aspex consulting

Department of Health and Human Services

Independent Review of New Arrangements for the delivery of Mental Health Community Support Services and Drug Treatment Services

Final Report

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List of Abbreviations

ADIS	Alcohol & Drug Information System
AOD	Alcohol & Other Drugs
APSU	Association of Participating Service Users
ATSI	Aboriginal & Torres Strait Islander
CALD	Culturally & Linguistically Diverse
CHP	Council to Homeless Persons
COATS	Community Offenders Advice & Treatment Service
DTAU	Drug Treatment Activity Unit
I&A	Intake & Assessment
ICSP	Individual Client Support Package
NDIS	National Disability Insurance Scheme
MHCSS	Mental Health Community Support Services
QDC	Quarterly Data Collection
VAADA	Victorian Alcohol & Drug Association
VAED	Victorian Admitted Episode Dataset
VEMD	Victorian Emergency Minimum Dataset
VHA	Victoria Healthcare Association
VICSERV	Psychiatric Disability Services of Victoria
VMIAC	Victorian Mental Illness Awareness Council

Acknowledgement

Aspex Consulting would like to thank the many consumers and carers, representatives from MHCSS and drug treatment services, peak organisations, community-based practitioners and referring organisations who participated in stakeholder consultations for this review.

1 Executive summary

This report presents the findings of an independent review of the new arrangements for provision of mental health community support services (MHCSS) and drug treatment services. The intent of the review is to identify those aspects of the reforms which are working well, identify areas where there are issues or challenges and consider options and potential solutions for mitigation/resolution. The final component of the review provides further comments for future strategic service planning for consideration as part of the ten year mental health plan and rollout of the National Disability Insurance Scheme.

Context

Substantial components of both sectors were re-commissioned through a competitive tender process. Newly appointed MHCSS services commenced in August 2014 and drug treatment services followed in September 2014. The recommissioning process was the culmination of an extensive policy and planning process with directions for reform set out in *New directions for alcohol and drug treatment services: a framework for reform, 2013,* and *Reforming community support services for people with a mental illness, 2013*. The reform process had broad stakeholder support.

For both sectors, the 2014 recommissioning was referred to as stage one recommissioning, with out-of-scope service categories to be considered for subsequent recommissioning in stage two. The government has, as yet, not committed to stage two recommissioning.

Method

The review has involved widespread consultation with both sectors, with feedback obtained through three main sources. Face-to-face consultation forums were held in every rural region and in metropolitan Melbourne. In total, 35 meetings were held, with over 350 people attending over a three week period from end-July to mid-August 2015. Sessions were structured to enable representation from service providers from drug treatment and MHCSS sectors, referring organisations and other community-based services. Separate sessions were held to enable carers, family and consumers to meet with the review team face-to-face. Additional teleconference meetings were held to accommodate service providers from more geographically distant areas. A joint meeting occurred with representatives from peak organisations – APSU, CHP, Tandem, VAADA, VHA, VICSERV and VMIAC – and the review team attended a VAADA CEO's forum.

On-line feedback was sought from stakeholders who identified themselves as consumers, service providers, referring organisations and other interested parties, with 431 responses submitted by the late August 2015 close-off date. The feedback form contained closed-ended questions on topics specific to the review and also canvassed general feedback with open-ended questions.

Additionally, stakeholders were invited to forward comments/submissions directly to the review team. Thirty-four written comments/submissions were received.

Stakeholder feedback was reviewed and the key themes were incorporated into the *Summary of Stakeholder Feedback Report*.

In addition to stakeholder consultation, the review involved data analysis to identify trends in service utilisation for both sectors. Whilst there are some apparent trends identified in the data analysis, there are significant limitations in the reliability of time-series data due to reporting changes since recommissioning.

Goals of recommissioning

In broad terms, the goals of recommissioning were similar across both sectors, namely:

- To strengthen the focus on person-centred, outcomes-based service delivery with client access enabled through a catchment-based intake system intended to be easy to navigate;
- Client eligibility for services is to be established through the consistent application of a screening tool with client access to services determined in accordance with priority of need;
- To develop recovery-oriented individual care plans on the basis of a comprehensive initial assessment leading to flexible packages of services;
- To coordinate with other health, human services and support services to address the needs of vulnerable clients with multiple service needs;
- To enable information and support to be provided for clients' carers/family;
- To strengthen accountability for service outcomes through a performance management framework; and
- To develop a robust approach for planning future service needs through a catchment-based planning function.

Whilst sharing several service model elements in common, there are specific and important differences between the two sectors. The most substantial difference relates to the intake and assessment role. In the MHCSS sector, the term '*intake and assessment service'* is a misnomer – in fact, the role involves *screening and referral*. The responsibility for the initial comprehensive assessment in the MHCSS sector lies with the MHCSS service provider and not with the intake and assessment service.

In the drug treatment sector, the responsibility for both screening, initial comprehensive assessment and referral is vested with the intake and assessment provider. (There is some flexibility to enable local drug treatment services to undertake intake and assessment for clients who 'walk-in' but this is not part of their designated role).

Other differences are notable in relation to the funding model for both sectors. In broad terms, the funding model design means that the MHCSS sector has greater flexibility in the use of funded resource units than the drug treatment sector.

The review is structured around the following key themes:

- Intake and assessment;
- Service delivery;
- Service relationships and partnerships;
- Workforce;

- Funding;
- Performance; and
- Service system planning and strategic development.

A brief outline of key issues relevant to each of these topics is outlined below together with recommendations.

Intake and assessment

There is general support for the determination of priority of access to services in accordance with a consistent screening tool across both sectors. Similarly, the consistent approach to undertaking a comprehensive assessment is endorsed.

Key issues for both sectors in relation to intake and assessment relate predominantly to the challenges of phone-based access and the difficulties this poses for both vulnerable clients and referrers in navigating the service system. To some extent, the access issues relate to the fact that previous entry pathways and referral modes no longer apply, so there is the challenge of change. That said, twelve months into the reforms, there remains strongly expressed discontent with the relevance of phone-based intake for vulnerable client groups who often lack the confidence, trust and resources to easily use this mode of access. Whilst face-to-face access options are also available, there is typically a reliance on phone-based intake for the initial screening component of intake for both sectors.

From the referrer perspective, there is reported to be continued frustration, lack of awareness and reluctance to use catchment-based intake. Some interim mitigation measures have proven effective, specifically the introduction of a GP hot-line has minimised call wait times and expedited access. However, the disruption of long-established referral pathways has created ongoing challenges. For example, streamlined placement of clients from clinical mental health services is reported to be more difficult. Service providers with established protocols in working with homeless services and ATSI clients are unable to facilitate direct intake, with the intake and assessment requirement a hurdle for reluctant clients.

The criticism of the catchment-based intake and assessment role goes beyond a concern that the system may create inconvenience to clients and referrers. A more fundamental critique is that some vulnerable clients are no longer accessing services *at all* as a consequence of the barriers experienced. Drug treatment service providers in particular have emphasised that there has been a substantial reduction in the volume of referrals subsequent to the reforms. Data analysis, which is indicative only, confirms that there has been a reduction of 21% in drug treatment service contacts in 2015 relative to 2014.[1] A slightly lower impact was observed for MHCSS with a 19% reduction in the number of clients receiving Individual Client Support Packages (ICSPs), or back-cast ICSP equivalents, over the same period.

For both sectors, there is a view that the screening tool that currently underpins the determination of client eligibility is overly complex. The MHCSS sector is concerned that the tool undermines recovery-oriented principles with its requirement that eligibility is determined

[1] Results of data analysis are indicative only given data integrity issues and reporting changes over the period of recommissioning.

by the presence of psychiatric disability, counter to the underlying policy of early intervention and relapse prevention. The drug treatment sector is not convinced that the tool is fit-for-purpose with concerns that individuals screened as less complex may be at risk of relapse or may need a service response beyond the capability of the primary care sector.

A further issue identified for both sectors is the perception that there is a relatively limited provision of follow-up support to clients who have completed the intake and assessment process and are waiting for a service place to become available. Whilst there is an expectation that support be provided by intake and assessment providers for clients on waiting lists, many regarded this as token and advocated for an enhanced support focus including provision of evidence-based 'brief interventions'.

Despite broad expectations that there would be more explicit attention paid to eliciting the needs of carers/family, stakeholders perceive that there is limited focus on carers/family at the intake and assessment stage.

A further stakeholder criticism is that there has been a narrowing of program focus, with the intake and assessment process focused tightly around eligibility for MHCSS and drug treatment services respectively but with insufficient focus on clients with multiple service needs including dual diagnosis clients and homeless clients.

A fundamental issue, specific to the drug treatment sector, concerns the separation of the assessment role from the treatment role. This issue drew overwhelming criticism on three counts:

- The quality of assessments is considered to be variable and this results in treatment providers repeating assessments;
- Clients are having to re-tell their story; and
- There is a disruption to the therapeutic intervention and rapport-building.

Proposed solutions relevant to intake and assessment services are summarised below.

Intake & Assessment

For drug treatment services, consideration be given to:

- Fully devolving the assessment function to treatment service providers. This recommendation requires a structural change to the design of the recommissioned service delivery service platform. It effectively makes redundant the catchment Intake & Assessment (I&A) function, and reduces a three tiered I&A service to two tiers.

  This recommendation is to be progressively transitioned over a period of one to two years through an orderly increase in I&A by treatment providers and a corresponding decrease in role for existing catchment I&A providers.
- Implementing complementary changes that address identified gaps including:
  - A Departmental sponsored marketing and information campaign promoting awareness of I&A services and how these are accessed. This could include a statewide 1800 number;
  - Support a service model that increases the proportion of supported referrals and outreach assessments, particularly for vulnerable client groups;
  - Streamline the current screening tool;
  - Introduce an evidence-based 'brief intervention' for clients waiting for a service place to become available;
  - Establish user-training, and a system of independent audits of client assessments to provide integrity and enhanced quality to the assessment system in lieu of the catchment I&A structure;
  - Program guidelines be developed to promote good practice in relation to the development of 'joined-up'

service planning for vulnerable clients with multiple service needs including young people; homeless people; ATSI clients; and CALD clients;

- Ensure that there is adequate training/information in relation to enhanced carer & family involvement at the I&A stage; and
- Develop a common assessment template for dual diagnosis clients.

For mental health community support services, consideration be given to:

- Undertaking only minor changes to the I&A structure at this time. These changes include all measures in the previous dot point. It is **not** considered appropriate to undertake structural changes to I&A for MHCSS given the future disruption foreshadowed as a result of the roll-out of NDIS in the short to medium term.

Service delivery

With recommissioning, the main changes to the service delivery model for both sectors were to combine multiple, discrete service types into broader service categories. For MHCSS, these comprised: intake and assessment; individualised client support packages (ICSPs); and youth residential rehabilitation. For drug treatment services, there are now four service types: intake and assessment; counselling; care recovery and coordination; and non-residential withdrawal services.

The anticipated advantages of service type consolidation are in relation to enhanced flexibility to tailor packages of care to individual needs. This outcome has been achieved to a greater extent with MHCSS. The ICSPs give considerable flexibility in the deployment of activities involving direct client and indirect client interaction. This includes provision for group activities. Despite this flexibility, there has been a relative lack of preparedness by service providers to deploy the flexibility of the service model to operate group activities. As a consequence, there has been widespread un-winding of group-based modes of service delivery and a discontinuation of drop-in services. In part this reflects an interpretation of a change of policy direction by service providers away from maintenance service models in favour of recovery-oriented models. This diminished focus on group activities has been exacerbated by the lack of appreciation of the potential application of ICSPs for this purpose.

A key risk identified by stakeholders, including carers and consumers, is that a reduced opportunity to access group activities will compound social isolation faced by consumers and potentially contribute to poorer health outcomes.

For drug treatment providers, there have been mixed reactions to the consolidation of service types. The capacity for service providers to provide counselling at two different levels of program intensity, standard and complex, has received a mixed reaction. Some have assumed there is a capping element to the number of sessions to be offered for standard (four) and complex (fifteen) counselling sessions, whereas the number of sessions is an average, with fewer or more sessions able to be deployed depending on the client.

Many considered there was insufficient flexibility in the drug treatment service model to address the inter-agency service coordination requirements of vulnerable clients including young people and the homeless. Whilst there has been provision in the service model for a specific service type ‘care, recovery and coordination’ to enable collaborative service planning, in reality many considered this was under-resourced.

For service delivery, consideration be given to:

- Developing **program guidelines** for the drug treatment and MHCSS sectors that enunciate service delivery expectations;
- Program guidelines should form part of the development of a broader **Service Framework** for each sector as the basis for service delivery and performance management. This should be developed within two years;
- Following client screening at I&A, clients are referred directly to a service provider along with the responsibility for management of clients (and any waiting lists);
- Implementing a new service category/stream for both sectors (including the funding model) focused on a 'brief intervention'. A brief intervention service would be applicable to clients and to carers/family interventions;
- Program guidelines would specify and promote family/carer interaction, and explain the role of day programs and group sessions in the context of ICSPs; and
- Introducing a specific intake and assessment pathway for dual diagnosis clients.

Relationships and partnerships

Unsurprisingly, there have been significant disruptions to service relationships and partnerships following the recommissioning. To some extent this is a transitional issue. Whilst many commented on the decline in levels of trust and cooperation that followed the competitive nature of the tendering process, there has also been considerable time and effort invested in re-establishing working relationships and building relationships with newly appointed service providers.

Structural elements of the intake and assessment arrangements have created tensions for drug treatment services. This is the case in catchments where the provider of intake and assessment services is also a provider of drug treatment services. There is a perception and an actual conflict of interest in this role since the intake and assessment role is effectively a gatekeeper role and a determinant of the referral destination. Some stakeholders perceive that the referral flows are not equitably distributed by the intake and assessment service.

Across every catchment in the drug treatment sector, services opted to form consortia. Whether this was in response to a perceived requirement of the tender process is unclear. The outcome however, is that many service providers believe that the decision to form a consortium was made out of necessity rather than from mutual interest and a long-standing commitment by members of the consortium. As a consequence, the level of investment of goodwill in many consortia is limited, a consistent theme identified at the majority of stakeholder consultation forums. Others perceive the consortia are over-engineered and that the investment of corporate resources for relatively small levels of clinical resources is a poor value proposition. Those providers of a smaller scale are concerned they have lost their opportunity to interact directly with the Department, with information flow from the consortium lead. Intake and assessment providers remain unconvinced that there are efficiencies to be gained from a consortia model and perceive that there remains considerable complexity in directing referrals to service providers within consortia.

For relationships and partnerships, consideration be given to:

- Enabling organisations to exit consortia; and
- In future service development initiatives for both sectors, retaining the option of organisations opting to form consortia, but on an entirely voluntary basis.

Workforce

Recommissioning has had a major workforce impact for both sectors. For some organisations, typically larger organisations operating across more than one catchment area, a positive outcome of the recommissioning is that there has been an impetus for workforce renewal and recruitment. More often the feedback has been that the capacity and capability of the workforce has been depleted, with a loss of experienced staff and challenges to recruitment.

In addition to the one-off transitional impact of recommissioning, many stakeholders highlighted that levels of workforce satisfaction were continuing to be negatively affected by the perceived shortcomings of key aspects of the new system. In the case of drug treatment services, the perception of professional de-skilling – a function of the separation of assessment from the treatment role – has been a key contributor to low morale.

For MHCSS, the most commonly reported future concern from a workforce perspective has been the uncertainty about prospective career opportunities with the transition to NDIS.

For workforce, consideration be given to:

- The Department, in collaboration with the drug treatment and MHCSS sectors, developing a workforce strategy that is designed to address the core components of future changes/service improvement initiatives.

Funding

Stakeholders' views of the appropriateness of the funding model were mixed.

Funding models were fundamentally altered with the recommissioning. They were altered to be consistent with, and to reinforce, the service model changes. Both funding models were also activity-based, transparent and intended to enable flexible provision of in-scope services. Therefore, potential changes to the funding models need to directly reflect and align with other service model and system design changes.

There is merit in reviewing the funding model for drug treatment services. There were concerns expressed about the funding model that warrant a re-assessment of the categories of service delivery, particularly the lack of a funding structure for dual diagnosis clients and the need for 'brief interventions' for clients waiting for a service place to become available. It could potentially extend to:

- The pricing structure relativities between service types and the perceived issues relating to under-pricing;
- The perceived operational difficulties in managing to drug treatment activity units (DTAUs); and
- The restricted application of the funding to categories of core services.

These issues can go to the core of the long-term credibility of the service model, not only as this relates to recommissioning. A key consideration is the medium to long-term veracity of the activity and costing data that is available to the Department.

Other concerns relate to more limited flexibility in applying the resources to other areas such as community education and health promotion. Funding is now more targeted to the specific

service categories and service outputs that were defined as in-scope, which does constrain providers to focus on the services for which funds are provided. It is appropriate for funders to ensure that the purposes for which funding is made available, and/or the priority of services, are made explicit. As such there is no basis for the Department to change from this policy-driven approach, unless there is a perception that the funded suite of services should be expanded.

Overall, there is little merit in altering the current funding model for MHCSS. There was one concern relating to funding for 'brief interventions' that could potentially be considered in conjunction with the transition to NDIS for some MHCSS services.

For funding, the main potential solutions proposed for the drug treatment funding model are that:

- A comprehensive review be undertaken in relation to the drug treatment funding model. The review would:
  - Consider the merits of additional service categories on the basis that they are supported by appropriate service models. These may include an 'intermediate' counselling category, and a 'brief intervention' category;
  - Consider the merits of drug prevention strategies/activities constituting a core funded activity;
  - Develop an integrated funding model that blends drug treatment and MHCSS for dual diagnosis clients;
  - Assess the suitability of resourcing for 'care recovery and coordination' services and the scope for coordinated service models for clients with multiple service needs including homeless clients;
  - Consider enhanced flexibility of the application of DTAUs, including removing the restrictions on the use of DTAUs:
    - The use of normative pricing for difficult or unpopular service types, and/or
    - Shadow the service types being delivered relative to the expected demand for each service type, and take corrective actions if necessary; and
  - Consider the merits of price relativities between service types, including any 'under-pricing' of service categories.
- In the absence of reliable and complete cost and activity data, the Department is encouraged to undertake a one-off costing study through the establishment of a representative group of providers, including the establishment of robust data definitions and collection and reporting of costs (and activity) that would be used as the basis for costing of each service category. This could then provide a solid foundation for determining sector prices.
- The review of the funding model, and any developments, be shared with the sector, and that a collaborative approach may assist with a more widespread understanding and ownership of how service categories and prices are determined.
- As a long-term measure, a commitment be made to the development of sustainable client-based activity and costing data systems for the sector.
- To address concerns relating to inflexibility and difficulties with the current model, the Department should be in a position to:
  - Provide information sessions and resource material (kits) that clearly explain the basis on which the service types and prices have been developed. This may include a 'help desk' service for a defined period of time; and
  - Develop the next iteration of spreadsheet activity reporting.
- There should be no change to the approach of activity-based funding as the basis for future funding, and that there be no guarantees of entity viability based on government purchasing of services.

The main action proposed for the mental health community support funding model is to:

- Develop a 'brief intervention' funding category.

Performance management and monitoring

The delay in the introduction of a performance management framework has been a source of frustration and disillusionment to both sectors. This has dissipated for the MHCSS sector since the development of a draft framework and its release in early 2015. Both sectors have expressed disappointment at the lack of robust and efficient IT systems for the collection and reporting of service utilisation and performance data. The continued reliance on spreadsheet-based reporting on an interim basis is cited as evidence of the lack of adequate lead time for implementation of the reforms.

A further point of contention is the lack of feedback on system performance. In some catchments, there were positive views expressed about the provision of timely information from intake and assessment providers on the flows of referrals, numbers of clients on the needs register and the allocation trends. Others perceived the information flows were inadequate.

It will be important that the Department is able to periodically disseminate system performance to the two sectors.

The quality, completeness and timeliness of the (client-related) activity data, along with client-related cost data, are strategic weaknesses of the service system.

For performance management, the main potential solutions are to:

- Focus on the collaborative development of a performance management framework for the drug treatment sector, with consideration being given to phased implementation.
- Develop effective IT data collection and reporting systems as a priority in consultation with the sector.
- Enable system level and service provider level performance measures to be reported online and to be made publicly available. This can only occur when there is a robust performance management framework in place.

Future service planning and strategic service development

The *catchment-based* service planning function that forms part of the recommissioned model has been well supported. There is an important role to:

- Assess the impact of the recommissioned and non-recommissioned services; and
- Assess and respond to current and latent demand, effectiveness of service models, and workforce needs across the diversity of the catchment areas.

More broadly, there are two areas of focus for future *system-wide* service planning and strategic service development:

- The implementation of potential changes arising from the options presented in this report; and
- The implementation of future service changes for out-of-scope services.

For future service planning, consideration be given to:

- Retaining the service planning capability in each catchment. Review the ongoing value of these functions after three full years of operation;
- Proposed priorities and timelines, summarised in section 10, for addressing proposed solutions identified in this review; and
- Collaborative engagement with both sectors to advance strategic service reforms to out of scope services.

2 Introduction

Aspex Consulting has been engaged by the Department of Health and Human Services (the Department) to undertake an independent review of the current status of the 2014 recommissioning of Mental Health Community Support Services (MHCSS) and Drug Treatment services.

2.1 Terms of reference

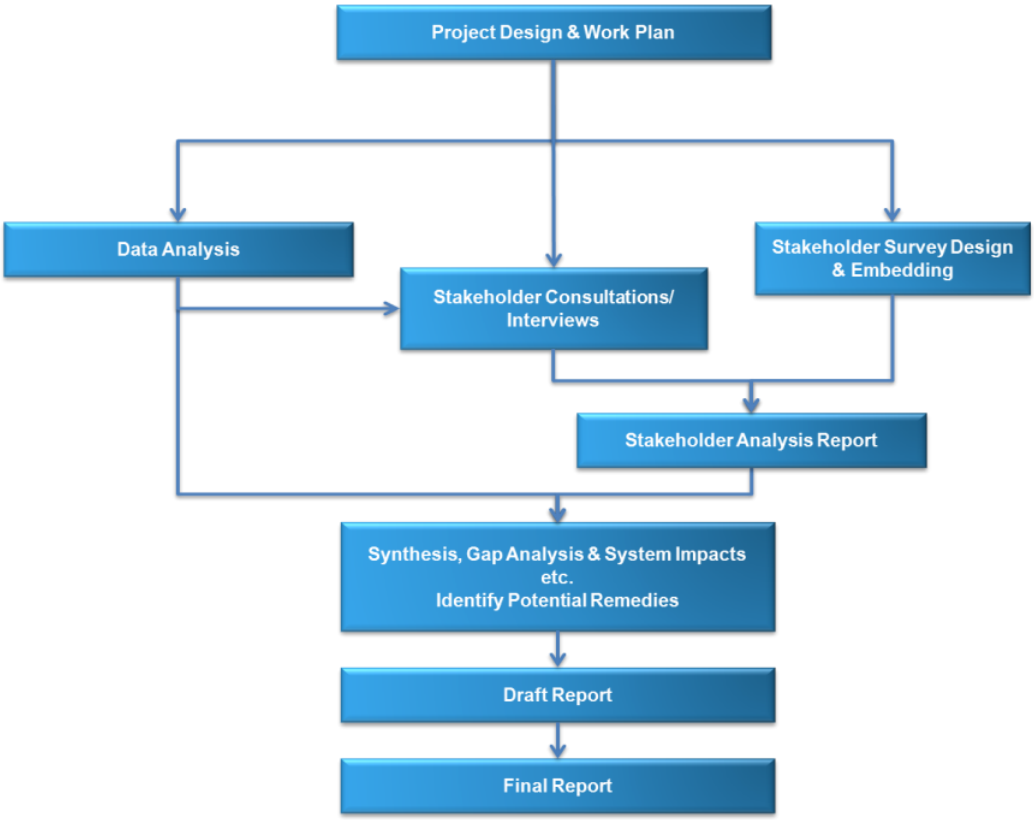
Specific objectives of the review were to:

- Identify what is working well with the new system;
- Explore any gaps or issues with the new arrangements, and identify potential solutions to address these;
- Listen to clients, carers, service providers and referrers about how the functioning of the system can be further improved;
- Identify where further work may be required to address any outstanding system functioning or implementation issues; and
- Provide a basis for future planning and strategic service development, including but not limited to development of the new ten-year mental health plan and preparation for transition to the National Disability Insurance Scheme (NDIS).

2.2 Project approach

The approach to the project is shown in Figure 2-1.

Figure 2-1: Project approach



2.3 Stakeholder consultation

A substantial component of the project involved stakeholder consultation. This took the form of:

- *Direct consultations:* There were 35 meetings involving over 350 people, with representatives from MHCSS and drug treatment services including carers and consumers. These meetings were held across all rural regions and metropolitan Melbourne over the period 28 July to 21 August 2015.
- *An online feedback form* – Responses were sought to an online feedback form for the period 24 July to late August 2015. This was completed by 431 respondents from MHCSS and drug treatment services, other referring services including clinical mental health services, community-based services, carers and consumers.
- *Submissions* –There were 34 submissions received for this review.

Stakeholder feedback was reviewed and the key themes were incorporated the *Summary of Stakeholder Feedback Report*. Additionally, a précis of relevant stakeholder themes is provided for each of the main sections of this report.

2.4 Data analysis

The review considered existing data available from the MHCSS and drug treatment services. There are substantial limitations in the reliability of analysis of activity trends over the period of recommissioning for both sectors given changes to service types, data integrity and discontinuities in reporting to the Department's minimum data-set in the case of MHCSS. For this reason, the data analysis presented here is ***indicative only***. Notwithstanding these caveats, key highlights of the analysis of activity trends are as follows.

Drug treatment services

A ***slight increase (3%)*** in the underlying demand for drug treatment services as measured by *intended* referrals from public hospital inpatient settings and a ***moderate increase (18%)*** in intended referrals from ED settings:[2]

- 3% *increase* in patient discharges with an *intended referral* from acute hospital inpatient settings (general acute and clinical mental health) between 2013/14 to 2014/15;
  - The largest volume and proportion (83%) of intended referrals was from general acute inpatients, with an *increase* of 7% in this referral source;
  - Acute clinical mental health services accounted for a small proportion (17%) of intended referrals and there was a 12% *decline* in this source of referrals; and
- 18% *increase* in patient discharges with an *intended referral* from acute hospital EDs 2013/14 to 2014/15.

Substantial reduction in the number of reported non-forensic drug treatment assessments:

- 40% reduction in non-forensic assessments from 2013/14 to 2014/15
- 50% reduction in the number of drug treatment assessments for non-institutional referrals (i.e. self/family/friends/employer referrals) and Y% reduction for GP referrals

Substantial increase in the number of reported forensic drug-treatment assessments:

- 46% increase in forensic assessments from 2013/14 to 2014/15

Substantial reduction in the actual number of reported drug treatment contacts

- 21% reduction in the number of total drug treatment contacts from 2013/14 to 2014/15

MHCSS

Slight 2% reduction in the underlying demand for MHCSS services as measured by *intended referral rates* from public hospital inpatient settings and a ***moderate 11% increase*** in intended referrals from ED settings.

- 2% *decrease* in patient discharges with an *intended referral* from acute hospital inpatient settings (general acute and clinical mental health) between 2013/14 to 2014/15.

[2] It should be noted that this analysis of referrals from public hospitals is based on health services' referral intentions at the time a patient is discharged from hospital. It is not a measure of whether an individual patient necessarily has decided to follow this referral pathway or been successful in accessing a MHCSS or drug treatment service.

- The largest volume and proportion (83%) of intended referrals was from clinical mental health inpatient services which underwent a 3% decline in intended referrals from 2013/14 to 2014/15;
- General acute hospital services accounted for a relatively small volume and proportion (18%) of MHCSS intended referrals and this referral source increase by 1% over the period.
- 3% decrease in patient discharges with intended referral from acute clinical mental health services 2013/14 to 2014/15

- 11% *increase* in patient discharges with intended referral from acute hospital EDs 2013/14 to 2014/15

Substantial reduction in the actual number of MHCSS clients reported to be receiving services from 2013/14 to 2014/15

- 19% change in the number of clients receiving ICSPS (and mapped ICSP equivalents for prior year) from 2013/14 to 2014/15

Summary of trends in activity data for MHCSS and drug treatment services

In the case of both drug treatment and MHCSS services there has been an observed steep reduction in activity in the second quarter of 2014/15, immediately following the recommissioning. For both sectors, there has been a subsequent upswing in remaining quarters of 2014/15 although not to the pre-recommissioning activity levels.

Across the full year, there has been a reduction of 21% in drug treatment service contacts in 2014/15 relative to 2013/14. A slightly lower impact was observed for MHCSS with a 19% reduction in the number of clients receiving Individual Client Support Packages (ICSPs), or back-cast ICSP equivalents, over the same period.

The reduction in reported activity at MHCSS and drug treatment services is consistent with feedback from stakeholders about the impact of recommissioning on service levels.

Demand for access to MHCSS and drug treatment services, as measured by intended referrals from public hospitals, has not changed appreciably for intended referrals from acute inpatient settings and has increased moderately for intended referrals from hospital ED settings. ***In other words, the decline in activity at MHCSS and drug treatment services in 2014/15 has occurred despite an increase in underlying demand from public hospitals.***

Appendix 1 provides a summary of the data analysis undertaken for this review.

2.5 Structure of report

The report is structured under the following headings:

- Context for the review;
- Intake and assessment services;
- Service delivery;

- Service relationships and partnerships;
- Workforce;
- Funding;
- Performance monitoring; and
- Implications for future planning and strategic service development.

For each section, consideration is given to issues that are common to both sectors as well as an outline of those issues specific to drug treatment services and MHCSS.

3 Context for the review

3.1 Recommissioning objectives

Reform objectives for MHCSS were explicitly stated in *Reforming community support services*[3] as follows:

Under a reformed system:

- *services will be easy to access and navigate*
- *new clients will receive an initial assessment and supported referral to MHCSS as well as other health, human services and social support services they may need*
- *clients will work in partnership with their service provider and carer(s) to develop a recovery plan*
- *clients will receive a support package based on their recovery plan that will help them to:*
  - *improve their daily living, self-care and social and relationship skills, as appropriate*
  - *achieve their broader quality-of-life needs regarding physical health, social connectedness, housing, education and employment*
  - *coordinate access to, and engagement with, the range of health and community services they need*
  - *carers and families will be actively supported in their caring role.*

Reform priorities for drug treatment services were identified in *New directions for alcohol and drug treatment services*: *A framework for reform*[4]

- *Priority area 1: Simplify and streamline the system*
- *Priority area 2: Integrate alcohol and drug treatment into the broader health and human services system*
- *Priority area 3: Strengthen the alcohol and drug treatment workforce*
- *Priority area 4: Underpin practice with quality tools and mechanisms*
- *Priority area 5: Shift accountability for service provision from outputs to outcomes*
- *Priority area 6: Manage information and data effectively*

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[3] Department of Health, 2013, *Reforming community support services for people with a mental illness Reform framework for Psychiatric Disability Rehabilitation and Support Services*, Victorian Government

[4] Department of Health, 2013, *New directions for alcohol and drug treatment services: A framework for reform*, Victorian Government

4 Intake and assessment

This section focuses on intake and assessment services. Key benefits of the intake and assessment (I&A) function are discussed followed by an assessment of the main issues identified in the course of the review. In the first instance, consideration is given to common issues across MHCSS and drug treatment sectors followed by an appraisal of issues specific to the drug treatment intake and assessment function.

Options for mitigating the issues are canvassed. The range of options is summarised under four main 'change strategies' which range from incremental refinement to structural change. Each change strategy is assessed against evaluation criteria and a preferred change strategy is recommended.

4.1 Role of intake and assessment

A cornerstone of the reform package was to establish catchment-based I&A services for both MHCSS and drug treatment services.

In the case of MHCSS, the I&A service involves *'screening and referral'*, with the comprehensive assessment being undertaken by MHCSS service providers. The intention of the reform was to have a screening process for eligibility (and three-level client 'categorisation') to ensure consistent access to MHCSS across the state, followed by referral to a MHCSS service provider.

For drug treatment services, the I&A function similarly involves a screening (and five-level client categorisation) process as well as a comprehensive assessment. The intention was to ensure consistent client access across the state using a common assessment tool, a clear pathway to service access, and more timely access to services by high priority clients. The separation of assessment from treatment services was intended to provide a degree of independence and greater objectivity of assessment.

Further details on the core components of the intake and assessment service for MHCSS and drug treatment services are described below.

4.1.1 CORE COMPONENTS OF I&A ROLE – MHCSS

- The I&A service screens people according to explicit eligibility criteria.
- The eligibility criteria comprise age (16-64 years) and presence of a disability that is attributable to a psychiatric condition and is permanent or likely to be permanent.
- The client population should reflect the diversity of the local population and the expected over-representation of disadvantaged groups.
- There is provision for different modes of screening including phone-based and in person.
- Typically the screening is phone-based.
- There is an expectation that I&A providers will work closely with MHCSS service providers to facilitate access for difficult to reach populations including the homeless.

- For the purpose of facilitating access to more vulnerable populations, I&A providers will accept supported referrals by MHCSS service providers. (A supported referral involves a MHCSS service provider liaising with the intake and assessment provider to facilitate a client's formal intake assessment and subsequent potential access to MHCSS.)
- There is an expectation that referrals will be made to providers on the basis of prioritised need.
- I&A providers are required to communicate the outcome of the intake assessment to the referring agency, the client and client's carers (if relevant).
- Clients from outside the catchment must be accepted.
- For clients screened as not eligible, referrals will be made to other services including health, human services and other support services.
- I&A services are expected to operate during business hours five days per week.
- I&A services must have in place arrangements for clients who need urgent referrals as part of an emergency response.
- I&A services are responsible for providing follow-up support (including self-management information and follow-up contact) for clients who are waiting for a service place to become available.
- I&A services are required to convene Regional Bed-Based Selection Panels to identify candidates for MHCSS bed-based services.
- I&A services are expected to respond to referrals made on behalf of carers/family members (with the clients' consent) and to provide information to clients about support available for carers/family members. (A brief carer assessment is not a responsibility of intake and assessment services. This option is available for carers where this is deemed appropriate by a service provider.)
- I&A services are required to identify any referral needs of vulnerable children.
- I&A services are required to be responsive to the needs of CALD and ATSI people.
- I&A services are block funded.
- Reporting requirements include:
  - Number of people screened at intake and assessment;
  - Number of eligible people referred for MHCSS;
  - Number of ineligible people referred for other services; and
  - Number of people waiting for MHCSS by priority.

4.1.2 CORE COMPONENTS OF THE I&A ROLE – DRUG TREATMENT SERVICES

Core components of the I&A role for drug treatment services are described below.

- There is a state-wide centralised intake and referral role. This provides telephone and on-line screening, early intervention and supported referral for assessment and treatment locally. It also provides a suite of self-directed care options for people who do not want or need face-to-face treatment.

- Each catchment has an I&A service accountable for screening and assessment. The I&A service effectively operates as a gatekeeper role for in-scope drug treatment services (those which were recommissioned) and out-of-scope drug treatment services (e.g. residential withdrawal, residential rehabilitation, youth treatment services).
- The I&A service screens people according to explicit eligibility criteria.
- Services must be targeted primarily to people with serious issues arising from their use of alcohol or other drugs and who are:
  - At risk of long term harm or impairment; and
  - Not able to be assisted by primary health providers alone.
- A five-tier complexity tool is used to categorise client need for service. Tiers 1 and 2 are low and moderate respectively and apply to people who have no substance dependence. People in tier 1 and 2 are referred to either self-management or other primary care interventions rather than to drug treatment services.
- There is provision for different modes of screening including phone-based, on-line, and in person.
- The majority of people have a phone-based screen although face-to-face is available.
- There is an expectation that screening should be available on an outreach basis.
- Clients screened as eligible are then invited to have a comprehensive assessment by the I&A provider. Typically assessments are undertaken in person at the I&A location although phone-based assessments are feasible or assessments may be undertaken in co-located or outreach settings.
- There is an expectation that referrals will be made to providers on the basis of prioritised need.
- There is an expectation that referrals will be allocated to drug treatment services on an equitable basis across the catchment.
- Clients from outside the catchment must be accepted for intake and assessment.
- I&A may be undertaken by service providers to enable timely access for people who may walk in or be referred in to a service provider. The service provider is able to resource these I&As through the 20% flexible funding rule, which provides for the diversion of DTAUs from core service categories. Outcomes of the I&A are to be advised to the intake and assessment provider.
- I&A services are expected to operate during business hours five days per week and demonstrate capacity for after-hours responsiveness.
- I&A services are required to provide follow-up support for clients who are waiting for a service place to become available.
- I&A services are required to identify carer/family support needs as part of the comprehensive assessment and to provide advice to assist carers/family members in their support role.
- I&A services are required to be responsive to the needs of CALD and ATSI people.

- I&A services are expected to promote the service to other health/human/support services and justice services, to build referrers' awareness of where to refer people with drug treatment issues.
- I&A services are funded on an activity-based funding model with prices for three different modes of contact (phone, face to face and on-line) as well as the development of a comprehensive assessment and preliminary treatment plan.
- Reporting requirements include:
  - Number of people screened at intake and assessment;
  - Number of eligible people assessed;
  - Number of eligible people referred for drug treatment;
  - Number of ineligible people referred for other services; and
  - Number of people waiting for drug treatment by priority.

4.2 Key benefits

In consultations undertaken for the review, stakeholders identified three main benefits associated with the catchment-based intake and assessment function:

- There is now a consistent basis for screening for eligibility;
- There is now a consistent basis for undertaking client assessment (with comprehensive assessments being undertaken separately from the intake/screening function for MHCSS services); and
- There is greater (but not universal) confidence in the system providing an equitable basis for enabling access to services.

4.3 Issues common to both MHCSS and drug treatment services

There were many issues raised by stakeholders in relation to the intake and assessment function common to both sectors. These have been distilled into the following:

- Phone-based I&A creates barriers for most clients and particularly for vulnerable clients (CALD, ATSI, homeless and youth) and clients with sensory disabilities;
- Diminished scope to provide I&A for walk-ins at provider sites;
- Confusion and resistance by referrers to I&A requirements, which are seen to be slow, convoluted and unnecessary;
- Pre-existing relationships and intake systems from referrers have been undermined;
- Confusion between the different I&A systems for re-commissioned and other services;
- Insufficient focus on carer/family involvement in I&A;
- Some concerns about the appropriateness of the screening tools;

- Separate I&A arrangements lead to silos between drug treatment and MHCSS, especially for dual diagnosis clients, and preclude joined-up services for clients with housing and other needs; and
- Conflict of interest between the screening/intake role being undertaken in some catchments by the same organisation responsible for service provision.

4.3.1 APPRAISAL OF ISSUES – INTAKE AND ASSESSMENT SERVICES

This section appraises each of the issues identified by stakeholders and identifies options that are potentially feasible for resolution/mitigation.

ISSUE	**1. Phone-based intake and assessment creates barriers particularly for vulnerable clients (CALD, ATSI, homeless), youth and those with sensory disabilities.** **2. Diminished scope to provide intake and assessment for walk-ins at provider sites.**
ASSESSMENT/ FINDING	There are three main methods currently available to mitigate difficulties experienced by consumers/clients in relation to phone-based intake and assessment. These are supported referrals, face-to-face interviews, and outreach/co-location of services. **Finding:** There is no system that can adequately eliminate phone-based intake and assessment. It is not logistically feasible, nor financially sustainable, to operate I&A without phone-based services, even for vulnerable clients. Nevertheless face-to-face interviews, supported referrals and outreach are a preferable method to phone I&A where possible for vulnerable client populations. ▪ *Supported* referrals – There is provision for MHCSS and drug treatment providers to deploy resources to support clients through the phone-based intake. Whilst acknowledging that the option of supported referrals is available, the overwhelming feedback to this review was that service providers are disinclined to re-allocate clinical care/treatment resources to overcome the barriers posed by a phone-based intake and assessment system. **Finding:** Deploying provider resources is generally not a cost-effective option to overcome entry barriers created by a predominantly phone-based intake and assessment system. Nevertheless, the extent to which supported referrals can be more formally recognised, and included in the pricing of services, should be actively considered. It would address a commonly raised issue. It does require a change to the current system. ▪ *Face to face* – There is provision for clients to attend in person at I&A offices in place of phone-based intake. **Finding:** The current catchment-based model of I&A services is premised on phone-based intake to a large extent. In turn, this creates barriers for flexible provision of I&A for vulnerable clients. However, a more common use of face-to-face assessments would create its own difficulties for some clients including an additional travel impost. The funding model for I&A may need adjustment to support an increased proportion of face-to-face I&A services. ▪ *Outreach and co-location* – I&A providers have available outreach and co-location in parts of each catchment to facilitate client access. **Finding:** Outreach and co-location are useful strategies to enhance ease of access for I&A services. However, there are geographic limitations on the range of outreach and co-location options. Smaller rural towns are unlikely to have a full time I&A presence. Nor

	would it be feasible to embed I&A staff in all metropolitan service provider settings. Part-time co-location options are sub-optimal given that client walk-ins are typically not planned. Nevertheless, a key consideration in the implementation of the current model is about risk mitigation, and an 'appropriate level' of access by outreach services. There is not an objectively established proportion of services that should be undertaken by outreach, face-to-face and supported referrals in lieu of phone I&A. Over time, it would be optimal for benchmarks to be developed, guided by good practice and service provider perspectives, on the intake and assessment strategies relevant to the needs of difficult to reach client populations.
OPTIONS/ POTENTIAL SOLUTIONS	**There are three options:** a. Apply funding or other incentives that generate more supported referrals; and/or b. Expand co-location/outreach of I&A with service providers as a more common form of I&A *(which could be reflected in a change to the price for outreach services)*; or c. Fully devolve the I&A role to treatment service providers *(requires structural change)* **Potential Solutions:** ▪ A system-wide introduction of mechanisms, and funding, to facilitate more supported referrals would not be cost-effective. It essentially diverts resources from service provision to overcome barriers associated with phone-based intake for the I&A function. ▪ Co-location and outreach of I&A are important but not sufficient strategies to address access challenges for vulnerable clients. ▪ To effectively address barriers to consumer access there is a need to consider structural change in the provision of I&A services. This recommended change would obviate the need for re-pricing of outreach services.

ISSUE	**3. Confusion and resistance by referrers** **4. Pre-existing relationships and intake systems from referrers undermined** **5. Confusion between the different intake and assessment systems for re-commissioned and other services**
ASSESSMENT/ FINDING	There is broad recognition that there have been communication/information challenges during the transition to the recommissioned service model. There are three main strategies that have been applied with the aim of building confidence and awareness among referrers and reducing confusion about referral pathways. ▪ *GP hotline* – The implementation of a GP hotline has enabled waiting times to be minimised for incoming calls from GPs. **Finding:** This is a cost-effective option to support improved responsiveness to GP phone-based referrals. ▪ *Supported referrals* – MHCSS and drug treatment providers have sought to streamline the flow from referring organisations by playing a facilitating role between the I&A provider and the referring organisation. Drug treatment providers have flexibility to directly undertake the I&A role by using flexible funding (20% of providers' total funding allocation is flexible). MHCSS have scope to use client support units (CSUs) to provide support to non-registered clients to assist with facilitated referrals.

	Finding: With some exceptions, there is limited scope to fast-track referrals from clinical mental health services or EDs given that clients who are referred are diverted to the I&A waiting list, without the option of direct referral to a MHCSS or drug treatment service. This creates discontinuity of services for clients. Service providers with established, culturally sensitive relationships with ATSI or homeless organisations are required to divert prospective clients through I&A, diminishing the ease of the referral process for vulnerable clients. ▪ Information sharing – An increasing focus has been placed on information sharing and building awareness among the health and human services sector by I&A, MHCSS and drug treatment services. **Finding:** There is consistent feedback that many community-based service providers and referring organisations are either confused about the I&A arrangements or disinclined to comply with requirements for referrals via catchment-based I&A. The intake pathway is dependent on the commissioning status of the service needed by the client. This conflicts with a 'no wrong door' policy and has increased the information demands on referrers. A key consideration is whether there are likely to be ongoing information and communication gaps that go beyond transitioning to a new system. The current information/communication issues are predominantly due to the way that the service system is structured, and therefore, it is likely to require a structural solution.
OPTIONS/ POTENTIAL SOLUTIONS	There are five options: a. Marketing and information campaign sponsored by the Department to promote awareness b. Introduce a single statewide 1800 number c. Extend funding flexibility to enable supported referrals d. Implement a single statewide I&A provider in place of three different MHCSS I&A providers and nine different drug treatment I&A providers (structural change) e. Fully devolve the I&A role to service providers (structural change) **Potential Solutions:** ▪ Marketing and phone-diversion strategies (options a and b) are useful but not sufficient strategies to address referrers' concerns. ▪ Reallocation of resources from service delivery to enable supported referrals (option c) is not a cost-effective option. ▪ To effectively address barriers to access by referrers there is a need to consider structural change (option d or e) to the provision of I&A services.

ISSUE	**6. Insufficient focus on carer/family involvement in intake and assessment**
ASSESSMENT/ FINDING	There are three main approaches used to facilitate carer/family involvement in I&A. ▪ Information sharing – I&A providers provide information to carers/families in response to telephone queries. I&A providers advise that there is no formal reporting of this activity under the I&A reporting rules for drug treatment services. By contrast I&A services for MHCSS are block-funded. **Finding:** The information and advice role served by I&A providers for carers/family members is

	important and should be accounted for in the funding model for drug treatment services. ▪ Carer/family support – Program expectations indicate that there is an expectation for I&A providers to consider carer/family support needs. **Finding:** Despite the policy focus on carer/family involvement at the I&A stage, stakeholder feedback suggests that this is not occurring in practice to the extent envisaged. ▪ Stakeholders perceive that the risks associated with family violence and vulnerable children are not addressed in current program guidelines. **Finding:** Given the policy focus on carer/family involvement, it is relevant for the Department to monitor the extent to which I&A services are undertaking brief carer assessments. Program guidelines should be developed to address risk management of family violence and vulnerable children in the context of I&A.
OPTIONS/ POTENTIAL SOLUTIONS	There are three potential solutions: ▪ Review reporting and pricing of the drug treatment I&A activities associated with information sharing with consumers, carers/family members, referrers and others as part of a broader review of the I&A component of the drug treatment funding model. ▪ Develop program guidelines on carer/family involvement in I&A and risk management in relation to family violence and vulnerable children in the context of I&A. ▪ Undertake training and reinforce program expectations for carer/family involvement in I&A.

ISSUE	**7. Appropriateness of the screening tool**
ASSESSMENT/ FINDING	▪ Both MHCSS and drug treatment services use a screening tool to determine client eligibility for service provision. ▪ MHCSS screening tool – Stakeholders perceive that the MHCSS screening tool is not consistent with a recovery model as it requires clients to demonstrate a psychiatric disability. Stakeholders perceive that the screening tool is overly complex and could be streamlined. **Finding:** The policy expectations around eligibility criteria for MHCSS were explicitly developed by the Department and approved by government. It is legitimate that an explicit determination has been made that psychiatric disability is a core eligibility criterion for MHCSS services. The application of this eligibility criterion should not of itself represent a departure from the core principles of the recovery model. Without compromising the integrity of the eligibility screen for MHCSS, it is appropriate to give consideration to wording modifications to enable alignment with the language and principles of the recovery model. Given the consistency of stakeholder views that the MHCSS screening tool is overly complex it is relevant to undertake a review of the screening tool with a view to shortening and streamlining the process for consumers. ▪ Drug treatment screening tool – Under the eligibility criteria established for the recommissioned drug treatment services, the Department approved the use of a five-tier screening tool to prioritise access to drug treatment services. Highest priority access is given to tier 5 clients. Clients screened as tier 1 or 2 are deemed to be low to moderate complexity, have no substance dependence, and are not eligible for referral to drug treatment services (excepting where there is clinical judgement that a client should

	receive treatment services for additional reasons). These clients may be referred for self-treatment online modules and/or primary care.
	▪ Stakeholder critiques of the screening tool are three-fold.
	  ▸ With the MHCSS screening tool, the tool is perceived to be overly long and could be streamlined with fewer questions.
	  ▸ Stakeholders considered that the drug treatment screening tool was not fit for purpose – that is, several stakeholders commented that it had originally been developed by Turning Point for use as a planning tool, not for application as a screening tool.
	  ▸ The majority of drug treatment stakeholders were critical of the underpinning policy decision that consumers screened as tier 1 and 2 were ineligible for referral to drug treatment services (notwithstanding the provision for over-ride of the eligibility screen by clinical judgement).
	Finding:
	As with the finding for MHCSS, the consistency of stakeholder feedback that the drug treatment screening tool is overly complex is of concern. To the extent feasible, the tool should be reviewed with a view to truncating and streamlining the process for consumers/clients.
	As part of the review of the screening tool, it would be relevant to consider other jurisdictions' approaches to screening and to revise the tool as appropriate based on the best available evidence around screening validity.
	The policy decision by the Department/government to target drug treatment services for more complex clients is plausible on the premise that there is scope for cost-effective alternative care options for those people screened as tier 1 and 2. Disseminating evidence to support this policy decision in relation to alternative care options for tier 1 and 2 consumers is warranted to build stakeholder confidence in the screening approach.

OPTIONS/ POTENTIAL SOLUTION	The following potential solutions are proposed: ▪ Streamline screening tools for MHCSS and drug treatment services to reduce time and information requirements; and ▪ Disseminate the policy evidence of the cost-effectiveness of alternative care options for consumers screened as tier 1 and 2.

ISSUE	**8. Silos between drug treatment and MHCSS problematic for dual diagnosis clients**
ASSESSMENT/ FINDING	▪ There are separate I&A requirements for MHCSS and drug treatment services. Many stakeholders identified this as problematic for dual diagnosis clients who are required to repeat the I&A process if there is a need for support from both sectors. **Finding:** The separate intake and assessment pathways for MHCSS and drug treatment services create silos between the two sectors and are not client-focused. The recommissioning has reinforced, rather than broken-down the silos for dual diagnosis clients, which is inconsistent with recommissioning objectives.
OPTIONS/ POTENTIAL SOLUTIONS	A potential solution is the development of a common assessment template for dual diagnosis clients to be implemented to promote integrated service responses for dual diagnosis clients and to avoid the requirement for repetition of intake and assessment by MHCSS and drug treatment services.

ISSUE	9. Limits joined-up service provision for clients with housing and other needs
ASSESSMENT/ FINDING	▪ I&A expectations include provision to identify client support needs including health, human services (including housing) and other support service requirements. ▪ Discontinuation of MHCSS program delivery by community health services and with one exception, by housing service providers, is a consequence of re-commissioning. Several stakeholders perceive that this has reduced the scope for joined-up service delivery. **Finding:** Stakeholders perceive that the predominant focus of the screen is to determine eligibility for the single service type (either MHCSS or drug treatment services for each respective sector) rather than a holistic needs assessment. Throughout the course of consultations, the point was reiterated that the initial comprehensive assessment does not preclude subsequent, continuous assessment over the course of the care episode. Consistent with good practice, the identification of physical health, housing and social needs both at the initial assessment, as well as over the course of a client's care episode, would be relevant and necessary to ensure joined-up service provision. Intake and assessment services are required to consider referrals for other health, human services and support services for clients screened as ineligible for MHCSS or drug treatment services. Whether there are advantages to be gained from delivery of MHCSS from a broad-based, multi-service primary care platform, such as through community health services, relates to the policy choices undertaken by the Department and government at the time of recommissioning. These matters concerning recommissioning are out of scope of the current review.
OPTIONS/ POTENTIAL SOLUTIONS	Potential solutions include: ▪ Establish user-training, and a system of independent audits of client assessments to provide integrity and enhanced quality to the assessment system in lieu of the catchment I&A structure; and ▪ Develop program guidelines to promote good practice in relation to the development of joined-up service planning for vulnerable clients with multiple service needs including young people; homeless people; ATSI clients; and CALD clients.

ISSUE	10. Conflict of interest if intake and assessment undertaken by same organisation as service provider
ASSESSMENT/ FINDING	▪ Several stakeholders drew attention to the tensions that had emerged in catchments in which the same organisation undertakes an I&A role and service provider role. There are two consequence of this: ▸ Diminished confidence in the fairness of the system, with a view from some service providers that referral flows from the I&A provider are disproportionate to an equitable catchment share and may reduce the financial sustainability of services due to diminished referral volumes; and ▸ Lower levels of trust and cooperation between service providers, adversely affecting the effectiveness of consortia. **Finding:** There is a conflict of interest for catchments in which the same organisation serves an I&A role and service provider role. This has the potential to undermine confidence in providers' views of the fairness of access to referrals and to adversely affect service

	providers' financial sustainability. It also detracts from inter-agency cooperation and trust.
OPTIONS/ POTENTIAL SOLUTIONS	There are three options: a. Implement performance reviews/audits to assure equity in referrals; b. Divest service provider roles from I&A roles *(structural change);* and *c.* Fully devolve I&A role to service providers *(structural change)* Option a. is ***not proposed*** as it is not considered likely to be an effective strategy to address the inherent conflict of interest. Options b. and c are potential solutions that offer effective strategies to mitigate the issue of conflict of interest. (Further evaluation of the structural change options b and c is provided in section 4.4 below.)

4.4 Issues specific to drug treatment services

ISSUE	**11. Variable quality of assessments** **12. Drug treatment services frequently repeating assessments** **13. Disconnect between initial assessment and therapeutic intervention**
ASSESSMENT/ FINDING	▪ I&A providers advise that they use a range of quality assurance strategies in relation to comprehensive assessments including training, internal peer review and follow-up with providers to address queries/concerns. ▪ Drug treatment providers consider that there have been improvements in the quality of assessments but they continue to have concerns. They consider that the variable quality of assessments since the early days of recommissioning is influenced by the following factors: ▸ Insufficient assessment capacity/capability; ▸ Client not providing the full story to the I&A service, and therefore the assessment is incomplete; or ▸ Client not being capable of providing accurate advice at the time or due to a change in circumstance between the date of assessment and date of service commencement. The cumulative effect is that drug treatment services are repeating assessments, leading to clients having to re-tell their stories. This contributes to client dissatisfaction and duplicates resources devoted to assessment. A further issue raised in consultations is that, irrespective of the quality of external assessments, there may be an overlying reluctance by drug treatment providers to accept externally-based assessments. Many drug treatment clinicians reported that they perceived that their professional roles had been usurped by the policy of allocating comprehensive assessments to external I&A providers. This perception of de-skilling further detracts from the standardised use of external assessments. **Finding:** Irrespective of the various factors influencing the quality of external assessments, the cumulative impact is that a large number of drug treatment providers are very frequently repeating assessments. This results in clients re-telling their story, which is contrary to the original reform objectives. Importantly, it also means that providers are using resources intended for treatment that are effectively used for reassessment. A critical question for the review was whether the current system could operate effectively

	without provider reassessments. The conclusion is that reassessment will invariably continue to be part of the behaviour of providers under the current system, and that this behaviour is reasonable for three reasons: ▪ Assessments are often incomplete in important respects as the clients may not be in a position to be accurate with the information they provide; ▪ Clients' circumstances and conditions change between the assessment and the presentation for treatment; and ▪ Drug treatment clinicians need to test the veracity of the assessment conclusions. Conversely, I&A providers do not consider that the separation of the initial assessment from treatment creates an impediment to building a therapeutic relationship for three reasons: ▪ Firstly, there is an expectation that the initial assessment will be built upon throughout the course of treatment – an assessment should not be seen as static, but a constant process; ▪ Secondly, there are many instances in which clinicians who undertake an assessment within a drug treatment setting would not necessarily be the same clinician who undertakes the treatment role; and ▪ Thirdly, one of the problems identified in the pre-reform context was that services lacked a comprehensive assessment tool. This led to clients being re-assessed when referred to a different treatment service. Drug treatment providers gave consistent feedback that the separation of the initial assessment from the treatment component disrupted the therapeutic relationship and slowed/compromised rapport-building between clinician and client. **Finding:** There are divergent views on whether the separation of assessment from treatment is problematic. That said, the system advantages of separating the assessment function from the treatment role are not apparent. The policy objective of achieving a consistent approach to the assessment of clients can be achieved through the use of a standard template, user-training and independent validation audits. The disadvantages of separating the initial assessment from treatment are potentially significant and include at the very least, a disruption in the care pathway, as clients are required to attend a different service for assessment versus treatment, as well as the risk to the therapeutic relationship. On balance, the disadvantages are substantial and alternative approaches to achieving consistency in client assessment, namely, re-integration of the initial assessment with treatment, are considered advisable.
OPTIONS/ POTENTIAL SOLUTIONS	The following options are proposed: a. Remove the restriction on local I&A from the current 20% of funding; b. Devolve accountability for comprehensive assessment to drug treatment services *(structural change); and* c. Fully devolve I&A role to drug treatment services *(structural change).* **Potential Solutions:** Option A provides a partial, but not sustainable solution. An incremental resource shift would be required from I&A providers to treatment providers. However, to the extent that an increased proportion of assessments are undertaken within the treatment setting, this calls into question the role and purpose of the I&A role. Option A is not recommended, except as a transition strategy. Options B and C are both considered feasible longer-term strategies to address the issue of duplication of assessments. Neither option B nor C would of itself address the issue of quality of assessments. Supplementary strategies would be required (potentially including user-training of the common assessment tool, and independent retrospective validation audits).

4.5 Evaluation of options – Intake and assessment

The options relevant to I&A can be grouped into four broad categories and are listed below.

1. Implement minor revisions to streamline I&A processes

a. Marketing and information campaign sponsored by the Department to promote awareness of I&A
b. Introduce single statewide 1800 number
c. Apply funding incentives for supported referrals
d. Co-location/outreach of I&A with service providers
e. Streamline screening tools
f. Training and audits to enhance quality of drug treatment assessments
g. Training and audits to enhance carer/family involvement in I&A
h. Training and audits to enhance appropriateness of assessments undertaken for vulnerable clients with multiple service needs
i. Develop a common assessment template for dual diagnosis clients
j. Remove any existing business rule that restricts I&A by local providers.

2. Establish a single statewide I&A provider

a. Statewide I&A service undertakes screening and intake role for MHCSS
b. Statewide I&A service undertakes screening, intake and assessment role for drug treatment services
c. Continue with common assessment tools
d. Waiting list managed by statewide I&A provider
e. Periodic statewide validation audits

3. Apply MHCSS I&A model to drug treatment services

a. I&A service undertakes screening role only
b. Assessment role undertaken by drug treatment services
c. Continue with common assessment tools
d. Waiting lists managed by catchment I&A
e. Periodic statewide validation audits

4. Fully devolve I&A role for both MHCSS & drug treatment services

a. Catchment-based I&A role replaced by a strengthened and revised central statewide information, screening & referral role
b. I&A role undertaken in full by MHCSS and drug treatment services
c. Continue with common screening and assessment tools
d. Waiting lists managed by MHCSS and drug treatment services and reported centrally

e. Periodic statewide validation audits

Taking into account the original policy objectives which underpinned both MHCSS and drug treatment recommissioning, the following criteria are considered relevant to evaluate the proposed options for enhancing intake and assessment services:

1. Consumer outcome focus
2. Ease of access
3. Timeliness of access
4. Equity of access
5. Ease of referral
6. Support for carers/families
7. Consistency of eligibility and assessment
8. Efficiency
9. Service integration

Table 4-1 summarises the rating of each of the four change strategies against each criterion.

Table 4-1: Evaluation of three change strategies, I&A services

CRITERIA	STATUS QUO	1. MINOR REVISIONS	2. ESTABLISH SINGLE STATEWIDE I&A PROVIDER	3. APPLY MHCSS I&A MODEL TO DRUG TREATMENT	4. FULLY DEVOLVE I&A ROLE
1. Consumer outcome focus	××	×	×	×	✓
2. Ease of access	××	××	××	×	✓
3. Timeliness of access	×	×	×	✓	✓✓
4. Equity of access	✓	✓	✓	✓	~
5. Conflict of interest	×	×	✓	×	✓
6. Ease of referral	×	×	×	×	✓
7. Carer/family support	××	✓	~	~	~
8. Quality	×	✓	~	~	~
9. Efficiency	×	×	×	✓	✓✓
10. Service integration	×	×	×	✓	✓✓

The relative merits of each change strategy are discussed in more detail below with respect to each criterion.

4.5.1 CONSUMER OUTCOME FOCUS

Consumer outcome focus in this context refers to the extent to which clients are streamed to receive an appropriate intervention tailored to their needs.

- I&A strategies in which MHCSS or drug treatment services are not accountable for clients placed on a waiting list are rated negatively.
- I&A strategies which are primarily based around catchment-based I&A without flexible screening/intake options at the service provider level are rated negatively given the adverse impact on access by vulnerable clients. This is because phone-based intake creates access barriers for vulnerable clients.
- Strategies in which *assessment* is undertaken separately from treatment are rated negatively. This is because there is a greater risk that the therapeutic intervention is interrupted with a separate organisation undertaking the assessment compared to treatment.

4.5.2 EASE OF ACCESS

Ease of access in this context refers to the extent to which I&A screening/intake can be undertaken flexibly either through phone-based intake or at the service provider level for consumers who 'walk-in' or are referred. It also refers to the extent to which assessment can be undertaken as a part of the continuum of care by a single organisation.

- Strategies which are primarily based around the *screening/intake* role being undertaken by an I&A provider separately from the service provision role are rated negatively.
- Strategies in which the *assessment role* is undertaken separately from the service provision role are rated negatively. This is because consumers are typically required to travel to two separate services: an assessment at an I&A service; and commencement of care episode at a drug treatment provider.

4.5.3 TIMELINESS OF ACCESS

Timeliness of access in this context refers to the extent to which I&A screening/intake and assessment can be implemented expediently.

- Strategies which are primarily based around the *screening/intake* role being undertaken by an I&A provider separately from the service provision role are rated negatively. This is because screening/intake is separate from the service provider role, limiting timely screening/intake of consumers who walk-in or are referred in.
- Strategies in which *assessment* is undertaken separately from treatment are rated negatively. This is because there is an additional step introduced between the screening/intake stage and the commencement of a care episode.

4.5.4 EQUITY OF ACCESS

Equity of access in this context refers to the extent to which *screening/intake* can be undertaken consistently to determine priority of clients' service needs and that consumer intake processes are structured to facilitate intake in order of client priority.

- Strategies in which *screening/intake* is undertaken by catchment-based I&A providers are rated positively.
- Strategies in which screening/intake is devolved to service providers would need to be supplemented by performance review/audit to assure the integrity of policy expectations around equity of access.

4.5.5 CONFLICT OF INTEREST

Conflict of interest in this context refers to the extent to which the screening/intake role is undertaken by the same organisation that undertakes a service provider role.

- Strategies in which the screening/intake role is undertaken by the same organisation as the service provision role, and there are other service providers in the same catchment reliant on referrals from the I&A provider, are rated negatively.

4.5.6 EASE OF REFERRAL

Ease of referral in this context refers to the extent to which external referring organisations can refer consumers to MHCSS and drug treatment services.

- Strategies that are primarily based around the *screening/intake role* being undertaken by an I&A provider separately from the service provision role are rated negatively. This is because screening/intake is separate from the service provider role, limiting timely screening/intake of consumers who are referred in.
- Strategies which are primarily based around the management of waiting lists by a catchment-based I&A provider separately from service providers are rated negatively. This is because referring organisations are unable to leverage established relationships with a local network of service providers to facilitate referrals. Rather, it is the I&A provider that allocates clients to catchment services based around priority of need.

4.5.7 CARER/FAMILY SUPPORT

Carer/family support in this context refers to the extent to which screening/intake and assessment functions facilitate carer/family support.

- Strategies which do not have explicit policy guidelines supported by training and performance review/audit are rated negatively.

4.5.8 QUALITY

Quality in this context refers to the extent to which there are explicit screening/intake and assessment criteria that are competently applied by capable staff supported by training and performance review/audit.

- Strategies which do not have explicit screening/intake and assessment criteria, explicit expectations around workforce capability as well as provision for training and performance review/audit are rated negatively.

4.5.9 EFFICIENCY

Efficiency in this context refers to the extent to which *intake/screening and assessment* arrangements provide value for money.

- Strategies in which *assessment* is undertaken separately from treatment are rated negatively. This is because:
  - Assessment quality is variable leading to re-assessment at commencement of the care episode; and
  - Elapsed time from intake, to assessment to service commencement leads to a change in client circumstance necessitating a re-assessment at commencement of the care episode.

4.5.10 SERVICE INTEGRATION

Service integration in this context refers to the extent to which joined-up service delivery models can be promoted.

- Strategies which are primarily based around the *screening/intake role* being undertaken by an I&A provider separately from the service provision role are rated negatively. This is because services cannot facilitate intake from other health and human service providers directly.

4.6 Options for change strategies – intake and assessment services

Change strategy 1 involves a series of minor revisions. These incremental changes are relevant to the enhancement of the I&A role. Specifically, this strategy is rated well against three criteria: equity of access; carer/family support; and quality. However, whilst performance on these criteria is important, this strategy is not sufficient to address other core criteria. That is, current performance issues identified with I&A would not be effectively mitigated by this strategy alone.

- Change strategy 1 should be pursued in combination with other strategies.

Change strategy 2, 'Establish a Single Statewide Intake and Assessment Provider', does not provide an effective means to address current shortcomings with the I&A role. It does however rate well on one criterion, mitigation of conflict of interest.

- Change strategy 2 is not recommended.

Change strategy 3, 'Apply MHCSS Intake and Assessment Model to drug treatment services', rates well on several criteria. In particular, the re-allocation of the assessment role to the treatment provider setting achieves improvements in relation to: timeliness; efficiency; and service integration. However, the continued reliance on phone-based intake and screening by the catchment intake and assessment provider adversely affects other criteria: client outcome focus; ease of access; ease of referral; and conflict of interest.

- Change strategy 3 is not the preferred option. However, it could be an option if the preferred option is not acceptable.

Change strategy 4, 'Fully devolve intake and assessment role', rates higher on most criteria. It is rated as equivalent to the incremental strategy in relation to: equity of access; quality; and carer/family focus. The most significant advantages of this strategy are in relation to: improvements in consumer outcome; ease of access; timeliness of access; conflict of interest; ease of referral; efficiency and service integration.

4.6.1 POTENTIAL CHANGE STRATEGIES FOR INTAKE AND ASSESSMENT SERVICES

Drug treatment services

- Change strategy 4, 'Fully devolve intake and assessment role' is the recommended approach for drug treatment services.
- In addition to change strategy 4, the incremental improvement strategies outlined in change strategy 1 should be implemented.

MHCSS

- In the case of MHCSS, it is **not** considered appropriate to undertake structural change to intake and assessment given the future transition of MHCSS to NDIS in the short to medium-term.
- Incremental improvement strategies outlined in change strategy 1 should be implemented for MHCSS.

4.6.2 KEY COMPONENTS OF A DEVOLVED INTAKE AND ASSESSMENT ROLE FOR DRUG TREATMENT SERVICES

The key components of a devolved intake and assessment role for drug treatment services are described below.

Each approved drug treatment service provider would be responsible for performing the intake and assessment role. This would involve the use of the revised screening tool to prioritise client access for treatment.

Service providers would report the following information on a regular basis to a centralised, statewide information and referral service:

- Results of each client screening outcome;
- The number of clients screened as eligible and waiting for service commencement by tier;
- The number of clients completed treatment; and
- The number of clients currently under treatment at the time of reporting.

The centralised, statewide information and referral service would be retained. This statewide service would continue to have a role in *phone-based screening and referral* for clients and referrers who prefer to make phone-based contact.

Catchment-based intake and assessment services would be discontinued for drug treatment services and the resources allocated to drug treatment services.

Catchment-based planning functions would continue as a valuable part of the identification and targeting of clients, as well as developing/evolving service models. The role of catchment-based planning could be reviewed as to their ongoing value after three full years of operation.

5 Service delivery

With the recommissioning of drug treatment services and MHCSS, the Department consolidated a large number of service types into a tighter group of service delivery streams.

For drug treatment services, there are four treatment streams:

- Intake and assessment;
- Counselling (standard or complex);
- Care and recovery coordination; and
- Non-residential withdrawal.

For MHCSS there are three service streams:

- Intake and assessment;
- Individualised client support packages; and
- Youth residential rehabilitation.

In addition, a catchment-based planning function for AOD and MHCSS respectively was introduced as part of the reforms.

5.1 Key benefits

Stakeholders identified key benefits of the reform to service delivery as:

- Consolidation of multiple service types into a small number of streams/products; and
- Flexibility to allocate program hours tailored to individual care plans.

These benefits are inter-related. The previous range of highly differentiated service types was acknowledged to be overly complex. The introduction of broader bands provides greater scope for providers to tailor programs to meet client needs. To a varying extent, there is also greater flexibility at the provider level to configure services according to local circumstances.

The perception has been that MHCSS has more flexibility for tailoring programs than drug treatment services on the basis that most drug treatment providers felt constrained by the funding model. This is discussed in Section 7.

In addition, the catchment-based planning function for drug treatment services and MHCSS received universal support. This initiative was considered far-sighted and there are expectations that it will lead to improved understanding of demand (including latent demand), improved targeting and improved models of care.

5.2 Issues common to both MHCSS and drug treatment services

The following issues raised by stakeholders in relation to service delivery were common to both MHCSS and drug treatment services:

- Lack of clear program expectations, leading to inconsistency between services;
- Insufficient access to bridging services between I&A and service commencement;
- Lack of early intervention focus;
- Siloed service provision;
- Prioritised access leading to clients being allocated to services anywhere in the catchment, potentially leading to inefficiency due to higher transport costs; and
- Insufficient support for carers/families.

To further expand upon the issues raised in relation to bridging support and early intervention, the challenge identified by many stakeholders is that there are delays encountered by clients in gaining access to a service following the screening and intake process. Whilst there is an expectation that support be provided by intake and assessment providers for clients on waiting lists, many regarded the support provided as token and advocated for an enhanced support focus including provision of evidence-based 'brief interventions'. The lack of adequate support was identified as leading to poorer outcomes and increased risks to health.

Each of these issues is considered in more detail below together with options and recommendations.

ISSUE	**14. Lack of clear program expectations, leading to inconsistency between services**
ASSESSMENT/ FINDING	A common view expressed by stakeholders was that in contrast to the strong focus on a consistent approach to intake and assessment services, there was a lack of guidelines for service provision and program outcomes. As a consequence, there is likely to be substantial variation between service providers in program delivery. **Finding:** Program delivery expectations should be clear and consistent as part of a Service Framework for each sector. A Service Framework is seen as a necessary and core requirement under which providers should be required to operate. This is a gap in the current recommissioned services. The Framework should not be prescriptive with respect to service models.
OPTIONS/ POTENTIAL SOLUTIONS	There are two options: a. Progressively develop program guidelines, with input by the sector. b. Develop a Service Framework for each sector. **Potential solution** The short-term objective is to improve program guidelines for the sectors. Therefore, Option A should be commenced in the near future. However, within 12-18 months a Service Framework should be operational.

ISSUE	**15. Insufficient access to bridging services between I&A and service commencement** **16. Lack of early intervention focus**
ASSESSMENT/ FINDING	In the context that there are significant delays between Intake and Assessment and service commencement, particularly for low to medium priority MHCSS clients, access to any form of maintenance service can be highly variable and depends on the capacity of the I&A provider to 'follow up' assessed clients not yet receiving their definitive service. Many stakeholders from the drug treatment sector further commented that the reforms had led to a narrowing of program focus, with less discretion for service providers to pursue harm minimisation, education and health promotion activities. **Finding:** There is a requirement for I&A services to undertake follow up support for clients screened as eligible and who are waiting for a place to become available. In spite of this explicit program expectation, bridging support was 'patchy'. There was often no service for low to medium priority MHCSS clients. The re-focusing of program expectations has been a challenge for many drug treatment service providers, limiting their discretion to pursue harm minimisation, education, and health promotion activities. Some saw this as an unintended consequence of the reforms. However, it is clear from the program objectives that the intention of government was to better target high priority clients. On this basis, the program is meeting its objective.
OPTIONS/ POTENTIAL SOLUTIONS	To facilitate evidence-based, brief interventions and to ensure accountability at the appropriate level in the service system, the following potential solutions are **offered**: ▪ Following screening of clients at intake and assessment, refer clients directly to service providers and transfer responsibility for management of clients on waiting lists to service providers. ▪ Implement a new service category/stream (including the funding model) focused on a 'brief intervention'.

ISSUE	**17. Siloed service provision**
ASSESSMENT/ FINDING	A consistent concern of stakeholders from both sectors is that the separate I&A systems have led to a siloed approach for dual diagnosis clients which is incompatible with program objectives. As outlined in relation to I&A services, a further criticism has been made about the recommissioning leading to a reduction in the range of MHCSS services operating from a multi-service, organisational context such as community health services. This was argued to be counterproductive to joined-up service delivery. **Finding:** The lack of service modules for dual diagnosis clients to enable shared care between MHCSS and drug treatment services is a significant program gap.
OPTIONS/ POTENTIAL SOLUTION	It is recommended that two service initiatives be implemented to reduce siloed service provision between sectors for dual diagnosis clients: ▪ Develop a new service product to enable integrated service modules for vulnerable

	clients with dual diagnosis ▪ Revise intake and assessment arrangements to remove the requirement for separate intake and assessment pathways for dual diagnosis clients.

ISSUE	**18. Prioritised access leads to clients being allocated to services anywhere in the catchment, potentially leading to inefficiency due to higher transport costs** **19. Insufficient support for carers/families**
ASSESSMENT/ FINDING	Several stakeholders commented adversely on the strict application of the requirement for client referral by order of priority. The outcome is that service providers are obliged to target resources to deliver services by strict order of client referral from the waiting list, rather than having the flexibility to match client intake according to other considerations including geographic proximity. **Finding:** The policy intent of the Department and government has been explicit with regard to priority of access being determined on the basis of assessed need. This is a legitimate policy objective. There are a range of strategies that service providers are expected to put in place to ensure that services are both accessible to clients in terms of timeliness and also in terms of geographic proximity. This policy objective is sound and should be retained. A consistent theme from consultations was that there was little engagement with carers/family in the client's recovery plan. This was attributed to a variety of causes including the difficulty in knowing who should be contacted, a view that clients often do not want family involved, and/or there is not the time or inclination to engage with family/carers. **Finding:** The apparent lack of support for carers/families is inconsistent with the program expectations underpinning the reforms for both sectors.
OPTIONS/ POTENTIAL SOLUTIONS	To promote effective support for carers/families in service delivery potential solutions include: ▪ Program guidelines, and a Service Framework, would specify and promote family/carer interaction; and ▪ Any introduction of a 'brief intervention' service category would be applied to family and carer interventions.

5.3 Issues specific to drug treatment services

Based on the consultations there were two issues that were commonly expressed, including:

- The perceived rigidity of 'standard' and 'complex' client counseling sessions (4 versus 15) limits effectiveness of treatment; and
- Service coordination requirements of clients with supported housing needs not readily met.

ISSUE	**20. Perceived rigidity of counselling sessions**
ASSESSMENT/ FINDING	The majority of stakeholders considered that the introduction of two bands for counselling – standard counselling (four sessions) and complex counselling (fifteen sessions) – was overly rigid. **Finding:** The program expectations are not prescriptive. The rigidity appears to be in the interpretation of the program. The number of sessions has been set as an average for clients who are 'standard' and 'complex' and the actual number of sessions per client is intended to be tailored to the client's needs. The interpretation by a majority of providers would appear to be due to: ▪ The absence of any consistent information regarding the application of the funding model; and ▪ Program guidelines.
OPTIONS/ POTENTIAL SOLUTIONS	To enable providers to effectively deliver programs with flexibility, potential solutions include: ▪ Information to be provided to the sector to explain the basis for the funding model and how the funding model is expected to be applied; and ▪ Review of the drug treatment funding model as discussed in Section 7, which would include consideration of a new service category for 'intermediate counselling'.
ISSUE	**21. Service coordination requirements of clients with supported housing needs not readily met.**
ASSESSMENT/ FINDING	Many considered there was insufficient flexibility in the drug treatment service model to address the inter-agency service coordination requirements of vulnerable clients including young people and the homeless. Whilst there has been provision in the service model for a specific service type 'care, recovery and coordination' to enable collaborative service planning, in reality many considered that this was under-resourced. **Finding:** ▪ The importance of inter-agency service coordination is highly relevant for vulnerable clients. Whilst the service model makes provision for this through the 'care recovery and coordination' service type, consistent feedback to the review indicates that the resourcing of this service type needs further consideration to ensure its effectiveness and responsiveness.
OPTIONS/ POTENTIAL SOLUTIONS	A potential solution proposed is proposed in relation to the funding model review: ▪ Review the suitability of resourcing for 'care recovery and coordination' services and the scope for coordinated service models for clients with multiple service needs including homeless clients and young people.

5.4 Issues specific to MHCSS

The one issue relevant to service delivery that was specific to MHCSS was a discontinuation of drop-in services and group services. This is perceived to have created a service gap, with risks of social isolation and relapse for vulnerable clients.

ISSUE	**22. Discontinuation of drop-in services has created a service gap, with risks of social isolation and relapse for vulnerable clients**
ASSESSMENT/ FINDING	It is widely reported that most drop-in programs were discontinued, and group sessions significantly curtailed. This is seen as detrimental for many clients who had relied upon drop-in programs as a mainstay of social engagement and 'maintenance' support. It has been reportedly difficult for MHCSS clients to find alternative opportunities for group interaction, particularly in a context of sharing groups with other consumers with lived experience. The opportunity to join mainstream, community-based groups such as those operated by neighbourhood houses, is more difficult for many clients to pursue, with key barriers including confidence, motivation, transport and resources. **Finding:** There appears to be two main reasons for the discontinuation of these services. Firstly, service providers interpreted the program reform's focus on recovery-oriented service models as incompatible with drop-in centres, with the latter potentially regarded as serving a maintenance role. Secondly, a perception that ICSP was not consistent with group programs. Whilst this perception is understandable, the reforms were not intended to diminish the focus on group programs. This may be an unintended consequence of the re-commissioning. It is also the case that several service providers have identified innovative approaches to using ICSPs including for provision of group services.
OPTIONS/POTENTIAL SOLUTIONS	Potential solutions include: ▪ Introduce program guidelines and a Service Framework to explicitly include day programs and group sessions as part of the suite of relevant services to clients, and provide information to service providers on approaches to delivery of recovery-oriented services through group sessions; and ▪ Include explanatory information on arrangements for group sessions within the funding model.

6 Service relationships and partnerships

This section assesses the changes that have arisen for both sectors in terms of service relationships and partnerships following the recommissioning.

6.1 Main benefits

A stronger emphasis on area-based service coordination and collaboration has been an explicit policy objective of both reforms together with an expectation that this would lead to a greater potential for 'joined-up' service delivery.

Another potential benefit from the reforms has been the innovation in systems and processes associated with recommissioned organisations undertaking specialist roles in an expanded catchment reach.

Whilst both of these benefits offer promise in the medium term, the realisation in practice is not yet apparent.

6.2 Key issues common to both sectors

The major issue common to both sectors is the disruption and fracturing of long-standing relationships associated with the re-commissioning.

ISSUE	**23. Disruption and fracturing of long-standing relationships.**
ASSESSMENT/ FINDING	Stakeholders provided consistent feedback that the recommissioning process had disrupted relationships between services providers. In most catchments, there has been a concerted focus on re-establishing good working relationships within the existing service providers and with new service providers. **Finding:** To a significant extent, the disruption and fracturing of long-term relationships is an expected outcome from tender-based recommissioning. For the most part, this is a transitional issue and in most catchments, service providers have actively sought to re-establish good working relationships. There are however structural design elements of the reform that have created continuing tensions. There are two issues in particular that are likely to cause ongoing levels of tension, including: ▪ The spectre of tendering of future services and the undermining of a service provider's position if they are too open in the relationship; and ▪ The allocation of referrals in catchments where the I&A provider is also a provider of treatment/therapy.
OPTIONS	Nil. Section 10 addresses proposed solutions in relation to future reforms.

6.3 Key issues relevant to drug treatment sector

One substantial issue that has been specific to the drug treatment sector is that consortia were formed out of necessity rather than mutual interest.

ISSUE	**24. Consortia formed out of necessity rather than mutual interest.**
ASSESSMENT/ FINDING	There are mixed responses from the sector on the advantages associated with consortia. In some catchments, the consortia arrangements are reported to be working smoothly, with stakeholders reporting benefits from shared information processes and good governance. This has not been the typical experience. Many stakeholders are less convinced of the value of forming consortia, with three main concerns raised: ▪ The allocation of corporate administration to oversight relatively small components of program delivery; ▪ The tensions associated with one lead agency liaising with the Department and potential gaps in communication flow; and ▪ Fundamentally, the perception that the decision to form a consortium was made out of necessity rather than mutual interest. Additionally, I&A providers indicate that from an operational perspective, it is not straightforward communicating and confirming referral pathways with the individual services within the consortia. **Finding:** An outcome of the recommissioning in the drug treatment sector has been the formation of consortia in every catchment. This has been of variable success and in some catchments service providers perceive there is limited benefit in remaining in the consortium. The value of consortia should be sustained by the entities themselves and that 'forced consortia' is to be discouraged.
OPTIONS/ POTENTIAL SOLUTION	Potential solutions include: ▪ Enabling organisations to exit consortia; ▪ In future service development initiatives for both sectors, retain the option of organisations opting to form consortia, but on an entirely voluntary basis.

7 Workforce

Recommissioning has had a significant workforce impact on both sectors. In part, the impacts are related to the transitional effects of organisational changes related to tender outcomes. Other impacts are linked to the changes in service models for both sectors that have been associated with the reforms.

7.1 Main benefits of reforms

One potential benefit of re-commissioning has been the opportunity for organisations – particularly those which achieved an expanded scope of service delivery – to consolidate their workforce capacity and capability. Although this has not been a widely reported benefit, there has been some positive feedback from stakeholders to this effect. The re-commissioning for these services has been an opportunity to invest in skills development and staff training with the aim of delivering successful outcomes within the new service model.

7.2 Key issues common to MHCSS and drug treatment services

The predominant feedback from other stakeholders has been less positive, with concerns raised about the adverse impact on the workforce in both sectors. There have been two main issues raised:

- Loss of experienced workforce following re-commissioning; and
- Workforce dissatisfaction/disillusionment due to transitional implementation issues and continued structural system deficits.

ISSUE	**25. Loss of experienced workforce** **26. Workforce dissatisfaction/disillusionment due to transitional implementation issues and continued structural system deficits**
ASSESSMENT/ FINDING	Both sectors consider that there has been a loss of experienced workforce following re-commissioning. This one-off effect has been compounded by the second issue, that is, the impact of transitional implementation issues and continuing challenges confronting the workforce due to perceived design shortcomings. Stakeholders have advised that the cumulative impact is that there is relatively low workforce morale with recruitment and retention challenges. There is less focus on training in a context where senior staff have limited time for clinical supervision. Uncertainties about the length of contracts in the period post re-commissioning have also been an important contributing factor in workforce instability. In the case of MHCSS, uncertainty about the future workforce impact associated with the NDIS rollout was cited as a significant concern. **Finding:** Re-commissioning has had a substantial impact on the workforce with two main contributing factors, and this can be expected to continue, particularly with the roll-out of the NDIS. It is noted that one of the pre-commissioning factors was the intention to develop sector-wide workforce development plans. These plans have not been developed at this time.
OPTIONS/ POTENTIAL SOLUTION	The proposed potential solution is that the Department develop a workforce strategy for both sectors as a core component of future change/service improvement initiatives.

7.3 Issues specific to drug treatment services

A further issue raised in the context of drug treatment services is that there has been a detrimental impact on morale due to the structure of the intake and assessment role vis-à-vis treatment services.

ISSUE	27. De-skilling of specialist drug treatment workforce
ASSESSMENT/ FINDING	The separation of assessment from treatment/therapy in the drug treatment sector has had the reported impact of the de-skilling of specialist workers. **Finding.** Whilst there is a strong perception of de-skilling by some providers, the issue is more likely to be around 'undermining' the professional integrity of skilled practitioners in being able to appropriately assess clients. In fact, drug treatment practitioners are also indicating that they need to re-assess anyway.
OPTIONS/ POTENTIAL SOLUTIONS	Nil. Other potential solutions adequately deal with the perceptions of de-skilling.

7.4 Issues specific to MHCSS services

An issue specific to MHCSS is the widespread uncertainty around the workforce implications of the future transition of MHCSS services to NDIS. This issue can only be addressed within a wider strategic appraisal of the future role that will be served by MHCSS.

8 Funding

This section considers the current issues and potential solutions relating to the funding models established as part of the recommissioning of the MHCSS and drug treatment services. This section considers:

- Issues that are common to both MHCSS and drug treatment services;
- Issues that relate only to MHCSS; and
- Issues that relate only to drug treatment services.

8.1 Issues common to MHCSS and drug treatment services

As a general statement, the issues relating to the funding models for both MHCSS and drug treatment services were not the focus of discussion of stakeholders during consultations. Nevertheless, there are implications for funding models if changes to the service model are contemplated. To state the obvious, changes to the service system and service model will be very difficult to implement and embed if they are not reinforced by a compatible funding model.

There were positive factors relating to the funding models for MHCSS and drug treatment services including:

- Relative to the previous funding model, a much tighter relationship between what is being 'purchased' by the Department and what the provider delivers. This provides greater clarity and sets output expectations;
- There are both implicit and explicit service category priorities embedded in the funding models; and
- A common (equitable), transparent, and consistent basis for funding across the sector. The funding model has effectively removed the historical and ad hoc, incremental basis that characterised the previous funding approach.

There were two issues common to both MHCSS and drug treatment services as outlined below.

ISSUE	**28. Limited capacity to flexibly apply resources**
ASSESSMENT/ FINDING	One of the stated objectives of the funding model was to enable the flexible application of funding to support client-focused and tailored service provision. The feedback from the sector is inconsistent with the stated objective of enhanced flexibility. **Finding:** For many service providers across drug treatment and mental health community support, the reduced flexibility relates to the more limited capacity to direct resources to areas that have been traditionally funded under the previous 'block grant' system. This perception is accurate. Funding is more targeted to specific service categories and service outputs. It is appropriate for funders to ensure that the purposes for which funding is made available, and/or the priority of services, are made explicit. This may legitimately constrain providers compared with their historical use of funds. The funding models do

	appear to reflect the priorities of the Department/government. As such there is no basis for the Department to change from this policy-driven approach. Having acknowledged this point, the capacity of providers to deliver primary care and/or prevention services would not be excluded from the suite of legitimate services for drug treatment and MHCSS providers, as long as the expected outputs are delivered within the funding provided. In the event that the Department/government seeks to expand the suite of services that are appropriate for priority funding (such as prevention programs in schools and community groups etc.), this may be considered as part of the broadening of the service categories by adding an additional service category.
OPTIONS/ POTENTIAL SOLUTION	**Funding inflexibility** With respect to concerns about inflexibility due to the provision of non-priority services, it is proposed that the funding models not be changed solely on this basis, as they reflect government funding priorities. However, as noted below, it is proposed that consideration be given to review the drug treatment services funding model for other reasons. Consideration could be given to assessing the merits of a new service category relating to 'drug use prevention' services, particularly if this has policy merit.

ISSUE	**29. Disaggregated funding for dual diagnosis patients.**
ASSESSMENT/ FINDING	One of the stated objectives of the recommissioning was to improve client-focused service integration. This is one of the main weaknesses of the recommissioned services, and is also reflected in the two funding models. **Finding:** The lack of a funding structure that can accommodate dual diagnosis clients is a weakness of the current system design. The service system's capability to deliver client-centred (tailored) care would be significantly enhanced if supported by a funding model that integrated mental health community support and drug treatment services. It is acknowledged that this system change may pose its own set of challenges.
OPTIONS/ POTENTIAL SOLUTION	**Dual diagnosis funding** The options are to: ▪ Continue with the current funding models, i.e. there is no intersection of the funding from the MHCSS and drug treatment service funding models for dual diagnosis clients; and ▪ Commit to the development of an integrated funding approach for dual diagnosis clients that 'blend' the drug treatment and MHCSS funding models for dual diagnosis clients, not for other clients. **Potential Solution** Consistent with current policy directions, it is proposed that over the medium term an integrated funding model be developed that blends funding from drug treatment and MHCSS for dual diagnosis clients.

8.2 Issues specific to MHCSS funding

In the context of the MHCSS funding model, there was only one key issue as discussed below. On this basis there is no requirement for any significant change to the MHCSS funding model, particularly with the imminent transition of some clients to the NDIS service system.

ISSUE	30. Funded service categories do not align with the service model
ASSESSMENT/ FINDING	The feedback indicates that MHCSS funding categories do not cover all service categories. The most consistent feedback was a service 'gap' relating to short one-off or transient contacts with the MHCSS system for: ▪ Periodic and ad hoc support and maintenance; or ▪ Single short interventions aimed at addressing the immediate transient crisis/disruption for a client or carer. **Finding:** The current funding approach is aimed at support around an episode of care and support. The concept of single episode of care/support services for clients and/or carers has merit. 'Brief Intervention' services are not recognised as part of the current funding model and could address an important gap in the funding model. In addition, it would introduce greater flexibility for a myriad of one-off client as well as carer/family services. It certainly warrants further investigation with respect to how it fits with the various MHCSS service models. This review cannot determine the merits or arguments for an additional 'brief intervention' service category. However, there appears to be a *prima facie* case for the introduction of a new MHCSS funding category that provides for brief interventions.
OPTIONS/ POTENTIAL SOLUTIONS	***Funding inflexibility*** The options available include: ▪ The continuation of the existing serviceable funding model for MHCSS; or ▪ The development of a 'brief intervention' funding category. **Potential Solution** The capability to fund brief interventions would enhance the service delivery system and is therefore a modification to the current MHCSS funding model.

8.3 Issues specific to drug treatment services

The review identified some positive as well as negative issues relating to the drug treatment funding model. The funding model issues that generated the most discussion related to its *design* and *implementation*.

Unambiguously positive factors relating to the funding model include:

- A much tighter relationship between what is being 'purchased' by the Department and what providers deliver. This provides greater clarity and sets output expectations; and
- A common (equitable), transparent, and consistent basis for funding across the sector. The funding model has effectively removed the historical and ad hoc, incremental basis that characterised the previous funding approach.

Notwithstanding these positive attributes of the recommissioned model:

- There were several issues or (perceived) shortcomings of the funding model identified by the drug treatment sector; or
- There were instances where there appeared to be no alignment between the sector feedback and the objectives of the funding model.

The main design issues include:

- Treatment categories (funded service types) were perceived to be inadequate or misaligned to the service models delivered;
- The DTAUs were 'poorly priced', i.e. there was insufficient funding to meet the necessary level of service provision (and consequential concerns relating to the cost data on which the prices were based); and
- The relativity between the prices of the different funded services types were misaligned with each other, i.e. the relativity in pricing of service types – intake & assessment, counselling, care recovery and coordination, and non-residential withdrawal services – does not appropriately reflect difference in the cost of service delivery.

The main implementation issues include:

- Difficulties using the DTAUs to operationally manage budgets and staff resources;
- Low referral rates to drug treatment services since the recommissioning undermines the viability of provider organisations because, unlike the previous grant-based payment system, funding is now output-based; and
- The business rules relating to the application of DTAUs were too inflexible or restrictive.

Distilling the relative impact of each of the above issues is problematic, as they are all inter-related. Nevertheless, each of these issues is described, along with an assessment and identification of options for consideration.

In releasing the new funding model as part of the recommissioning, it is particularly important to note:

- The Department recognised that the funding model was of necessity based on a modelling approach due to the paucity of cost and activity data that was available from the drug treatment service providers. There was an acknowledgement that the funding model would need a review post-commissioning; and
- The intention of the funding model was to make funding more transparent, flexible and equitable.

Whilst there were other stated objectives of the funding model, there was no alignment between the expected impact and the feedback from the drug treatment sector. These issues are summarised in the table below:

ISSUE	**31. Funded service categories are not aligned with the service model**
ASSESSMENT/ FINDING	There are four treatment types and five funding categories for drug treatment services, including: Intake & Assessment; Counselling (two types – standard and complex); Care

	Recovery and Coordination; and Non-Residential Withdrawal. The feedback indicates that these funding categories do not adequately reflect the range of services provided. Some specific feedback has been provided with respect to: ▪ Inclusion of an 'intermediate' counselling category between clients assessed as 'standard' and 'complex' on the basis that the gap between the two categories is too great. **Finding:** There is a significant gap between the average indicative price for a standard and a complex client. The arguments for an intermediate counselling service type are based on the view that there is an inflexible application of the model of four or fifteen counselling sessions. While the model is more flexible than this observation implies, there is nevertheless merit in considering an intermediate counselling service category if it is consistent with identifiable service models for particular client cohorts that fit in the middle of the current service types, not simply because the 'gap is too great'. ▪ 'Brief Intervention' service type. This would be based on the fact that there are clients who have brief, often one-off contacts with service providers, but there is no basis for this to be recognised and funded within current service categories. Anecdotally, there may be very few clients for some agencies and a significant number for others. There is no basis on which this can be tested as part of this review. **Finding:** This concept has merit on the basis that it provides a level of flexibility for a myriad of one-off and intermittent client contacts, and carer/family support contacts. It warrants further investigation with respect to how this aligns with the various service models. ▪ The lack of any integrated funding approach to dual diagnosis clients. **Finding:** This is both an accurate assessment and a gap in the service system design, not only the funding model. It will necessitate a change to the funding model to incorporate 'funding packages' for dual diagnosis clients to reinforce or consolidate any system design changes that better integrate services for dual diagnosis clients. ▪ Service coordination requirements of clients with supported housing needs not readily met. **Finding:** The importance of inter-agency service coordination is highly relevant for vulnerable clients. ▪ Lack of funding for drug use prevention activities. **Finding:** This issue can be assessed as part of the general review of the drug treatment funding model if considered appropriate by the Department. This would recognise that 'prevention services' are part of a core suite of services to be funded.
OPTIONS/ POTENTIAL SOLUTIONS	**Gaps in service categories funded** With respect to the adequacy of service categories, this review cannot determine the merits of arguments for additional or modified service categories. **Potential solutions** As suggested in the Department's recommissioning documents, it is proposed that the funding model be reviewed. The review should examine the merits of additional service categories to address gaps.

	A specific focus of the funding model review is the suitability of resourcing for 'care recovery and coordination' services and the scope for coordinated service models for clients with multiple service needs including homeless clients and young people. Unfortunately, the review would need to contend with the ongoing paucity of reliable or complete activity and cost data for drug treatment services, which means that the Department will again need to use a modelled approach. In this event, it is proposed that the modelling be shared with the sector, and that a collaborative approach may assist with a more widespread understanding and ownership of how service categories and prices are determined.

ISSUE	**32. Under-priced DTAUs**
ASSESSMENT/ FINDING	Feedback has been provided that indicates that the prices provided through DTAUs are too low to cover costs associated with service provision. There are a number of possible scenarios: ▪ Some providers have cost structures that are too high for what might be reasonable funding levels; ▪ Funding for some activities is too low to meet reasonable costs; and ▪ Price relativities are misaligned (as discussed below); or ▪ All three of these reasons. **Finding:** We note that the price established for each service category was based on modelled costs at drug treatment services where both activity and cost information was obtainable. The Department notes that the veracity of some of this data was questionable, but that it was the only data available. Therefore, there may be merit in the arguments relating to under-pricing of some or all service categories. As noted above, the current activity and cost information is no more reliable than it has been over previous years. Even more reliable and complete activity and cost datasets are a necessary pre-requisite for an output-based funding approach. The credibility of the system will rely on robust activity and cost measurement systems.
OPTIONS/ POTENTIAL SOLUTION	**Low activity pricing** The options for the Department are to determine, with input from the drug treatment sector: ▪ A narrow range of costs and activity for all providers that is accurate and complete, and auditable; or ▪ The complete range of activity and cost data at sampled providers. Collection of valid cost data would then provide a basis to determine prices. **Potential solution** It is proposed that the Department give consideration to undertaking a costing study through the establishment of a representative group of providers, including the establishment of robust data definitions and the collection and reporting of costs (and activity) that would be used as the basis for costing of each service category. This could then be used as a more solid foundation for determining sector prices.

ISSUE	33. Relative prices for different service types are not properly aligned
ASSESSMENT/ FINDING	There were widespread comments that the price being provided for one service category was disproportionate to the price for other services. In other words, prices were not seen to have relativity with the expected resources/costs of delivery. Whilst most feedback related to the relatively 'high' cost of assessment services, there was also feedback to indicate assessment services were under-funded. The important consideration was that there was widespread concern about this issue. **Finding:** There may be merit in the arguments relating to misalignment of pricing, but due to the paucity of reliable data noted above and/or lack of transparency about the basis for the modelled costs, the arguments are difficult to validate. Another potential reason for the misalignment of relative prices is that the Department is exercising normative pricing for some type of service categories. We understand that this was not the case when establishing the funding model. Any inadvertent misalignment of prices will impact on incentives and change models of care in ways that are not intended. Therefore, this is an important issue to examine.
OPTIONS/ POTENTIAL SOLUTION	**Pricing relativities** The proposed potential solution is for price relativities between service categories to be examined as part of the recommended review of the funding model. Ideally, this should occur as part of, or following, the costing study from a sample of providers.

ISSUE	34. Operational Management difficulties using DTAUs
ASSESSMENT/ FINDING	A consistent theme from the consultations with the sector was that 'managing' local operations using DTAUs was 'difficult' (with some stakeholders saying it was impossible). **Finding:** The issues relating to effective internal (agency) management under an activity-based funding approach (i.e. DTAUs) are not straightforward. One of the issues is cultural, in that drug treatment services are required for the first time to 'match' costs with service outputs (as well as staffing resources). Aligning resources to an activity-based funding approach is a common issue for health services in a transition from 'block grant' funding. Hence, this is an expected transitional issue. However, for the drug treatment sector the concern may be more than transitional for two reasons: ▪ The 'basic spreadsheet' reporting requirements established by the Department for DTAUs is a 'band-aid' solution at best, and does not assist providers to establish internal systems to manage under DTAUs. ▪ The second issue is more fundamental. The drug treatment sector does not have an important 'building block' for activity-based funding. There is no common/system-wide database for drug treatment services that can capture client-level activity data, or client-level cost data in order for providers to effectively manage their resources relative to their income.
OPTIONS/ POTENTIAL SOLUTION	**Operational management difficulties using DTAUs** With respect to these system deficiencies, options include a discussion with the sector to

	more comprehensively understand the diversity of issues relating to managing under the DTAU approach and: ▪ Provision of information sessions that better enable the sector to manage under DTAUs (including how DTAUs are developed); and/or ▪ Provision of resource kits that better enable the sector to manage under DTAUs; and/or ▪ Refining and developing the next version of the reporting spreadsheet (as an interim solution); and ▪ Committing to the longer-term development of a client-based data system, and client or service-based cost system (that enables data linkages) between the two systems. **Potential solution** The potential solution proposed is that the Department commit to the development of sustainable, client-based activity and costing systems for the sector in the long-term. In the interim, the Department should be in a position to assist the sector in the development of resource-kits, information sessions and the next generation of the reporting spreadsheet.

ISSUE	**35. Low volumes of activity undermine viability of the organisation**
ASSESSMENT/ FINDING	There was concern expressed by several providers that having an activity-based funding model (potentially) compromised the viability of the drug treatment program or the entity, if there were insufficient referrals to cover fixed costs. **Finding:** There are two main elements to this issue: ▪ There is a government policy direction to move away from block grant funding and a clear expectation that services be 'purchased'. At this overarching level, there can be no guarantees of viability by government. ▪ The second element is more closely associated with the recommissioning. There is concern that the recommissioning process itself has resulted in: ▸ 'Artificially' reducing demand by making access more difficult and therefore undermining viability; and ▸ Permitting the I&A provider to also be the treatment service provider in catchments where there is more than one treatment provider. This has created a potential conflict of interest should there be a tendency for an I&A provider to 'feed' clients to their own service in preference to other services, which undermines the viability of the 'other' providers in the catchment.
OPTIONS/ POTENTIAL SOLUTIONS	**Low referrals and activity** It is **proposed** that there be no change to the approach of activity-based funding and that there be no guarantees of entity viability based on government purchasing of services. The solution to structural or design issues relating to recommissioning are not related to the funding model, and are separately discussed in Sections 4 and 5.

ISSUE	36. Inflexibility of the Funding Model
ASSESSMENT/ FINDING	One of the stated objectives of the funding model was to enable the flexible application of funding to support client-focused and tailored service provision. The feedback from the sector is that the stated objective of enhanced flexibility is not being met. **Finding:** As a general statement, the sector has narrowly interpreted the 'business rules' relating to the funding model. For example, the funding 'package' is based on individual client service packages, which have been interpreted as cessation of 'group sessions'. Further, the DTAU for counselling for standard and complex has been interpreted as enabling 4 and 15 counselling sessions respectively, rather than providing greater or fewer sessions to meet a client's needs. The funding model in fact allows and supports tailoring of services within the DTAUs, which are average pricing units based on indicative average sessions on which the funding was based. However, the narrow interpretation has not been universal. There are providers who have indicated an approach more consistent with the intention of the recommissioning objectives. Hence, the concerns relating to 'inflexibility' of the funding model appear to be due in part to the interpretation as much as any inherent issue with the funding model itself, or more particularly, the business rules relating to the funding model. Whilst this is a general finding, there may be one aspect of the business rules relating to the model that may be inflexible. This is the requirement to allocate discrete proportions of DTAUs to specific service types, with an overall flexible use of 20% of funding. Reasons for this type of business rule relate to incentives for providers to shift between service types where there are differential operating margins, thereby potentially skewing services inconsistent with actual demand. Whilst this business rule is designed to ensure that some 'core services' are retained by providers, the benefits of the 'restrictive' use by service type may be illusory, and limit providers from responding to changing need.
OPTIONS/ POTENTIAL SOLUTIONS	**Model Inflexibility** With respect to the inflexibility of the funding model, the proposed solution is to: ▪ Provide information sessions and resource material (kits) that clearly explain the basis on which the service types and prices have been developed. This may include a 'help desk' service for a defined period of time; and ▪ Undertake the above information sessions as part of a broader 'performance management and reporting program'; With respect to the business rule that requires a minimum proportion of DTAUs to be allocated to particular service types, and a 20% flexibility, options could include: ▪ Retention of the existing business rule to ensure a 'floor' is placed under the type of services provided; ▪ Remove the restrictions on the use of DTAUs and use normative pricing for difficult or unpopular service types; and/or ▪ Remove the restrictions on the use of DTAUs on any particular service types, but shadow the service types being delivered relative to the expected demand for each service type, and take corrective actions if necessary. **Potential Solution** The proposed potential solution is that all business rules that restrict the application of DTAUs to particular service types and shadow actual service provision be removed in favour of normative pricing to address disparities in the service mix at a system level.

9 Performance monitoring

The reforms sought to achieve better performance measurement, with a stronger focus on outcomes across both sectors.

9.1 Main benefits of the reforms

The reforms identified the importance of performance management as integral to service improvement. This policy aspiration has not been fully realised, with the draft MHCSS performance management framework released several months post-reform in 2015 and the performance management framework for drug treatment services not yet available.

9.2 Key issues common to both sectors

Aside from the delayed introduction of the performance management framework, many stakeholders expressed concern at the lack of effective IT data collection and reporting systems to support the recommissioned service models.

ISSUE	**37. Delayed introduction of performance management framework** **38. Lack of effective IT data collection and reporting systems**
ASSESSMENT/ FINDING	The delayed introduction of the performance management framework for MHCSS, and the continued absence of a performance management framework for drug treatment services, drew substantial criticism from stakeholders. These delays have been cited as evidence that the reforms were rushed with an inadequate lead-time for implementation. A further criticism has been levelled at the Department by peak organisations in relation to the unilateral way in which the MHCSS performance management framework has been implemented, that is, without sector consultation. The lack of reliable IT systems to support client-level data collection and reporting was also widely commented upon. Reliance on spread-sheet based reporting on an interim basis was regarded as further evidence of the lack of system preparedness for implementation. Stakeholders considered that there had been an increase in the reporting burden post-reform. The absence of efficient reporting systems was considered to divert resources from service provision into administration. **Finding:** The lagged implementation of the MHCSS performance management framework, and the continuing lack of a framework for drug treatment services, is evidence that there was an inadequate lead-time for implementation of the reforms. The reliance on spreadsheet-based reporting systems is a 'band-aid' solution. Whilst a transitional issue, it is less than optimal, detracts from the objectives of reforms and reduces the effectiveness of performance management strategies. This may be one of the more challenging aspects of the reform of the service system.
OPTIONS/ POTENTIAL SOLUTIONS	Even though there is appropriate criticism of the absence of a performance management framework for drug treatment services, fast-tracking a framework would not be prudent unless there has been a rigorous testing of the framework. It is **proposed** that the focus be placed on collaboratively developing the performance management framework with the drug treatment sector, with consideration being given to phased implementation.

	The development of effective IT data collection and reporting systems is a priority and should be undertaken in consultation with both sectors.

ISSUE	**39. The lack of transparent provision of information back to the sector by DHHS from existing minimum data-sets**
ASSESSMENT/ FINDING	The absence of feedback on system performance has been a consistent theme raised by stakeholders. However, in some catchments, there is a flow of information from intake and assessment providers to service providers on client numbers, including those waiting for a service place. One consequence of the patchiness of information on key service metrics is that there is lack of reliable information on waiting times and numbers of clients waiting. In turn, this can detract from service providers' confidence in the reforms. Many consultation forums involved re-iteration of anecdotes of long wait times that were largely based around the immediate period post-reform. Most intake and assessment services confirmed that whilst there may have been initial backlogs with client waiting times for intake and assessment, these have subsequently reduced. The second aspect of this issue is the lack of reporting of the impact of the reforms from the Department. **Finding:** The lack of routinely available system performance reports undermines stakeholder confidence in the reforms.
OPTIONS/ POTENTIAL SOLUTIONS	Disseminating key performance metrics is a relevant and necessary performance management strategy. The **proposed potential solution** is that system level, and service provider level, performance measures be reported online and be made publicly available. This can only occur when there is a robust performance management framework in place.

10 Future service planning & strategic service development

There are two areas of focus for future service planning and strategic service development:

- The implementation of potential changes arising from the options presented in this report; and
- The implementation of future purchasing reforms for out-of-scope services.

10.1 Service changes relevant to stage one recommissioning

This review has identified several aspects of the stage one recommissioning where there will be advantages in undertaking redesign of core system components. Specifically, this relates to the design of the intake and assessment function, and of the funding model, for drug treatment services.

In other areas, there are potential solutions that seek to refine components of the reformed service system to improve performance and mitigate issues and problems.

10.1.1 INTAKE AND ASSESSMENT SERVICES

Priorities for redesign and refinement for intake and assessment services are summarised in Table 10-1 below. There are three **high priority** potential solutions:

- *Fully devolve the assessment function to treatment service providers*
  - This potential solution involves structural change of the drug treatment sector, a one to two year implementation timeframe and has an interdependency with the funding model review;
- *Streamline the current screening tool*
  - This potential solution involves incremental change for both sectors and a six to twelve month implementation timeframe;
- *Develop a common assessment template for dual diagnosis clients*
  - This potential solution involves incremental change for both sectors and a six to twelve month implementation timeframe.

Table 10-1: Potential Solution by priority ranking and timeline, intake and assessment services

POTENTIAL SOLUTION	SECTOR	DESCRIPTION	INTER-DEPENDENCY	PRIORITY	TIMELINE
▪ Fully devolve the assessment function to drug treatment service providers.	Drug Treatment	Structural change	Funding Model	High	1-2 years
▪ Streamline the current screening tool.	Both	Incremental Improvement	-	High	6-12 months

POTENTIAL SOLUTION	SECTOR	DESCRIPTION	INTER-DEPENDENCY	PRIORITY	TIMELINE
▪ Develop a common assessment template for dual diagnosis clients.	Both	Incremental Improvement	-	High	6-9 months
▪ A Departmental sponsored marketing and information campaign promoting awareness of I&A services and how these are accessed. This could include a statewide 1800 number.	Both	Incremental Improvement	-	Medium	6 months development & 6 months roll-out
▪ Support a service model that increases the proportion of supported referrals and outreach assessments, particularly for vulnerable client groups.	Both	Incremental Improvement	Funding Model	Medium	1-2 years
▪ Establish user-training, and a system of independent audits of client assessments to provide integrity and enhanced quality to the assessment system in lieu of the catchment I&A structure.	Both	Incremental Improvement	-	Medium	1-2 years
▪ Program guidelines be developed to promote good practice in relation to the development of 'joined-up' service planning for vulnerable clients with multiple service needs including homeless people; young people; ATSI clients; and CALD clients.	Both	Incremental Improvement	-	Medium	1-2 years
▪ Ensure that there is adequate training/information in relation to enhanced carer & family involvement at the I&A stage	Both	Incremental Improvement	-	Medium	6-12 months

10.1.2 SERVICE DELIVERY

Priorities for redesign and refinement of service delivery are summarised in Table 10-2 below.

There are three high priority potential solutions.

- *Following client screening at I&A, clients are referred directly to a service provider along with the responsibility for management of clients (and any waiting lists);*
  - This potential solution involves structural change of both sectors, a one to two year implementation timeframe and is interdependent with the funding model review.
- *Implement a new service category/stream for both sectors (including the funding model) focused on a 'brief intervention'. A brief intervention service would be applicable to clients and to carers/family interventions;*
  - This potential solution involves incremental change of both sectors, a one to two year implementation timeframe and is interdependent with the funding model review.
- *Remove the requirement for separate intake and assessment pathways for dual diagnosis clients;*
  - This potential solution involves structural change of both sectors, a one to two year implementation timeframe and is interdependent with the funding model review.

Table 10-2: Potential solutions by priority ranking and timeline, service delivery

POTENTIAL SOLUTIONS	SECTOR	DESCRIPTION	INTER-DEPENDENCY	PRIORITY	TIMELINE
▪ Following client screening at I&A, clients are referred directly to a service provider along with the responsibility for management of clients (and any waiting lists).	Both	Structural Change	Funding Model	High	1-2 years
▪ Implement a new service category/stream for both sectors (including the funding model) focused on a 'brief intervention'. A brief intervention service would be applicable to clients and to carers/family interventions;	Both	Incremental Improvement	Funding Model	High	1-2 years
▪ Remove the requirement for separate intake and assessment pathways for dual diagnosis clients	Both	Incremental Improvement	Funding Model	High	1-2 years
▪ Develop **program guidelines** for the drug treatment and MHCSS sectors that enunciate service delivery expectations.	Both	Incremental Improvement	-	Medium	1-2 years
▪ Program guidelines should form	Both	Incremental	-	Medium	1-2 years

POTENTIAL SOLUTIONS	SECTOR	DESCRIPTION	INTER-DEPENDENCY	PRIORITY	TIMELINE
part of the development of broader **Service Framework** for each sector as the basis service delivery and performance management.		Improvement			
▪ Program guidelines would specify and promote family/carer interaction, explain the role of day programs and group sessions in the context of ICSPs; and	Both	Incremental Improvement	Funding Model	Medium	1-2 years

10.1.3 RELATIONSHIPS AND PARTNERSHIPS

The two potential changes in relation to *relationships and partnerships* are ranked as medium priority and are incremental in focus with timelines listed in Table 10-3 below.

Table 10-3: Potential solutions by priority ranking and timeline, relationships and partnerships

POTENTIAL SOLUTIONS	SECTOR	DESCRIPTION	INTER-DEPENDENCY	PRIORITY	TIMELINE
▪ Enable organisations to exit consortia.	Drug Treatment	Incremental Improvement	-	Medium	Immediate
▪ In future service development in both sectors, enable the formation of consortia, but on an entirely voluntary basis.	Both	Incremental Improvement	-	Medium	Ongoing

10.1.4 WORKFORCE

The single workforce action, listed in Table 10-4 below, is rated as a high priority for implementation within one to two years.

Table 10-4: Potential Solution by priority ranking and timeline, workforce

POTENTIAL SOLUTIONS	SECTOR	DESCRIPTION	INTER-DEPENDENCY	PRIORITY	TIMELINE
▪ The Department, in collaboration with the drug treatment and MHCSS sectors, develop a workforce strategy that is designed to address the core component of future changes/service improvement initiatives	Both	Incremental Improvement	-	High	1-2 years

10.1.5 FUNDING

Priorities for redesign and refinement of funding are summarised in Table 10-5 below.

There are five high priority potential solutions for funding:

- *The Department undertake a comprehensive review in relation to the drug treatment funding model;*
- *In the absence of reliable and complete cost and activity data, the Department is encouraged to undertake a one-off costing study;*
- *The review of the funding model, and any developments, be shared with the sector, and adopt a collaborative approach to assist with a more widespread understanding and ownership of how service categories and prices are determined*;
- *To develop a 'brief intervention' funding category*
- *Review the suitability of resourcing for 'Care Recovery and Coordination' services and the scope for coordinated service models for clients with multiple service needs including homeless clients.*

Each of the above potential solutions has interdependencies with structural changes to intake and assessment services and has a one to two year implementation timeframe.

Table 10-5: Potential solutions by priority ranking and timeline, funding

POTENTIAL SOLUTIONS	SECTOR	DESCRIPTION	INTER-DEPENDENCY	PRIORITY	TIMELINE
▪ The Department undertake a comprehensive review in relation to the drug treatment funding model.	Drug Treatment	Incremental Improvement	Structural Changes of I&A services	High	1-2 years

POTENTIAL SOLUTIONS	SECTOR	DESCRIPTION	INTER-DEPENDENCY	PRIORITY	TIMELINE
▪ In the absence of reliable and complete cost and activity data, the Department is encouraged to undertake a one-off costing study.	Drug Treatment	Incremental Improvement	Structural Changes of I&A services	High	1-2 years
▪ The review of the funding model, and any developments, be shared with the sector, and adopt a collaborative approach to assist with a more widespread understanding and ownership of how service categories and prices are determined.	Drug Treatment	Incremental Improvement	Structural Changes of I&A services	High	1-2 years
▪ To develop a 'brief intervention' funding category	MHCSS	Incremental Improvement	Structural Changes of I&A services	High	1-2 years
▪ Review the suitability of resourcing for 'Care Recovery and Coordination' services and the scope for coordinated service models for clients with multiple service needs including homeless clients.	Drug Treatment	Incremental Improvement	Funding Model	High	1-2 years
▪ As a long-term measure, a commitment be made to the development of sustainable client-based activity and costing data systems for the sector	Drug Treatment	Incremental Improvement	Performance Monitoring	Medium	3-5 years
▪ To address concerns relating to inflexibility and difficulties with the current model, the Department should be in a position to: ▸ Provide information sessions and resource material (kits) that clearly explain the basis on which the service types and prices have been developed. This may	Drug Treatment	Incremental Improvement	-	Medium	6 months Development & 6 Months Roll-Out

POTENTIAL SOLUTIONS	SECTOR	DESCRIPTION	INTER-DEPENDENCY	PRIORITY	TIMELINE
include a 'help desk' service for a defined period of time; ▸ Develop the next iteration of spreadsheet activity reporting					
▪ There should be no change to the approach of activity-based funding as the basis for future funding, and that there be no guarantees of entity viability based on government purchasing of services.	Drug Treatment	Incremental Imrovement	-	Medium	Ongoing

10.1.6 PERFORMANCE MANAGEMENT

All three performance management potential solutions are ranked as a high priority for both sectors with implementation timelines of one to two years as summarised in Table 10-6.

Table 10-6: Potential solutions by priority ranking and timeline – performance management

POTENTIAL SOLUTIONS	SECTOR	DESCRIPTION	INTER-DEPENDENCY	PRIORITY	TIMELINE
▪ Focus on the collaborative development of a performance management framework with the drug treatment sector, with consideration being given to phased implementation.	Drug Treatment	Incremental Improvement	-	High	1-2 years
▪ The development of effective IT data collection and reporting systems as a priority and should be undertaken in consultation with both sectors.	Both	Incremental Improvement	-	High	1-2 years
▪ System level and service provider level performance measures be reported online and be made publicly available. This can only occur when there is a robust performance management	Both	Incremental Improvement	-	High	1-2 years

framework in place.

10.2 Future reforms to purchasing

An incremental and collaborative approach to future purchasing reforms is advocated for MHCSS and drug treatment services. Whilst there have been important system benefits associated with the stage one reforms, the reliance on a competitive tender approach within compressed timelines has been detrimental to effective reform. A major drawback of this approach is that stakeholder confidence and trust in the reforms has been seriously compromised. Opportunities for collaboration and co-design were perceived by stakeholders to be undermined by probity limitations and process shortcomings.

For this reason, in approaching future purchasing reforms, it will be critical to ensure a serious commitment to developing an effective consultation process that can facilitate contribution from the sector and from carers/consumers. Adequate lead-times are required to facilitate:

- Input on policy directions; and
- A change management strategy with implementation planning and risk management given a pre-eminent focus

Appendix 1 Data analysis

This appendix presents the results of time-series analysis of activity data for drug treatment and MHCSS services. An outline is given of the key data sources used for the analysis and data integrity issues.

The activity analysis involves the following:

- Trends in referrals to drug treatment and MHCSS sector from public hospital services (general acute and clinical mental health services) and emergency departments;
- Trends in the number of total assessments for drug treatment and MHCSS; and
- Trends in the number of service contacts for in-scope services for drug treatment and MHCSS.

1.1 Data sources

The following data sources have been used for this analysis.

Referrals from public hospital services

- VAED has been used for time-series analysis of referrals from public hospitals (general acute and clinical mental health services)
- VEMD has been used for time-series analysis of referrals from public hospital emergency departments.

Drug treatment services

- ADIS has been used for time-series analysis of the number of assessments and service treatment contacts.

MHCSS

- QDC has been used for time-series analysis to 2013/14. Service providers discontinued reporting to QDC in 2014/15.
- Spreadsheet-based reporting, introduced in 2014/15, has been used to analyse the number of clients on the needs register; new referrals; and allocated places.

1.2 Data integrity

The level of data integrity cannot be assured for data reported to the minimum data-sets for drug treatment services and MHCSS. For this reason, the data analysis presented here is indicative only. Prior to 2014/15, services were not funded on an activity basis and data integrity audits were not routinely applied. With recommissioning, there has been a discontinuity of reporting systems for MHCSS, with services no longer reporting to QDC. This substantially limits the extent to which reliable time series analysis can be undertaken pre- and post-recommissioning.

Additionally, the department advised the review team of the following known data integrity issues.

Forensic clients

- The reporting of forensic clients to ADIS is not considered accurate. Accordingly, time-series analysis of the number of forensic clients has been based on the COATS data-base. In order to analyse non-forensic activity, clients with referral source related to the forensic system have been excluded.

Time from assessment to treatment

- The date entry fields for date of assessment and date of treatment commencement are not considered accurate. For this reason, no analysis has been undertaken of time elapsed from assessment to treatment.

Unique client identifier

- The absence of a unique client identifier at a system level for drug treatment services limits the extent to which an assessment can be made of the total number of unique individual clients receiving services. For this reason, the analysis of drug treatment services has focused on levels of activity (number of assessments and number of service contacts) in place of analysis of changes in number of clients treated.

New service types

- For both service sectors, a number of new service types were introduced with recommissioning, replacing previous service types. In addition, a new service type was introduced for the intake and assessment function, a new role which was not previously reported. As a proxy, in prior years, the reported number of assessments has been used based on a pre-existing assessment ADIS data field for drug treatment services.

Assessment data

- Assessments are not formally captured in ADIS as a stand-alone component. The data used is a proxy by using "screening date" in a client's treatment record to count the number of assessments. This is not a mandatory reporting field and not all agencies are able to capture this information in their internal systems. Additionally, pre 1 September 2014, this may have included clients where only a minimal amount of treatment or a brief intervention was undertaken.
- As the number of assessments undertaken are now formally collected via a supplementary spreadsheet, agencies would be less likely to record this in ADIS and those that are assessed or provided with a brief intervention and do not formally go on to treatment are no longer captured in ADIS at all.

- Additionally, the one agency that does capture assessments in ADIS as a stand-alone course of treatment is ACSO and there was an issue in Quarter 1 that meant that this service was unable to provide all of the client information for ADIS and the results are 1400 less than the actual assessments undertaken. Combined this skews the assessment results.

Contacts

- Whilst service treatment contacts are broadly captured in ADIS for each course of treatment, it is not a mandatory reporting field and not all agency systems are currently able to capture or extract this information from their internal systems.

Referrals

- The referral process for drug treatment has changed for adult non-residential and most treatment services are now receiving their referrals from the catchment Intake and Assessment service rather than directly from the external source and are likely recording this as the referral source. As a result, treatment services may not be recording the original referral source to the treatment system. This will be significantly skewing results.

1.3 Referrals from public hospitals

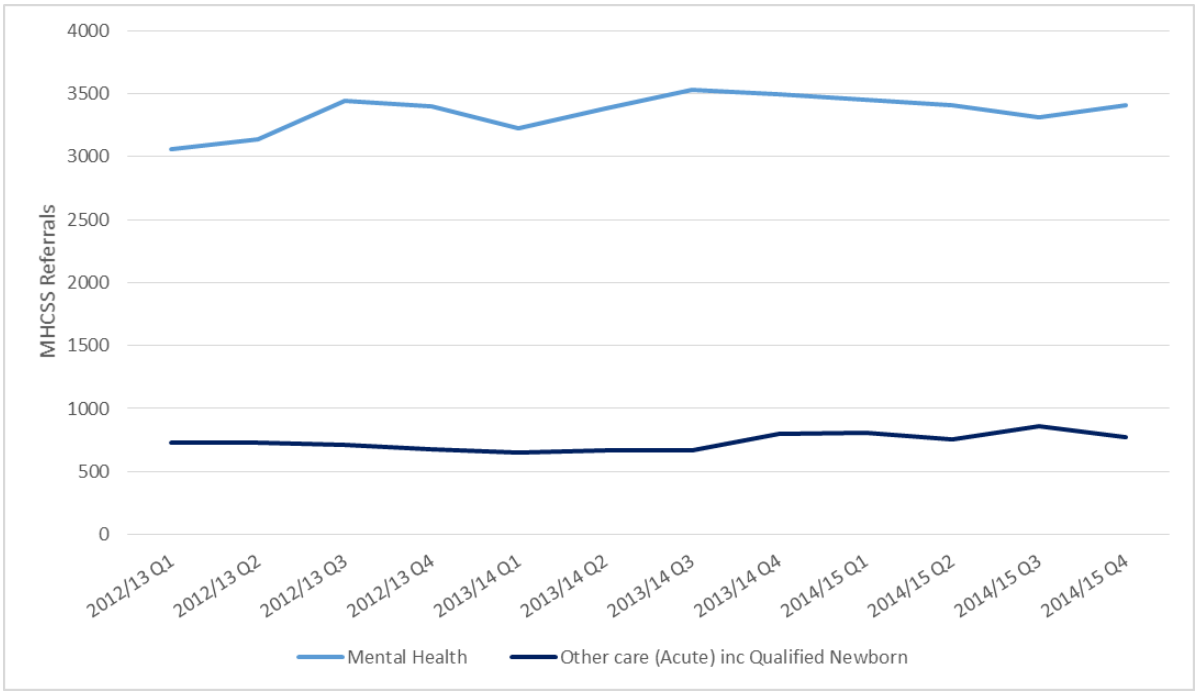
It should be noted that this analysis of referrals from public hospitals is based on health services' referral intentions at the time a patient is discharged from hospital. It is not a measure of whether an individual patient necessarily has decided to follow this referral pathway or been successful in accessing a MHCSS or drug treatment service.

1.3.1 MHCSS

In 2014/15, 16,448 separations from Victorian public hospitals flagged a discharge referral to MHCSS services. The majority (82%) of separations were referrals from clinical mental health services. The remaining 18% were referred from acute general hospitals.

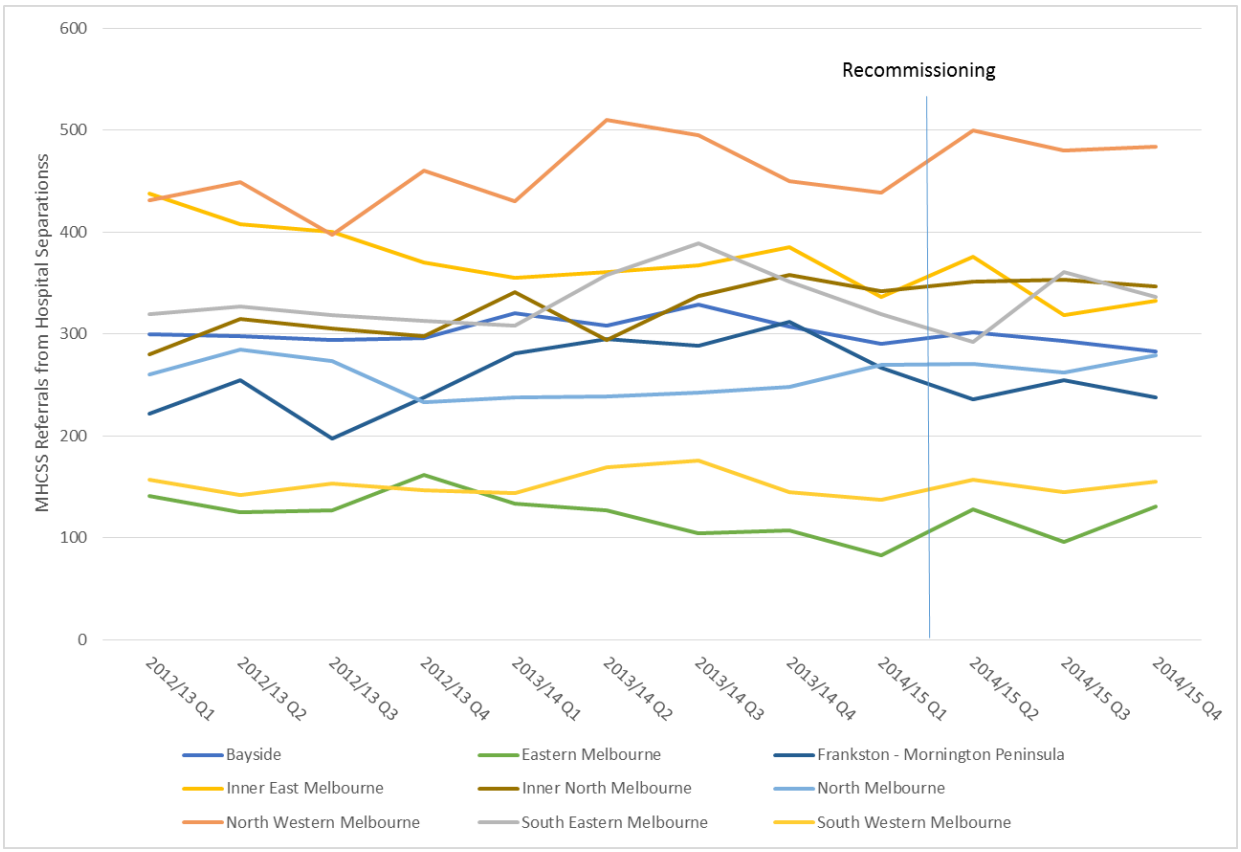
The recommissioning does not appear to have had a major effect on the volume of MHCSS referrals from hospitals. MCHSS referrals decreased by 2% in 2014/15, reversing a trend of around 5% per annum growth in the preceding three financial years. At the time of re-commissioning, referrals declined by 2% in both Q4 2013/14 and Q1 2014/15, before increasing by 2% in Q2.

Table 10-7: Total referrals from public hospitals to MHCSS, 2012/13 to 2014/15



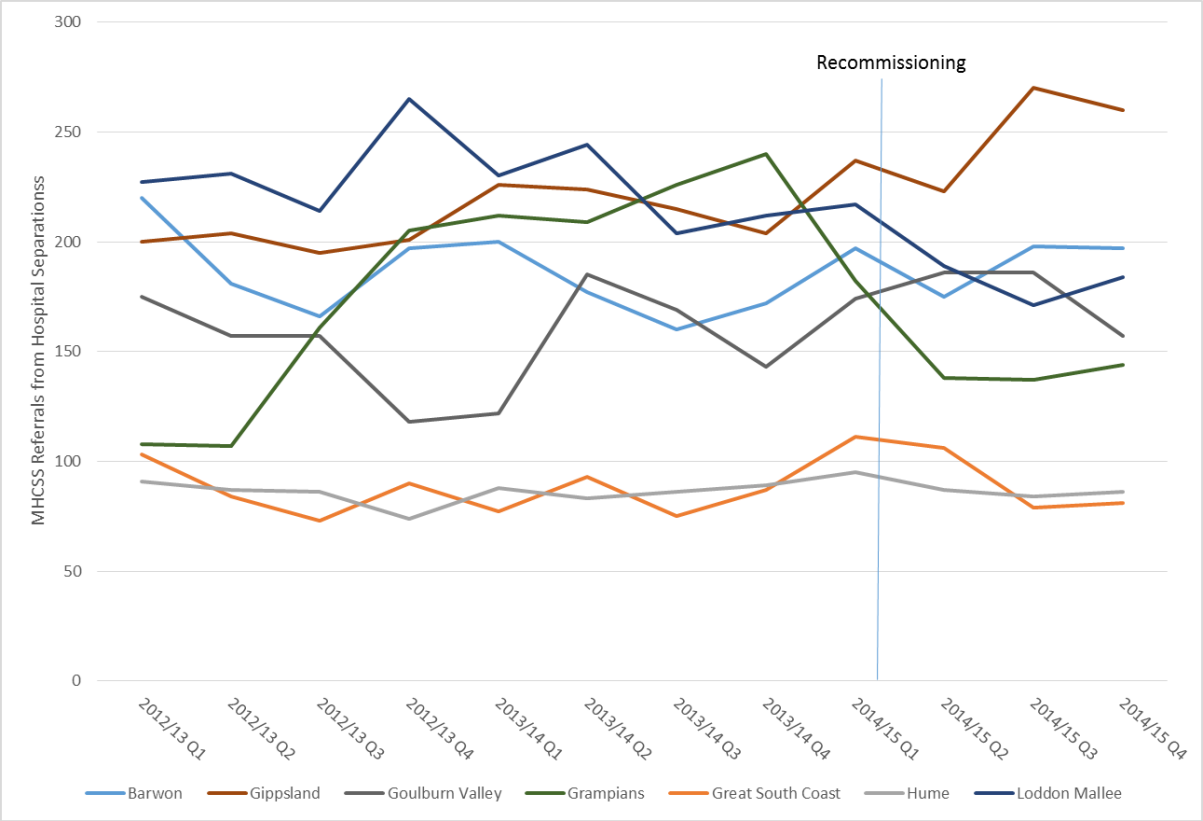
In metropolitan catchments, Inner East Melbourne, South Eastern Melbourne and Frankston Mornington Peninsula all dipped in Q2 2014/15, whereas Eastern Melbourne increased by 54%. Inner East Melbourne and Inner North Melbourne also increased following recommissioning.

Figure 10-1: Referrals to MHCSS from public hospitals, metropolitan catchments, 2012/13 to 2014/15



In rural areas, all catchments except Goulburn Valley recorded decreases in Q2 2014/15 post recommissioning. The largest changes were seen in Grampians which fell by 24% in both Q1 and Q2 2014/15. There have been some increases in the latter quarters of 2014/15, although with the exception of Gippsland, catchments have generally not returned to pre-recommissioning levels.

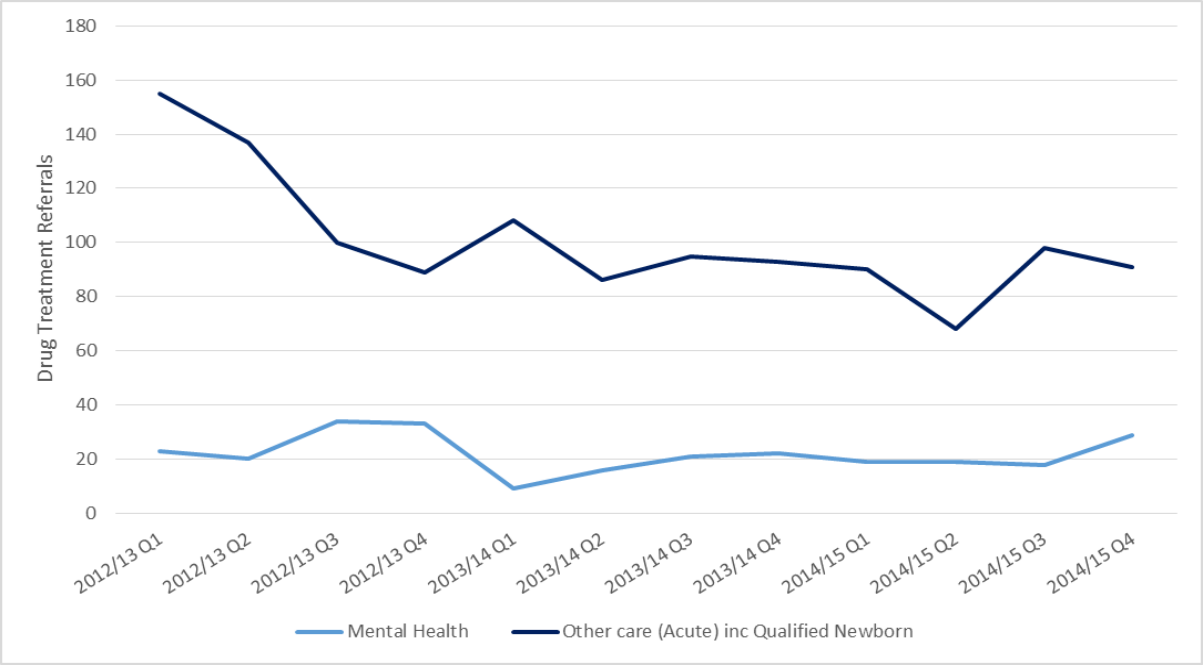
Figure 10-2: Referrals to MHCSS from public hospitals, rural catchments, 2012/13 to 2014/15



1.3.2 Drug Treatment Services

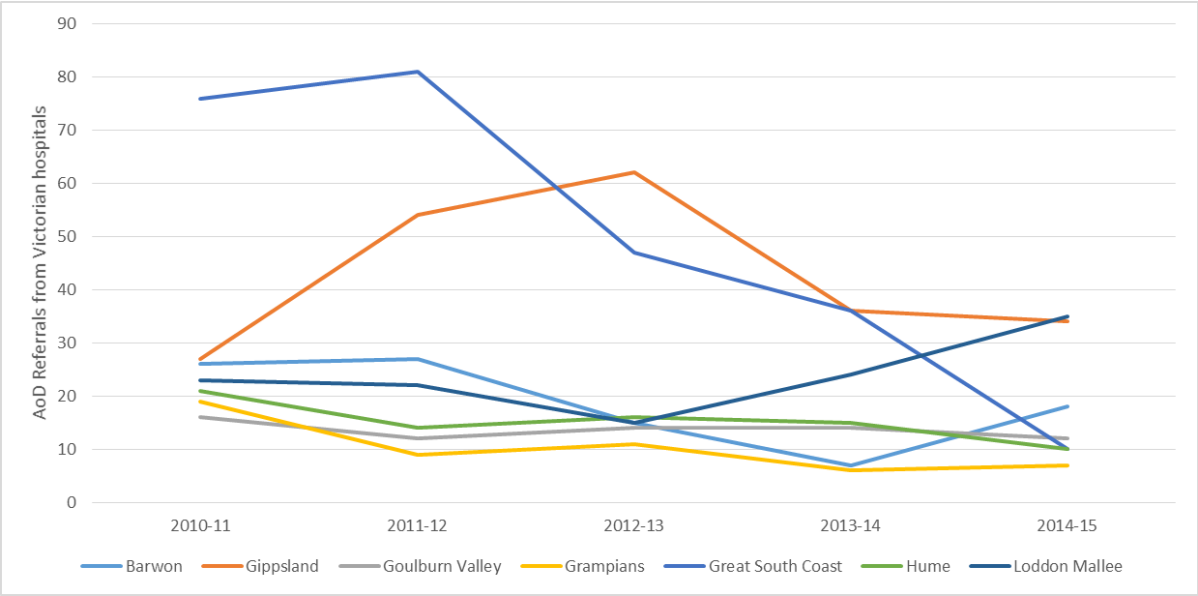
Referrals for drug treatment from Victorian public hospitals are fewer in number than MHCSS referrals, with 442 recorded in 2014/15. Referrals remained relatively constant since a substantial decrease in 2012/13. A 'dip' in referrals was seen post recommissioning in 2014/15, however referral numbers returned to previous levels in Q3.

Figure 10-3: Referrals to drug treatment services from public hospitals, 2012/13 to 2014/15



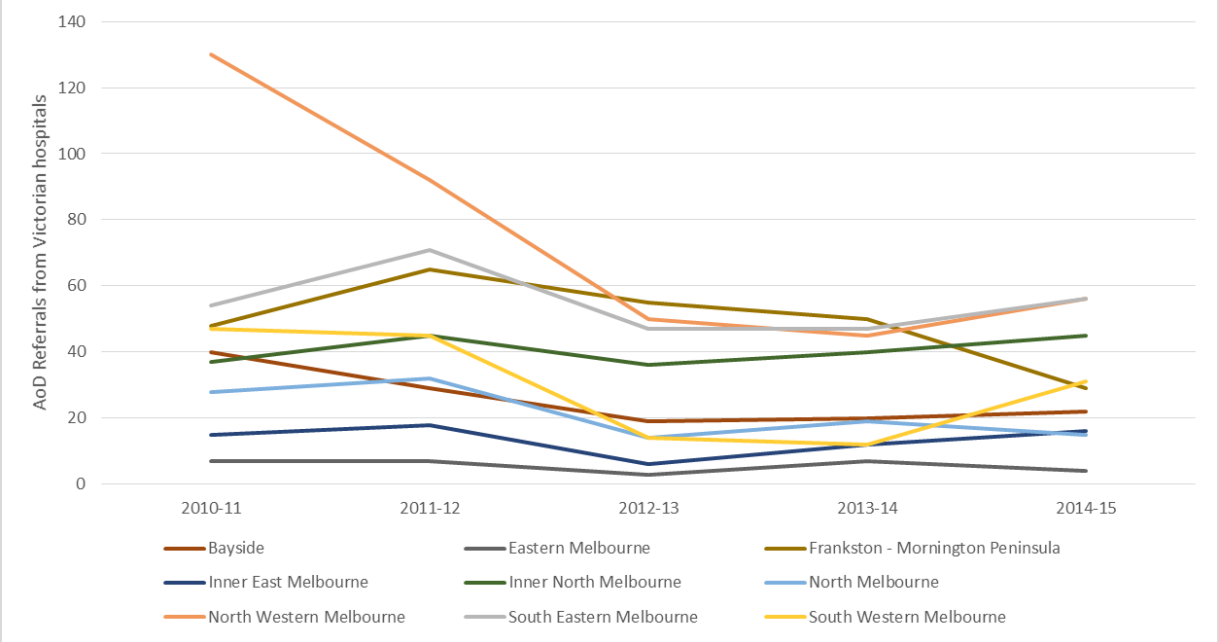
There has been substantial variability between catchments. In rural areas, Great South Coast and Hume both underwent significant reductions in 2014/15, with Great South Coast declining by 72%.

Figure 10-4: Referrals to drug treatment from public hospitals, rural catchments, 2012/13 to 2014/15



In metropolitan catchments, Frankston – Mornington Peninsula, North Melbourne and Eastern Melbourne declined in 2014/15, with all other catchments increasing.

Figure 10-5: Referrals to drug treatment from public hospitals, metropolitan catchments, 2012/13 to 2014/15



1.4 Emergency Department referrals

It should be noted that this analysis of referrals from public hospital emergency departments (EDs) is based on health services' referral intentions at the time a patient is discharged from hospital ED. It is not a measure of whether an individual patient necessarily has decided to follow this referral pathway or been successful in accessing a MHCSS or drug treatment service.

1.4.1 MHCSS

Referrals to MHCSS from hospital EDs[5] rose by 11% in 2014/15, following flat growth in the previous year. Following recommissioning, the final three quarters of 2014/15 were the highest quarterly referral totals in the five years of data analysed. There were 9,365 referrals to MHCSS recorded in 2014/15, with a 14% increase across the state recorded following the recommissioning process in Q2 compared to the previous quarter. The Q2 2014/15 result was also 16% higher than the corresponding quarter in 2013/14.

[5] From public hospital EDs reporting to the VEMD. Smaller health services with Urgent Care Centers (UCC's) and some smaller publicly funded EDs do not report to this dataset.

Comparing Q2 2013/14 to Q2 2014/15 across catchments, only two of the 16 mental health catchments recorded decreases post recommissioning. Eastern Melbourne decreased slightly by 3%, although compared to Q1 2014/15, it was up by 11%, while Inner Eastern Melbourne recorded a 7% decrease compared to the previous year, although the quarter to quarter figures showed an 18% increase. All other mental health catchments recorded significant increases.

Table10-8 Changes in MHCSS referrals from Mental Health Catchments, 2014/15

Catchment	2014/15 Q1 - 2014-15 Q2	2013/14 Q1 - 2014/15 Q1
Barwon	23%	39%
Great South Coast	17%	11%
Eastern Melbourne	11%	-7%
Inner East Melbourne	18%	-3%
Gippsland	5%	35%
Grampians	-1%	16%
Goulburn Valley	-10%	35%
Hume	16%	26%
Loddon Mallee	19%	12%
Inner North Melbourne	2%	8%
North Melbourne	6%	21%
North Western Melbourne	31%	19%
South Western Melbourne	70%	42%
Bayside	12%	20%
Frankston - Mornington Peninsula	711%	508%
South Eastern Melbourne	7%	8%
Interstate/Overseas/Unknown	7%	30%
Total	**14%**	**16%**

Figure 10-6 Referrals to MHCSS from Hospital EDs, metropolitan catchments, 2012/13 to 2014/15

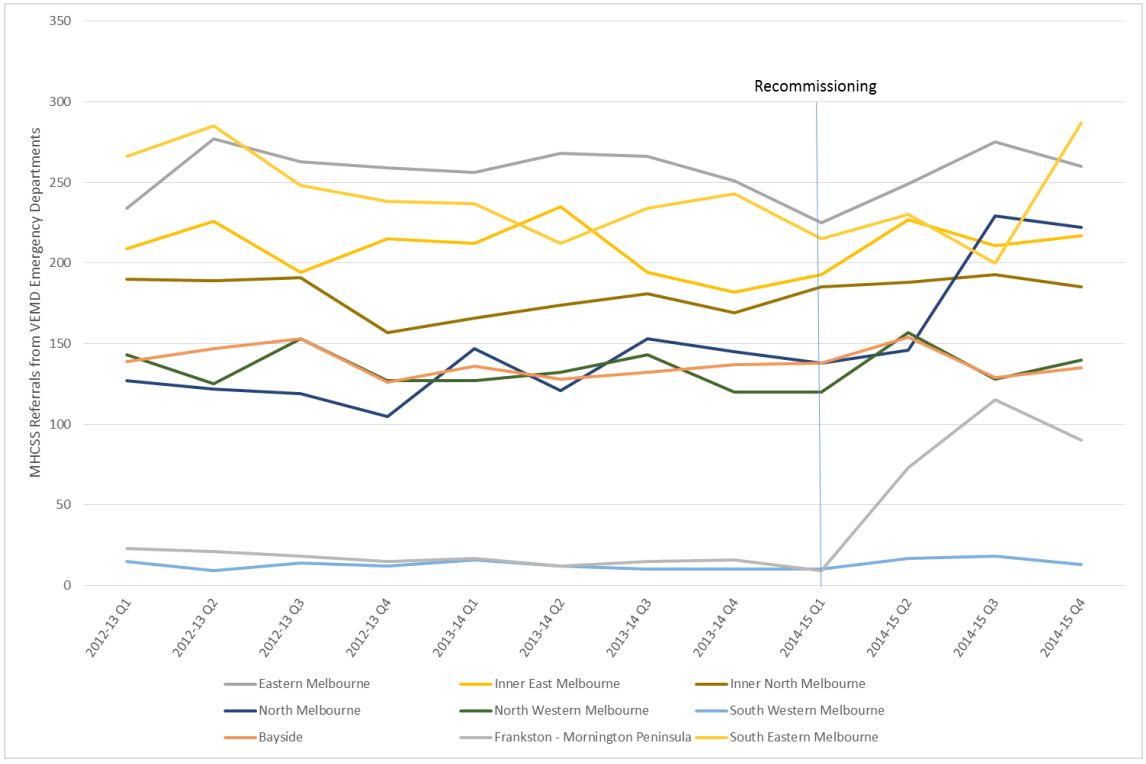
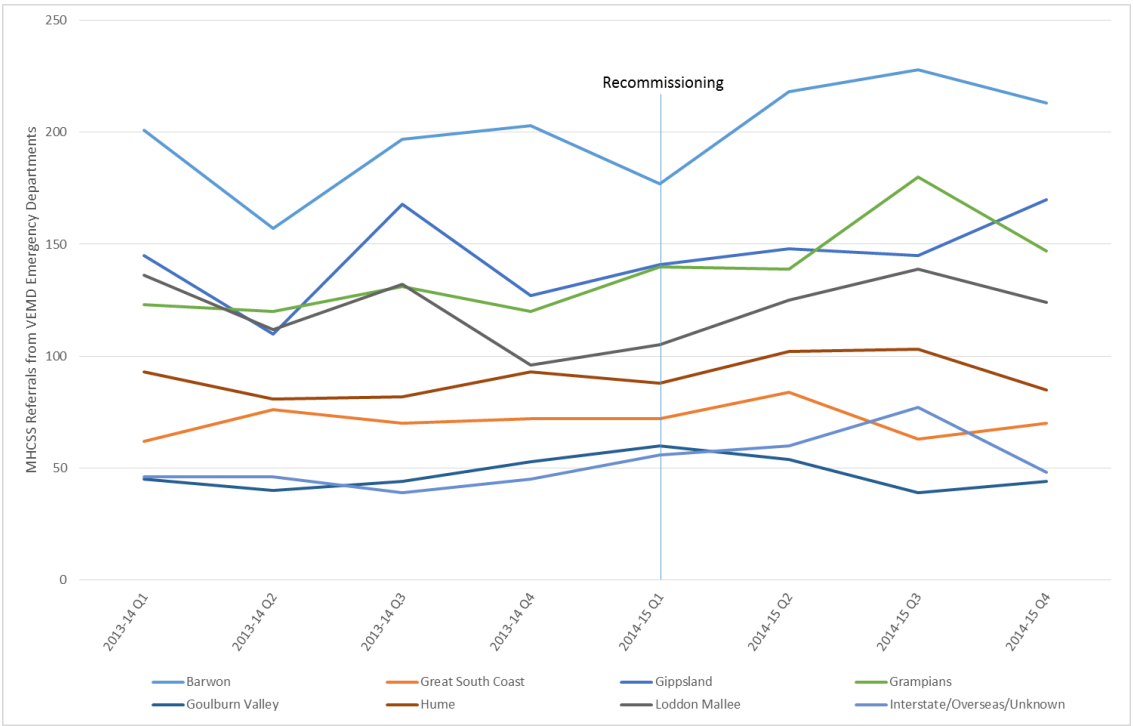


Figure 10-7: Referrals to MHCSS from public hospital EDs, rural catchments, 2012/13 to 2014/15



1.4.2 Drug Treatment Services

Referrals for drug treatment from EDs are fewer than MHCSS referrals. There were 492 referrals recorded in 2014/15, an increase of 18% following two years of flat growth. In 2014/15, ED referrals to drug treatment increased in all metropolitan catchment areas save South Western Melbourne (from a very small base) and Eastern Melbourne. In rural areas, Hume and Goulburn Valley recorded decreases, also from very small bases.

Figure 10-8 Referrals to drug treatment services from public hospital EDs, metropolitan catchments, 2012/13 to 2014/15

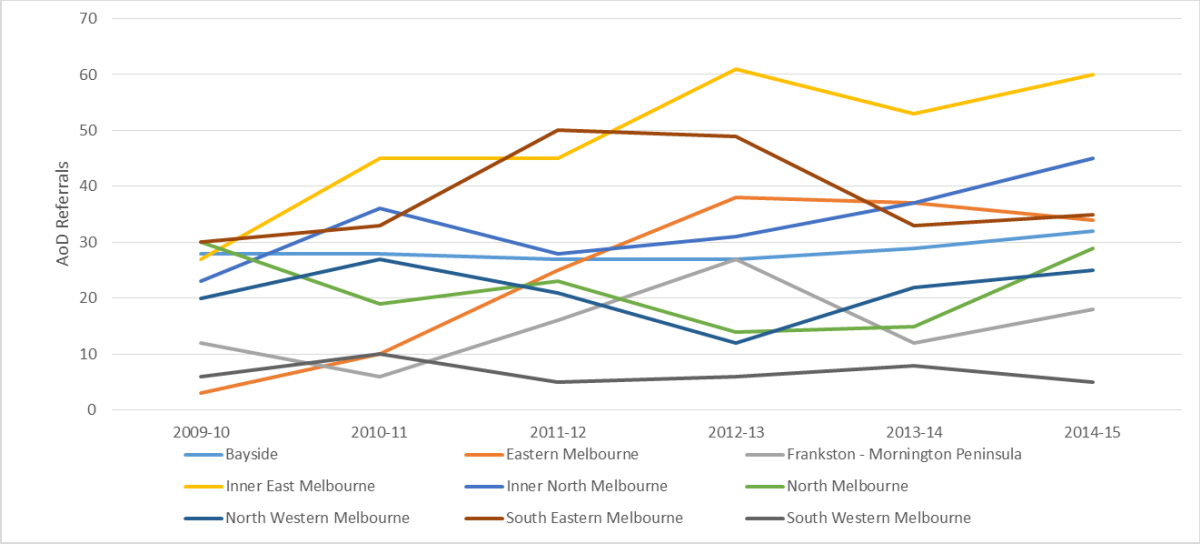
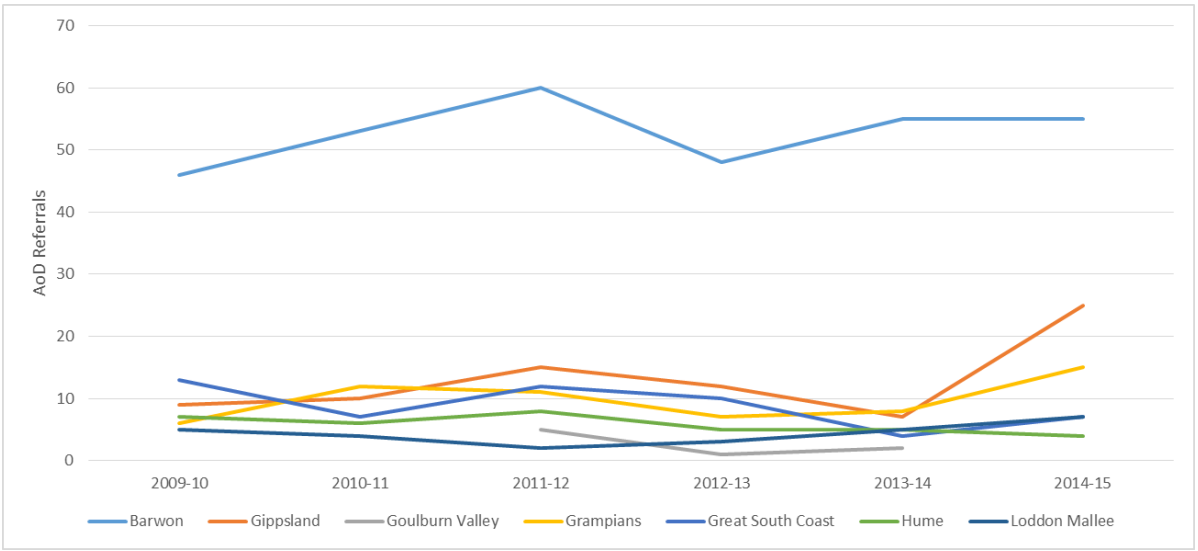


Figure 10-9 Referrals to drug treatment services from public hospital EDs, Regional Catchments 2012/13 to 2014/15



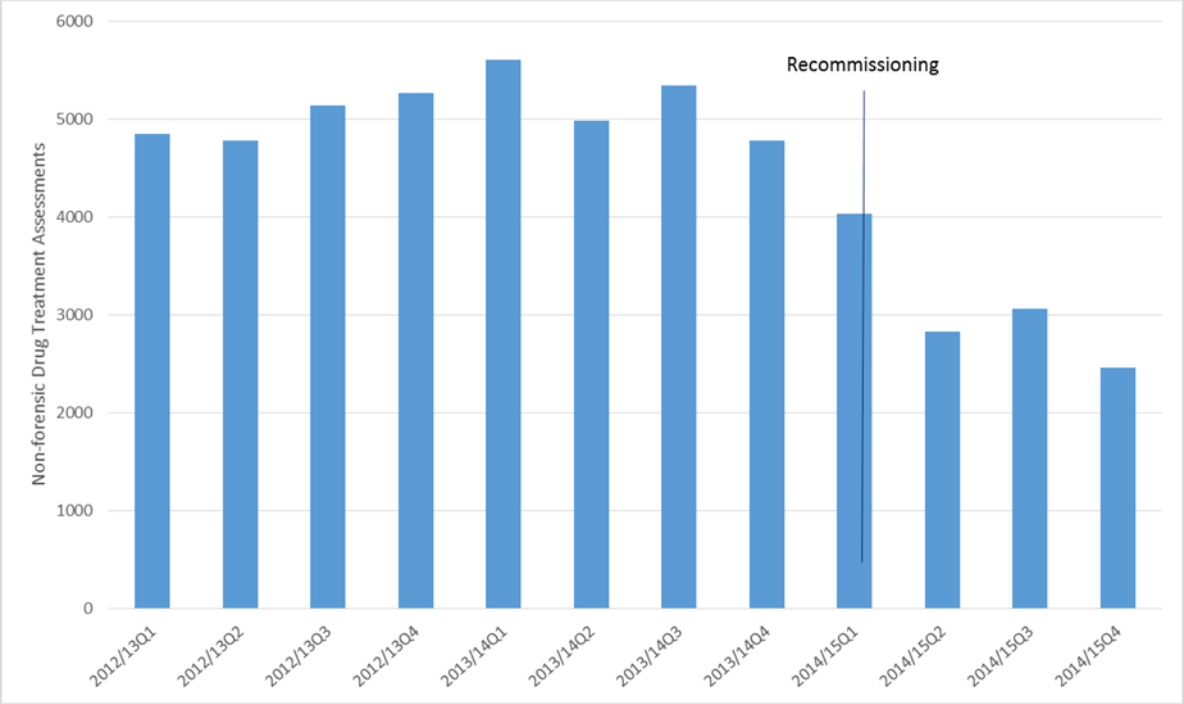
1.5 Drug treatment assessments

1.5.1 Non-forensic assessments

The following analysis is based on all drug treatment services reporting to ADIS for the period 2012/13 to 2014/15.

The ADIS dataset shows a significant reduction in assessments undertaken for non-forensic clients[6] around the recommissioning process. In total 12,391 assessments were recorded in 2014/15, compared to 20,718 in 2013/14, a decrease of 40%. Assessments decreased by 16% in Q1 2014/15 compared to Q4 2013/14. Q2 decreased by a further 30%, with a slight recovery in Q3 2014/15 followed by a further decrease of 20% in Q4.

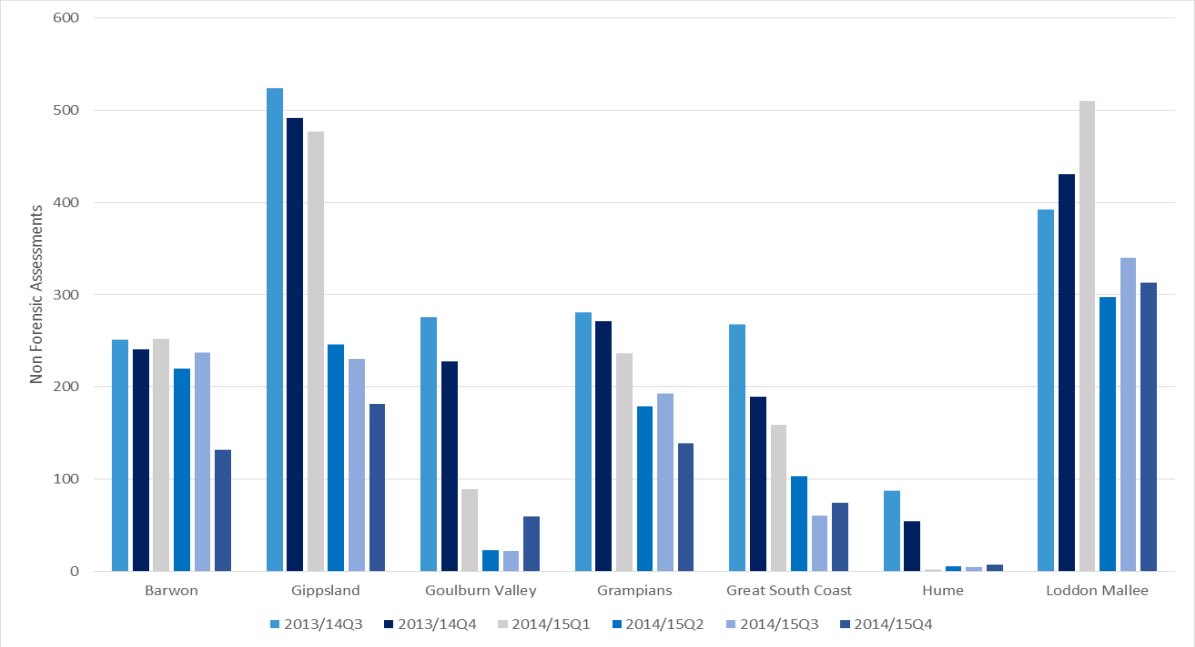
Figure 10-10: Non-forensic drug treatment assessments, ADIS, 2012/13 to 2014/15



The decreases did not occur evenly across the catchment areas. Hume was the most affected, decreasing by 99% from 143 assessments in Q2 2013/14 to 2 assessments in Q1 2014/15. Goulburn Valley also fell sharply with a 61% decrease in Q1 followed by a 72% fall in Q2. Great South Coast has decreased in all quarters between Q3 2013/14 and Q3 2014/15.

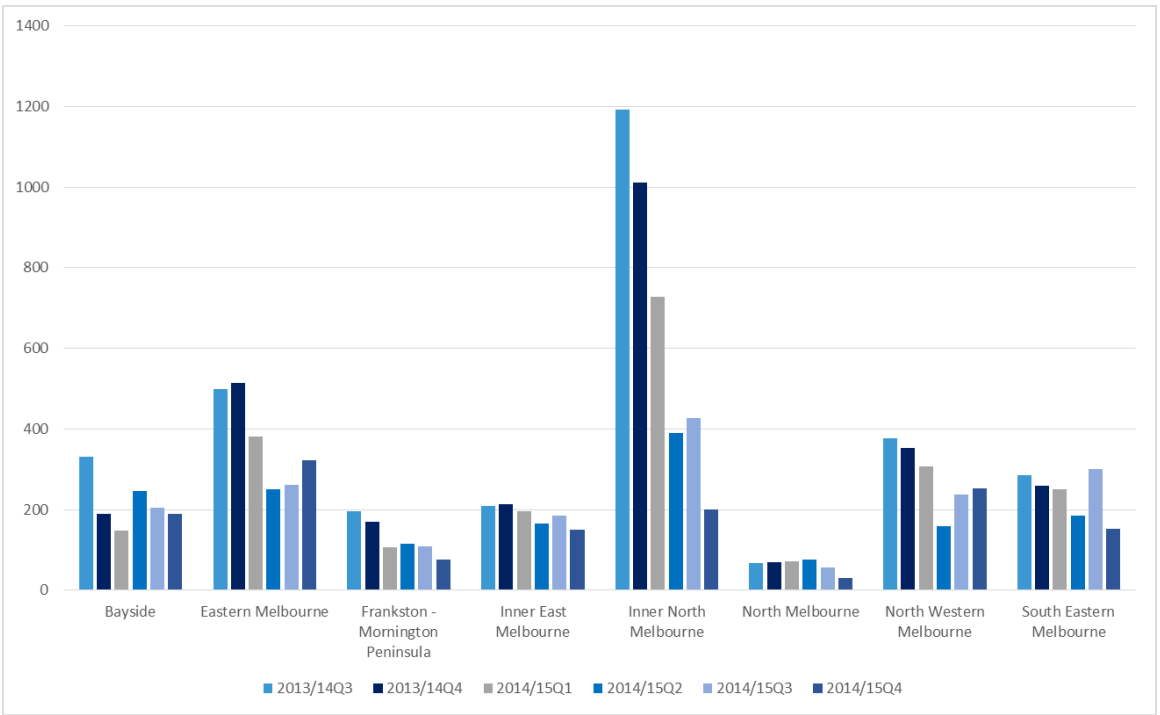
6. Non-forensic cases in this analysis include those reported as non-forensic, excluding assessments with a referral source related to the forensic system. This includes Courts, Child Protection, Corrections Victoria, Juvenile Justice, Drink Drive, Police including Justice Panels and Prison Health Service.

Figure 10-11: Non-forensic drug treatment assessments, ADIS, rural Victoria, 2012/13 to 2014/15



In metropolitan catchments, inner North Melbourne recorded the largest decrease, falling from being the largest catchment with 1,207 in Q3 2013/14 to 202 in Q4 2014/15. Eastern Melbourne decreased by 25% in Q1 2014/15, followed by a 36% decrease in Q2, while South Eastern Melbourne recorded a drop of 30% in Q2 2014/15 following a decrease of 16% in Q1. This was followed by a 59% rebound in Q3 and a 49% fall in Q4.

Figure 10-12: Non-forensic drug treatment assessments, ADIS, metropolitan Victoria, 2012/13 to 2014/15



1.5.2 Referral Source

The ADIS data shows a greater decrease occurring in **non-institutional referral types**. The analysis shows:

Self-referrals, Family/Friends and ***Employer*** referrals as a group fell by 19% in Q1 2014/15, then by a further 41% in Q2.

These non-institutional referral types account for the bulk of assessments. In Q3 2013/14, 60% of assessments were accounted for by self, family/friends or employer referrals. Between Q3 2013/14 and Q2 2014/15 these referral types decreased by 1,796 assessments, or 58%.

Assessments from referrals originating from the ***Non AOD Health System*** (Acute Hospitals, Community Health Services, GPs and Medical Specialists) also decreased markedly over the recommissioning period. Assessments dropped by 65% between Q3 2013/14 and Q2 2014/15. This includes:

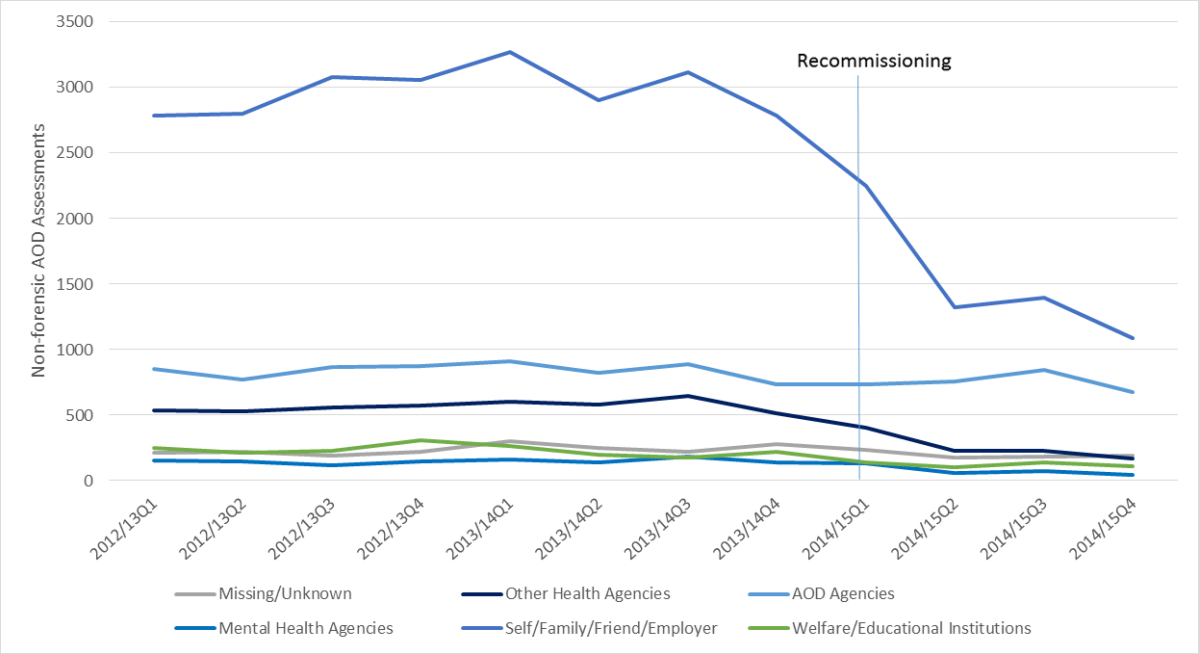
- A decline in ***GP referrals*** of 47% in Q2 2014/15 following a fall of 22% the previous quarter.
- A 42% reduction in ***CHC/CHS referrals*** in Q1 2014/15, followed by a further reduction of 32% in Q2.
- A fall of 43% in Q2 for ***Medical Specialist*** referrals
- Increases in ASCO non forensic referrals due to the uptake of rural assessment contracts.

Assessments referred from ***non-drug treatment mental health agencies*** fell by 67% during the recommissioning period, albeit from a small base of less than 3% of assessments.

Reductions were also seen from both the welfare system and educational institutions during the recommissioning period, although these assessments account for a relatively small proportion (2%) of the total volume.

Conversely, ***assessments referred from the drug treatment system*** were not affected in the same way by the recommissioning period. AOD referred assessments fell by 15% during the recommissioning period, however the decrease occurred before recommissioning in Q4 2013/14. For the first two Quarters of 2014/15, less than 3% fluctuation a quarter was observed.

Figure 10-13: Non-forensic drug treatment assessments by referral source, 2012/13 to 2014/15



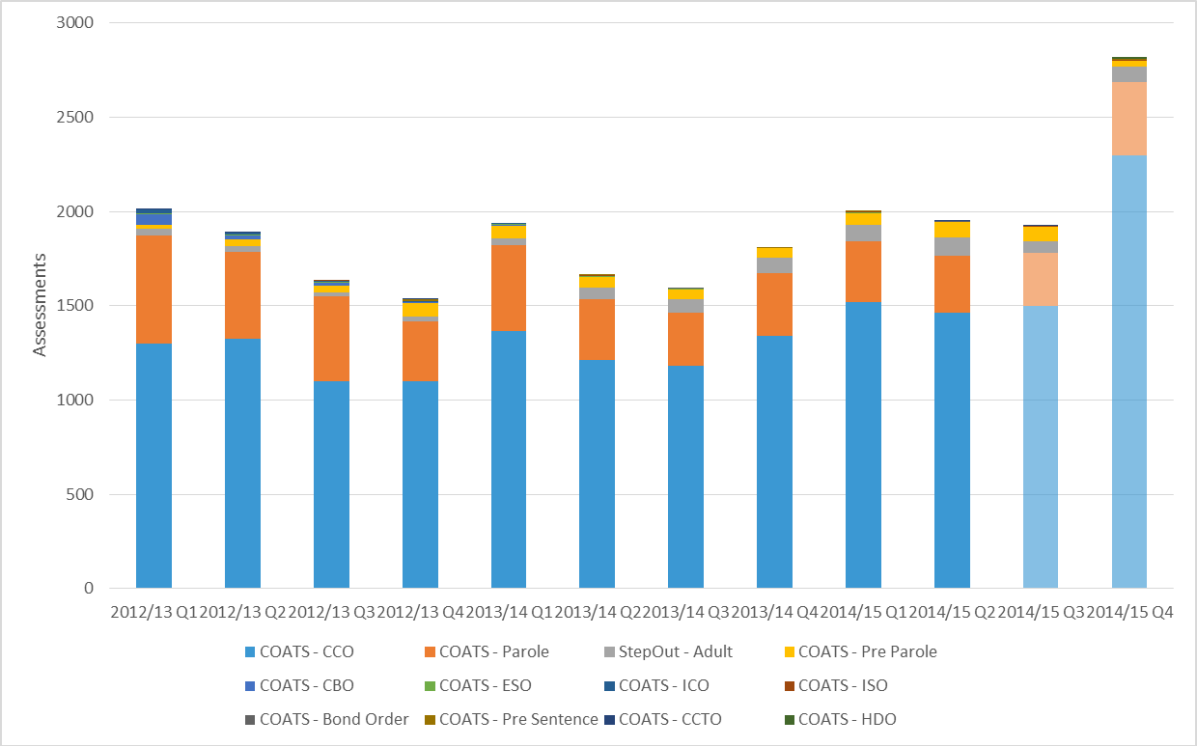
1.5.3 Forensic Clients

There has been an increase in the volume of forensic assessments[7] in 2014/15 compared to prior years.

In Q4 2014/15 a marked rise of 46% in referrals occurred, primarily due to a 53% increase in Community Corrections Order (CCO) referrals, as well as an increase of 39% in COATS – Parole and Stepping Out (Adult) referrals. Overall, an additional 1,011 assessments were undertaken in Q4 2014/15 compared to the corresponding quarter of the previous year.

[7] Data on forensic assessments has been sourced from the COATS (Community offenders advice and treatment) minimum data-set

Figure 10-14: Forensic Drug Treatment Assessments, COATS, 2012/13 to 2014/15



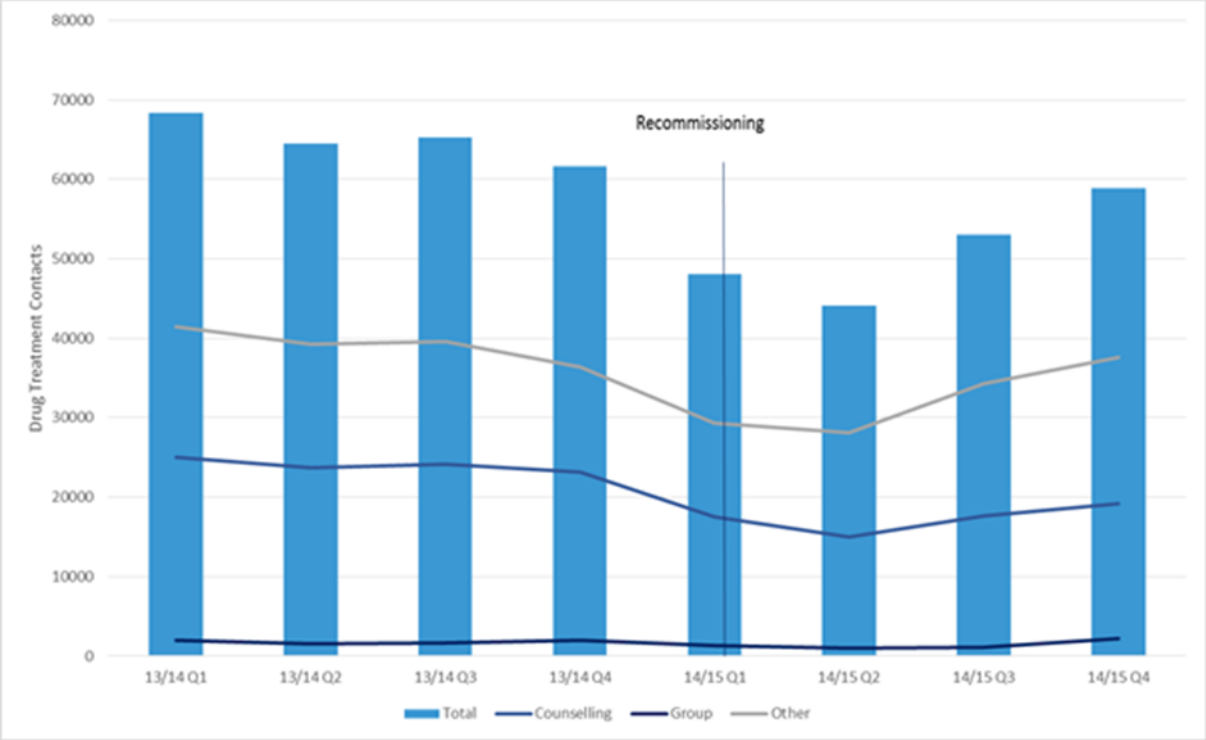
1.6 Service Delivery

1.6.1 Contacts

Contacts recorded in the ADIS dataset, excluding assessments, show a noticeable decrease in the immediate timeframe around recommissioning, with some recovery apparent in the latter quarters of 2014/15 although still below activity levels of the prior year. (This analysis is based on all drug treatment service types including out of scope services.) In total, 204,145 contacts for drug treatment services were recorded in 2014/15, a drop of 55,632 contacts or 21%, compared to 2013/14.

Total contacts decreased from a high of 68,384 in Q1 2014 to 44,113 in Q2 2014/15. The decreases in contacts primarily occurred in Q1 2014/15, when contacts decreased by 22%, with a further 8% fall in Q2 2014/15. Contacts have since rebounded strongly, increasing by 20% in Q3 and 11% in Q4 of 2014/15. 58,925 contacts were recorded in Q4, 14% lower than Q1 2013/14, though just 4% lower than pre-recommissioning in Q4 2013/14.

Figure 10-15: Drug Treatment Contacts by Contact Type, 2013/14 to 2014/15



Counselling contacts were relatively steady quarter to quarter in 2013/14, before falling by 25% in Q1 2014/15 and by a further 14% in Q2. In the two quarters since, counselling contacts rose by 18% in Q3 and 9% in Q4 2014/15. Counselling contacts are, however, still below pre-recommissioning levels by around 17%.

Group contacts decreased by 33% in Q1 2014/15 and a further 25% in Q2. In the latter half of 2014/15, however, group contacts have more than doubled, although off a low base, and now exceed pre-recommissioning levels.

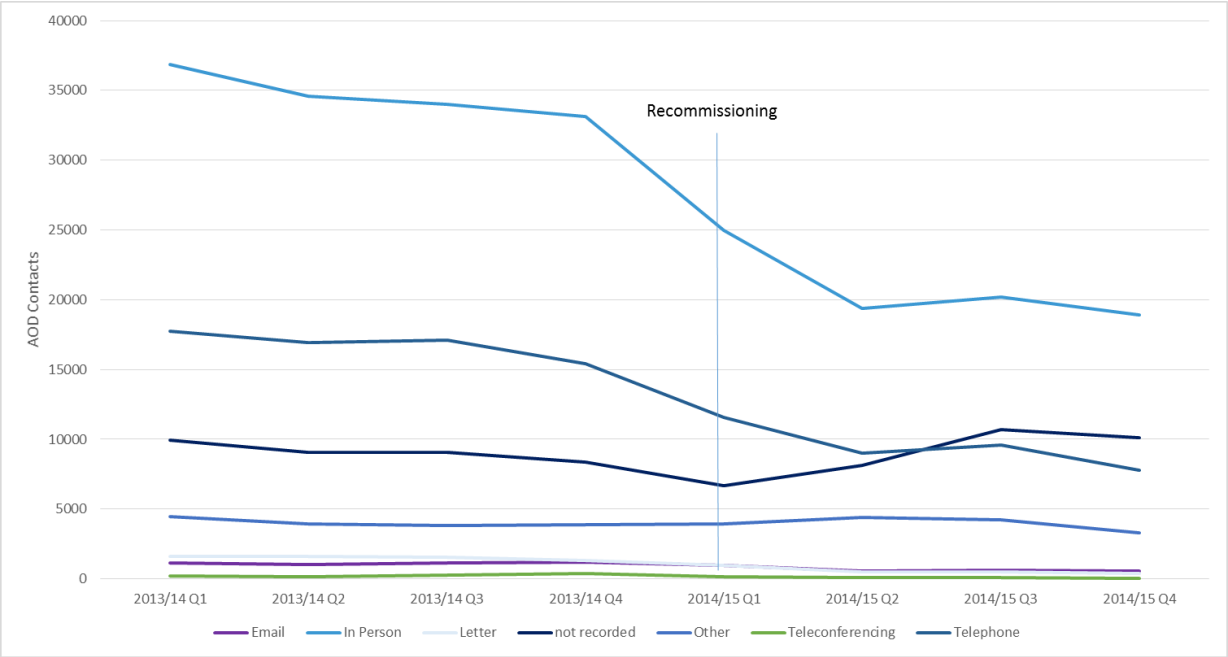
Other contact types fell by 22% collectively in Q1 2014/15, though in Q2 the decrease reduced to 4%. Other contact types have also rebounded and are tracking to pre-recommissioning levels.

Data reporting limitations to ADIS preclude more detailed analysis of re-commissioned service types (and mapped equivalents for prior years) for drug treatment services

In terms of method of contact, the analysis shows:

- ***In person*** contacts decreased by 40% following stable years in 2012/13 and 2013/14.
- ***Email*** contacts decreased by 39%, reversing strong year on year growth over the analysis period.
- ***Telephone*** contacts decreased by 44%, following a large gain in 2010/11 and less than 0.3% change over the 3 previous years.
- ***Letter*** contacts decreased by 60% in 2014/15, continuing a declining trend.

Figure 10-16: ADIS Contacts by Contact Method, 2013/14 to 2014/15



1.7 Mental Health Community Support Services

Time-series analysis of MCHSS activity is difficult for a range of reasons:

- The temporary cessation of the use of the QDC dataset following recommissioning. As a consequence, there is currently no central dataset available and the most reliable data is spreadsheet data sent by agencies and collated by the department.
- Changes in service types. The introduction of Individualised Client Support Packages replacing multiple programs under the previous system has meant accurate mapping of services has been challenging.
- Changes in measuring units. The introduction of Client Support Units as a primary measure of activity has meant that some data from before recommissioning has no direct comparison.
- Changes in catchment boundaries has meant that service mapping for the purposes of this report has been undertaken at a regional level rather than the newer and more granular Catchment Area.

1.8 Service activity trends

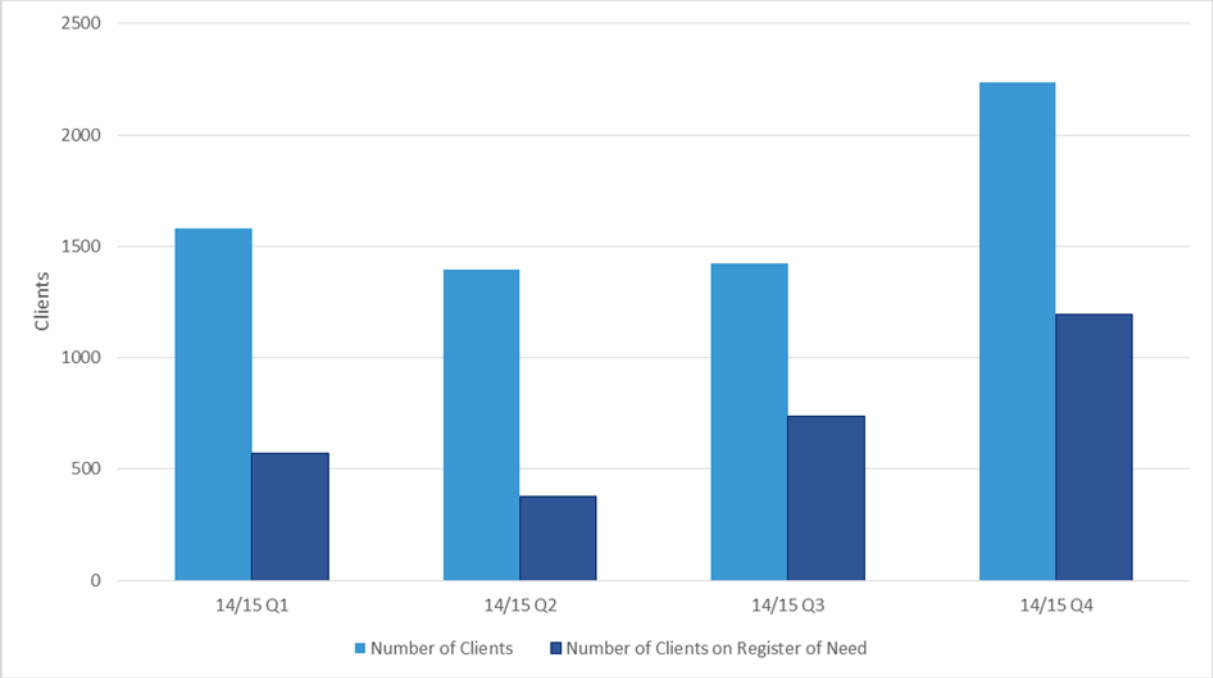
1.8.1 Assessments

In the case of MHCSS, there has been no time-series reporting of client assessment to QDC prior to re-commissioning. Accordingly, analysis is limited to reporting from the first quarter of 2014/15.

Since recommissioning, there has been steady increase the number of Community Intake Assessments undertaken. The number assessments increased by 57% from 1,580 in Q1 2014/15 to 2,234 in Q4 2014/15.

Over the same time period, the number of clients on the register of need has more than doubled, increasing by 110% from 570 in Q1 to 1,195 in Q4.

Figure 10-17: MHCSS Community Assessment Function Clients, 2014/15



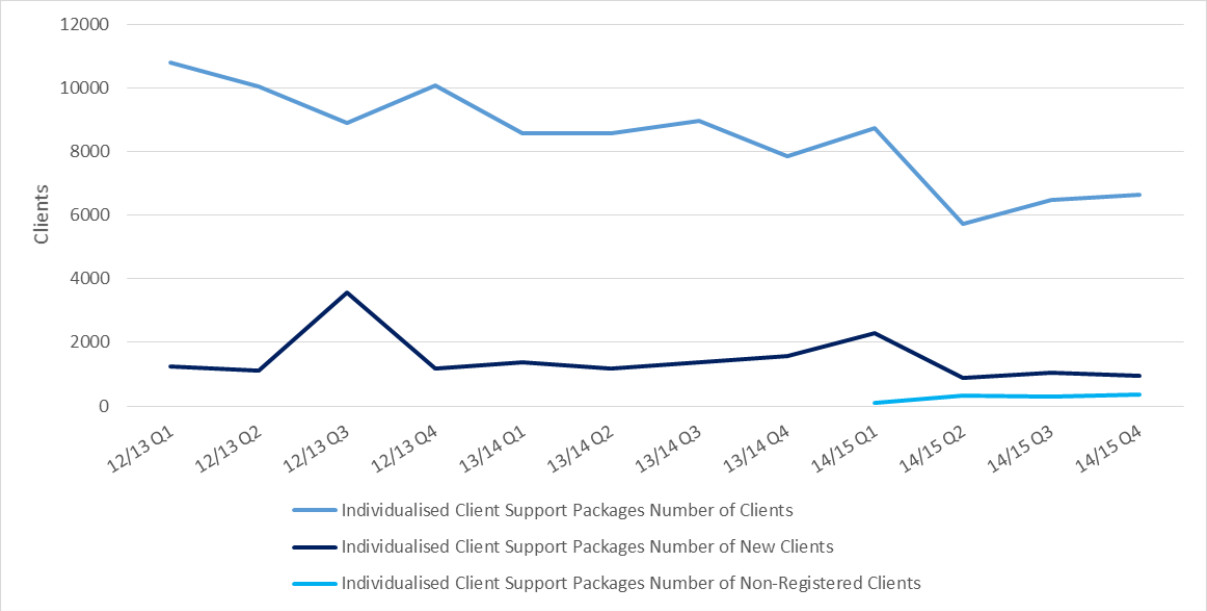
1.8.2 Number of Clients

The chart below shows the trend in the number of clients Receiving Individual Client Support Packages (ICSP) or mapped service equivalents for the period prior to 2014/15.

The number of clients receiving ICSPs has decreased from 10,798 in Q1 2012/13 to 8,733 in Q1 of 2014/15, a decline of 19%.

Following recommissioning, client numbers have increased in both Q3 (13%) and Q4 (3%) relative to Q1 of 2014/15. New clients were up by 19% in Q3 following the decrease in Q2.

Figure 10-18: MHCSS Clients receiving ICSPs (or mapped service equivalents), 2012/13 to 2014/15



1.8.3 Regional Trends

All regions[8] recorded a significant decline in client volumes in Q2 2014/15 relative to Q1, with the exception of Loddon Mallee which was stable. The most dramatic decline occurred in the Gippsland and Eastern Metropolitan Regions, with reductions of over 50% in Q2 2014/15 relative to Q1 2014/15.

8. Due to the unavailability of reverse mapped MHCSS data to the new mental health catchments, departmental regions have been used for this analysis due to data consistency.

Figure 10-19: MHCSS Individualised Support Packages Clients by Catchment, 2012/13 to 2014/15