both the process of change and shortcomings of the reform itself had been challenging.

We identified a number of benefits from the analysis of participant responses:

- Relationship building ~ in areas where new service constellations have been a product of recommissioning
- Continuity of care ~ praise for the intention to improve continuity of care in the sector, although improvements have generally not been realised
- Standardised assessments ~ support for having a standardised approach so that client information can be shared across treatments
- Clinical governance ~ an opportunity to improve internal operations in tandem with the recommissioning changes
- Care and recovery co-ordination ~ support for the intention of the model but not for how it has been operationalised
- Catchment-based planning ~ support for having dedicated resources for planning; a recognition of the potential benefit from this investment

Issues

The analysis of priority issues identified in each forum led to the identification of eight items that were represented at one or more forums. These items were: intake and assessment; treatment types and restrictions; professional relationships; workforce impacts; funding and drug treatment activity units; administration and bureaucracy; client voice; and evaluation. The six issues that were prioritised at more than one forum have been explored in detail.

Intake and assessment

Intake and assessment was identified as a priority issue at every forum. The concerns raised were about the initial process and the multiple steps needed to get to treatment. There were particular concerns for complex clients and in rural areas.

Specifically, participants reported that the system was more difficult to access and that the referral pathway from I&A to treatment was problematic when multiple organisations were involved. Initial contact has become more difficult and it is not engaging. At some locations there has been a notable lack of referrals from I&A to treatment services and other referral services have been experiencing difficulties *("as a service provider you try once or twice, then you give up")*.

The reform has created competition for referrals across agencies and in some locations treatment services are dependent on other organisations for referrals. This sets up a relationship whereby an agency is dependent on a competing organisation for their workflow *("we are dependent upon the intake and assessment service for our workload")*.

The multiple steps to enter treatment include initial contact, screening, assessment, referral to treatment, a possible wait for treatment, and then treatment entry. This journey is sometimes more complicated, for example when a GP refers to an AOD treatment service that must then refer the client to the I&A who may then refer them back to the AOD treatment service. Some clients are not getting through these multiple steps and there has been marked reductions in the proportion of complex clients post the reform *("services are wondering where the more complex clients are ending up")*.

At some forums concerns were raised about the quality of assessments and whether individual treatment plans were completed (or appropriate to client need). An associated concern was whether it was feasible to complete an assessment in one sitting, with limited time *("we need more time at assessment with complex clients")*.

Separating assessment from other treatments was seen as a mistake, both in terms of the lost opportunity to build rapport with the client and the lapse between assessment and treatment. Where organisations / consortia provided I&A themselves (or through an outposted I&A) this was not so difficult – as continuity of engagement and treatment planning was more feasible.

Centralised intake appears to be a poor fit with the realities of service provision in rural areas, both in relation to the statewide screening and catchment-based I&A services. Further, the reconfiguration of the system has disrupted long-standing models of integrated care, limited the capacity to adapt models (i.e., for outreach), and brought service viability into question with the reduction in funding for treatment clinicians. The need for centralised I&A in rural Victoria is questionable *("there's generally one town with one service provider"; "clients who may have accessed treatment previously by walking in the door but don't access it now"*). It appears that the importance of health and support service networks and ways of working have been overlooked *("AOD workers in smaller agencies in rural settings have to be skilled in multiple areas and build relationships with multiple agencies on behalf of their clients")*.

Treatment types and restrictions

Forum participants felt that defining treatment in terms of five modalities restricted practice flexibility and responsiveness. In combination with the constraints of funding targets and unit costing, this has meant that not all work can be reported.

There are support gaps in the system, when clients are 'in-between services' and requiring 'bridging support'. This results in "significant drop off" after assessment. Some I&As have started providing interim support however this means the distinction between assessment and treatment is blurred and there are concerns that this undermines the role and legitimacy of treatment services.

Service gaps include early and brief intervention along with assertive engagement and outreach. Supported accommodation has not been sufficiently addressed in the reform and CRC workers in some locations have been overwhelmed by the workload required. Other services have been reluctant to take on management of the properties.

Another concern about the reformed system is about specific segments of the treatment population, namely young people and families. The partially reformed sector and the inclusion of clients aged from 16 years in the general / adult services is perceived as creating multiple entry points for young people and confusion among referrers, while I&A clinicians may not be appropriately trained. Further, the standard I&A may not be an appropriate way to engage younger clients. Although services to families were a priority in early discussions about sector reform, the reformed sector did not have scope to undertake this work.

Professional relationships

The process of change has disrupted professional relationships and in some locations it has been difficult to overcome these concerns. Having a new service in the sector (I&A) required attention to communication pathways with treatment services and with referral agencies, although this attention has been lacking. Forum participants called for leadership from VDHHS that would include better lines of communication with services and strategies to promote sector changes to referral agencies.

Workforce impacts

Reform impacts on the AOD workforce include "*stress for staff*" from the ongoing uncertainty regarding sector changes and "*an exodus of skilled workers*" during the change period. In rural areas recruitment has always been a challenge and "*it has worsened since recommissioning*".

Separating the workforce into I&A staff and treatment staff was seen as counterproductive as assessment is a highly skilled activity and there is a risk that treatment clinicians will be de-skilled by not being involved in this area. Participants felt that treatment providers have reduced capacity to use their judgement in deciding on treatment pathways. There was substantial concern about workforce

sustainability and the lack of professional development opportunities (*"we cannot say the Department has invested in the sector's workforce"*).

Funding and DTAUs

Forum participants reported that the amount of funding assigned to DTAUs is not sufficient and that the treatment definitions are too narrow – not allowing for *"any work outside of direct clinical work"*. There was widespread confusion about translating the DTAUs into practice in terms of EFT and no information about the rationale behind the targets.

The cost of maintaining good relations with consortia partners is significant and not factored into DTAUs. As mentioned previously, contractual changes have resulted in some organisations being in both competition with and dependent on other organisations for referrals *("a decrease in referrals may result in a decrease in the funding base and agencies feel powerless"*).

Administration and bureaucracy

Sector reform has resulted in increased administration and bureaucracy. This is particularly the case for recording and reporting systems, including 'doubling up' because of the separation of I&A from AOD treatment services and the use of multiple reporting systems as there is no single database that is shared across organisations. Forum participants also identified that there was particular pressure on rural services where increased reporting demands have been accompanied by staff reductions.

Directions

The over-riding message from this study is the need for urgent attention to address negative consequences of the reform. The issues we have explored and associated suggestions provide the basis for sector development. However, the initial step is to compare our findings with other sources of information – particularly the Aspex report.

The reform of Victoria's AOD treatment sector was a bold initiative. The complex nature of major reform and the issues raised by study participants suggest that a public value management approach to remedying these concerns is needed. This approach moves away from a neo-liberal perspective and emphasises strong relationships between policy and practice stakeholders – an important strategy when dealing with complex social problems. To enable this process to be adequately informed, we suggest the formation of a working group that combines expertise from policy, practice, and academic domains. The group will focus on design and implementation planning, and account for services subject to stage one of the reform and those not involved.

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Attachment: Notes on the research approach

Ethics approval

The study methodology was detailed in a submission to the ACU ethics committee and approval was obtained in August 2015 (review number 2015 19374).

Forum guide

A series of questions was used to guide discussion:

1. As you all know, the sector has changed a lot since the reform that was implemented in September 2014. Just briefly, what are some of the benefits of the reform?

2. And are there particular challenges that have arisen in relation to service delivery?

3. Is there anything particularly important to your region in terms of service delivery, given the population, geography, and other characteristics involved?

4. One goal of these forums is to focus on key issues that have come about as a result of sector reform and to work together to problem-solve strategies to overcome a selection of these issues.

a. To start, I would like each group to write down what you see as the major issues arising from the reform. Working as group, please circle four items from your list that you see as being the most important issues.

b. [Display and discuss group lists. Identify common items and combine into a forum list. Prioritise and rank items from one to four].

c. So let's focus on [top item from the forum list].

5. Please take a moment to think about some possible strategies to address this issue. [Discuss / write down in groups depending on group size and engagement].

6. Discuss.

7. Repeat steps 5 to 6 for the second ranked item on the forum list, if there is time.

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