VICTORIAN ALCOHOL & DRUG ASSOCIATION

Challenges & Opportunities

Key findings from VAADA's Alcohol and Other Drug (AOD) Sector Recommissioning Survey

VAADA Vision

A Victorian community in which the harms associated with alcohol and other drug use are reduced and wellbeing is promoted

VAADA Purpose

To represent the membership by providing leadership, advocacy and information within the AOD sector and across the broader community in relation to alcohol and other drugs

August 2015

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About VAADA

The Victorian Alcohol and Drug Association (VAADA) is the peak body for alcohol and other drug (AOD) services in Victoria. We provide advocacy, leadership, information and representation on AOD issues both within and beyond the AOD sector.

As a state-wide peak organisation, VAADA has a broad constituency. Our membership and stakeholders include 'drug specific' organisations, consumer advocacy organisations, hospitals, community health centres, primary health organisations, disability services, religious services, general youth services, local government and others, as well as interested individuals.

VAADA's Board is elected from the membership and comprises a range of expertise in the provision and management of alcohol and other drug services and related services.

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

Acknowledgements

VAADA would like to express our thanks to those AOD services who participated in this survey. The survey was substantial and required respondents to provide their views on a number of issues that are contested and lacking in accurate baseline data. We are grateful for the detailed responses provided by many respondents.

Disclaimer

The findings and information contained in this report is indicative only. We have sought to represent the broad views expressed in a fair and accurate manner. This report provides insights into a number of changes associated with recommissioning but VAADA acknowledges it is a snapshot of a point in time and further data collection and input from stakeholders will be required as we move forward to canvass ongoing challenges and, more importantly, solutions to any identified challenges.

This findings presented in this report will inform future VAADA activities including the upcoming Regional Voices project which aims to identify and explore in further detail the specific needs of services at a local level, and work towards the development of solutions to identified needs.

Executive Summary

The findings of this survey, while not intended as an evaluation of the recommissioned AOD service system, point to some substantial challenges and pressures on AOD providers. It appears the changes associated with recommissioning have had wide-ranging effects on AOD agencies, their staff and most importantly, on service users themselves.

The scale and complexity of changes associated with recommissioning has meant the experience of agencies is variable yet this survey suggests there are some striking commonalities as well. It is clear there are a number of demands and pressures on AOD services at the present time including access issues, wait-times for services, challenges with relationship building both within and outside of the AOD sector, negotiating the interconnections between 'in-scope' and 'out-of-scope' programs as well as the ongoing delivery of a range of evidence-based interventions including brief and early interventions and family work.

There are also issues with capacity for provision of support for people while they wait to access treatment, particularly residential treatment services and there is some evidence of challenges with appropriate treatment matching for people entering the AOD service system.

Additionally, the results from this survey suggest there may have been some substantial shifts in the AOD workforce, including the loss of experienced staff through the recommissioning process and some suggestion of a possible de-skilling in some areas of activity.

It is important to acknowledge that the process of change can be difficult and some of the challenges identified in this survey may be improved as AOD agencies and service providers bed down systems and processes and strengthen relationships at the local level.

The findings outlined in this report provide a partial picture of what is happening across the Victorian AOD service system following recommissioning. VAADA acknowledges this survey is a snapshot of issues at a particular point in time, and therefore represents part of the picture of the changes associated with recommissioning.

There are a range of official data sources that are needed to provide further insight into the issues outlined in this report. The findings offer guidance on areas requiring attention and further investigation to find solutions moving forward. Nonetheless, these findings add weight to a growing body of evidence on the impacts of recommissioning.

Accessible services

Results from this survey indicate that as of April 2015, the recommissioning process has not successfully improved equity or timeliness of access and in some instances, issues of access may have deteriorated.

In 2011, an evaluation of the AOD sector by the Victorian Auditor-General (The VAGO Report) found "navigating entry into the AOD service system should be easy but in reality this is not the case". Many responses to this survey suggest this remains a significant issue.

Respondents also pointed to the new Catchment based Intake & Assessment model as a reason for a possible changes to demand and numbers of people actively in treatment. The particular issues articulated in relation to the accessibility of services, and specifically Intake & Assessment included entry points being more difficult to find and services not always being located where people need them as well as a view that for some clients, telephone based Intake & Assessment services are disadvantageous.

Person-centred, family – inclusive and recovery-oriented treatment

Survey respondents placed a clear spotlight on the diminished capacity to offer family support and interventions. Some respondents suggested incorporating families into AOD treatment, or providing direct support to individual families, is increasingly difficult in the recommissioned AOD system.

Family work also appears to be constrained by current funding and some AOD agencies struggle with inadequate mechanisms to accurately record and report this work to the Department of Health and Human Services (DHHS).

The introduction of the Self-Screening tool may have made the system less person-centred, family-inclusive and culturally appropriate, according to survey respondents. This may be of particular concern in circumstances where its application has been overly-prescriptive and clinical appraisal has not been a key part of the decision making process.

High-quality and evidence-based treatment

There are a number of pressures resultant from recommissioning that have impinged on the continued delivery of high quality, evidence-based treatment.

There was a view amongst survey respondents that the new process of intake, particularly the screening tool, had introduced a more rigid and prescriptive approach to intake across the AOD system. There was also some concern that the use of the screening tool and tiered complexity model as a demand management tool was not evidence-based. Connected to this were concerns that some potential service users may have been denied access to services they need due to the introduction of the screening tool and the application of the tiered complexity model. Additionally, some respondents noted that there were fewer opportunities to deliver a range of evidence-based interventions since recommissioning, including offering brief and early interventions and supporting people at risk of relapse.

Integrated and earlier intervention

Respondents to this survey suggested that overall, the recommissioned system has less capacity for early intervention. There is also evidence to suggest that the degree to which effective referral pathways have been established is variable. This also appears to be impacting on service provider capacity to ensure that integrated care and support is available to those most in need. Some catchments appear to be doing well in this area, yet others are struggling with fragmented relationships and referral pathways.

The introduction of a separate assessment process appears to have made the provision of integrate and seamless care a bigger challenge than previously.

A responsive and sustainable system

There was significant concern among respondents about how people with multiple and complex needs can access and navigate the new AOD system, and capacity of the new system to work with these people. Some drew attention to the shorter counselling episodes and limitations with the capacity of the Care & Recovery role as challenges in providing support to those with complex needs.

Respondents indicated there had been little improvement in responses to Aboriginal people or CALD communities since recommissioning. VAADA believes this could be indicative of a variety of issues, not all of which are identifiable from this survey's findings. Some respondents indicated they thought it was too early to determine the extent to which the recommissioned system is meeting the needs of diverse groups including Aboriginal and CALD communities, GLBTIQ communities, and young people.

A capable and high-quality workforce

The findings from this survey suggest there could be substantial changes to the AOD workforce and the loss of a number of experienced staff from across the AOD sector in the lead-up to recommissioning, during the transition period and following the commencement of recommissioning. This represented, according to survey respondents, a considerable loss to the sector.

Significant challenges appeared in both recruitment and retention of highly skilled staff. Whilst the survey indicated a possible change in the composition of the AOD workforce, further investigation is needed to determine if particular segments of the AOD workforce have been disproportionately impacted by recommissioning. For example, there was some evidence in the survey that there have been particular impacts across regional settings in relation to loss of skilled and experienced nursing staff.

Background

In 2014 the state government recommissioned Victoria's adult non-residential Alcohol & Other Drug (AOD) treatment services. The review of the AOD treatment system released by the Auditor-General (VAGO) in 2011 provided much of the impetus for change. The report, *Managing Alcohol and Drug Treatment Services (the VAGO report*) found a number of significant areas of concern with the AOD treatment system including fragmentation across the service system, inconsistent quality of service delivery; inequitable distribution of resources and substantial concern that the system was often difficult for people to access and confusing to navigate. The *VAGO report* also identified that the system was under-resourced.

The interest in reform and change had been long-standing as the system had not seen whole-scale change since the 1990s. In 2012, the Department of Health and Human Services (DHHS) released *New directions for alcohol and drug treatment services: A Roadmap* which made a case for reform and outlined the general directions and desired outcomes of change across the AOD treatment system. In light of the findings of the *VAGO report*, the new AOD service system would be accessible and easy to navigate; inclusive and family-friendly; evidence-based and high quality and inclusive of diversity (DHHS 2012).

The focus for reform was the adult community based non-residential treatment system with stage two of recommissioning, that being the youth and residential service systems, earmarked for change to occur at a later date. At the time of writing this report, the current state government has indicated that future recommissioning will not occur as initially identified.

The processes of reform, including the key stages and activities as well as the consultation approach adopted by the then state government, has been detailed in a 2015 report commissioned by VAADA and produced by the Drug Policy Modelling Program at the National Drug and Alcohol Research Centre, University of New South Wales (Berends & Ritter 2015).

The key changes resulting from recommissioning of the adult non-residential AOD treatment system include the consolidation of funded activities into six treatment streams; the adoption of the consortia model of service delivery and the establishment of centralised Intake & Assessment Services (also known as Catchment Based Intake & Assessment) across the 16 service catchments. The establishment of a new intake & assessment model sought to streamline service access; create consistency in assessment processes and assist clients with treatment matching and navigation of the broader AOD treatment system.

This survey was undertaken seven months into the new arrangements in April 2015.

Introduction

This report details the findings of a survey undertaken by VAADA on the recommissioning of AOD services in Victoria.

The survey was distributed to AOD services over a one-month period in April 2015. AOD services were requested to participate in the survey via individual telephone and/or email invitation. Invitations were extended to around 80 agencies with a total 49 responses received.

The survey included 33 questions and covered a range of issues related to the recommissioning of Victorian AOD services including topics such as changes to demand and numbers in treatment; staffing and workforce issues and the benefits & challenges of the newly introduced Catchment Based Intake & Assessment services. The survey, while covering a number of issues related to recommissioning, did not include every aspect of recommissioning.

The survey was not intended as an evaluation of the impacts of recommissioning but contributes to our understanding of some of the challenges and consequent impacts of recommissioning that agencies are facing seven months after the new arrangements began.

The survey responses show a degree of commonality of experience across different AOD services but nonetheless we have aimed to represent the diversity of views expressed by survey respondents, wherever possible.

In writing this report, VAADA has organised the survey responses into six key themes. These themes align with the 'features of a redeveloped system' as outlined in a DHHS *Framework* document.

Demographic information on the survey participants including geographic regions in which they provide AOD services, consortia arrangements and the AOD treatment services provided can be found in Appendix 1.

Importantly, a number of respondents to the survey showed a degree of reservation about drawing conclusions about the impacts of recommissioning. VAADA agrees with this sentiment but recognises a need to assess how the AOD treatment system is progressing post recommissioning and look to solutions to identified problems.

It is clear that recommissioning has resulted in substantial changes to the AOD treatment system, particularly in relation to Intake & Assessment processes. This report provides an overview of the key findings of a VAADA survey on the recommissioning with the intention of adding to our growing knowledge-base in this area.

Section 1: Accessible services

Key points:

- **Many respondents felt recommissioning had made access to AOD treatment difficult for potential service users and traditional referrers such as General Practitioners**
- **The separation of Intake & Assessment functions from broader AOD treatment provision was seen as a contributing to the identified access issues**
- **Many respondents felt service user demand had dropped, alongside a perception that the number of people in treatment had dropped on the whole, but this requires further investigation and validation through official data sources**

A key aim of the recommissioning of AOD services, according to the *Roadmap* document, was to create a service system that is accessible and easy to navigate, with services located where people need them and offering holistic assessment, supported referral and tailored treatment planning (DHHS 2012, p.4).

The introduction of Centralised or Catchment Based Intake & Assessment services at a regional level was one of the proposed solutions to these challenges, and arguably the most significant change to the AOD service system associated with recommissioning.[1]

VAADA believes one of the key measures of the success of recommissioning will be whether the recommissioned AOD system has provided the mechanisms for improved access to AOD treatment. The findings of this survey suggest significant and ongoing challenges with issues related to access to AOD treatment services, and this has been highlighted as a concern for many in the sector who responded to this survey.

This section of the Report draws together responses to a range of questions that focused on access, as well as responses to broader questions where access was raised by respondents in their feedback.[2]

Of particular note, respondents highlighted that clients were struggling to navigate entry into the AOD system and that the new arrangements had created extra barriers for service users, their families and the broader health and community sectors in terms of accessing AOD treatment and support.

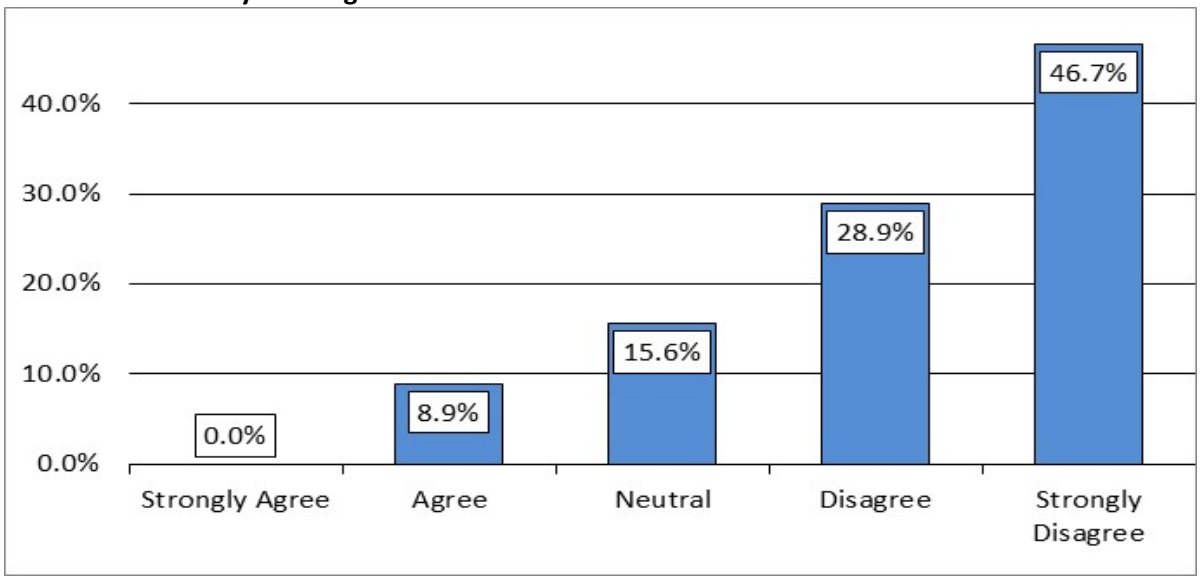
[1] The survey included a section specifically focused on the Catchment Based or Centralised Intake & Assessment model in recognition that this marks a significant change to service provision and delivery brought about by recommissioning. The new Intake & Assessment providers are expected to manage the process of entry into the AOD system and match clients to appropriate treatment services. Intake & Assessment is offered by a funded service in each of the 16 catchments. Respondents were asked to identify current challenges & opportunities with the new Catchment Based Intake & Assessment model as well as proposed solutions to those challenges. Answers to those questions are integrated throughout the Report.

[2] A full copy of the survey is attached in Appendix 2.

Reduced access points and fewer front doors

Around three quarters of responses (75.6% n=34) to the question *To what extent do you agree that the new AOD system is more accessible and easy to navigate*, disagreed that accessibility had improved, as shown in Figure 1 below.

Figure 1: Extent to which respondents agree or disagree that the new AOD system is more "accessible and easy to navigate"



Almost half of respondents to this question, (46.7% n=21) strongly disagreed that the new AOD system is more 'accessible & easy to navigate' with a further 28.9% (n=13) disagreeing with the statement. Around 16% (n=7) of respondents to this question felt neutral on this topic and only 9% (n=4) agreed that the new AOD system was achieving the goal of being accessible and easy to navigate.

Qualitative responses across the survey further explained these findings and detailed concerns around access including the view regularly raised, that the new system in particular, the introduction of a new Intake & Assessment model had reduced access points and added additional barriers for clients seeking access to AOD treatment.

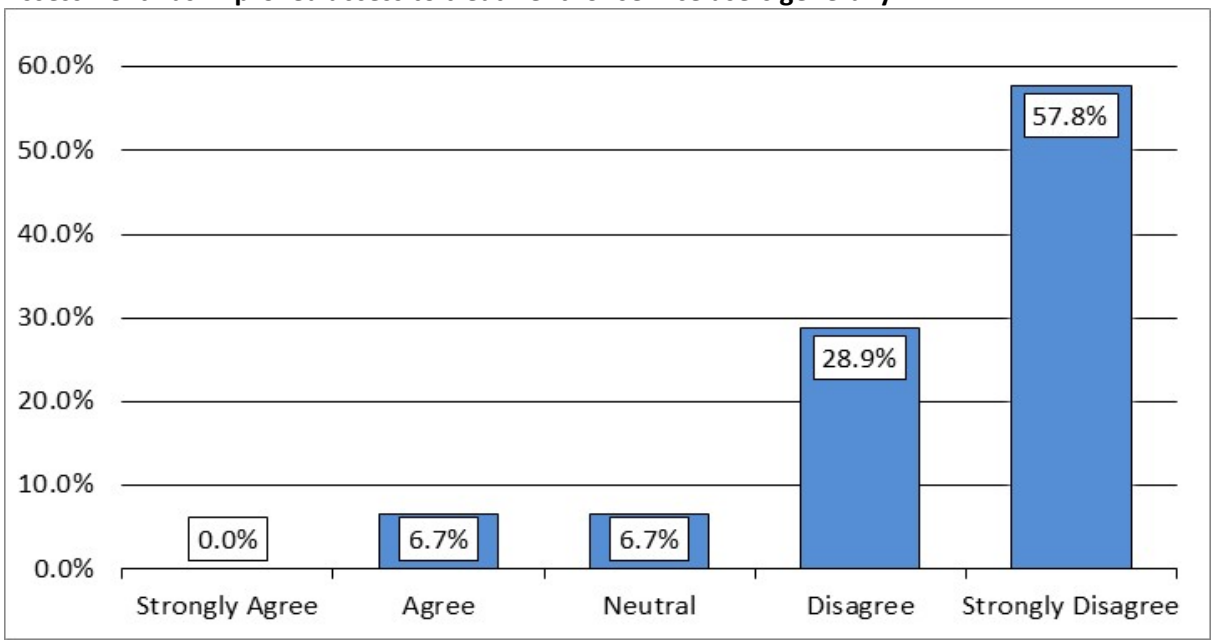
> *"The design of the new system in the separation of Intake and Assessment from service delivery has made access to treatment difficult. Referrers such as GPs as well as prospective clients want to speak to the treatment providers directly and have found it challenging to engage with a telephone based access point that is not connected to where service is delivered"*– survey respondent

Whilst the previous AOD service system had been criticised for being disjointed and inconsistent in terms of entry and assessment criteria, one of the key challenges with the introduction of the new Intake & Assessment model, according to survey respondents, is the view that it has reduced access points and resulted in "fewer front doors" for people seeking to access treatment.

The new Intake & Assessment process was viewed as confusing and difficult. It was labelled "complex", "cumbersome", and "a hindrance" with "multiple barriers" and "additional steps" to entry for service users, families and other service providers.

"[The] Centralised Intake & Assessment process is not conducive to client engagement, is difficult to navigate, and there are missed opportunities for initial engagement, which occurred through assessment at the point of referral when it was the treating agency" – survey respondent

Figure 2: Extent to which respondents agree or disagree that "Catchment Based Intake & Assessment has improved access to treatment for service users generally"



The bulk of responses to the question 'Please rate the extent to which you agree or disagree with the statement 'Catchment Based Intake & Assessment has improved access to treatment for service users generally' either disagreed or strongly disagreed. A convincing majority, or 86.7% (n=39) of respondents to the question, were in disagreement with the statement. Equal numbers were neutral or in agreement with the statement with just 6.7% (n=3). The various reasons for this have been outlined in the discussion throughout this report.

"Some clients have reported difficulty in understanding how the system works" – survey respondent

Survey respondents broadly agreed that recommissioning has resulted in AOD services being more difficult to find and harder to navigate:

"The Intake [and] Assessment system does not meet community needs and expectation of access" – survey respondent

> *"This model creates an additional barrier for consumers attempting to access services. It has been a challenge for GPs in our region as they have found it extremely difficult to contact [the Intake & Assessment provider] directly in making a referral. The intention of the model was to stream line services and make it easier for people to access; however, this has not been the case"* – survey respondent

Conversely though, a small number of respondents identified the benefit of having one single access point for all AOD services. Connected to this was the view that clients could be prioritised according to need.

> *"There has been feedback from other non-AOD services that it is good having a single point of entry into all AOD services in the area as in the past they would have had to provide multiple numbers for the various services"* – survey respondent

Telephone-based provision of Intake & Assessment

There was a view amongst some respondents that the increasing shift towards delivery of Intake & Assessment services via telephone brought about some challenges for clients, particularly for those who had more complex needs or those who may struggle to discuss issues related to AOD use and mental health over the phone due to language barriers or for cultural reasons. The capacity of the system to work sensitively and appropriately with Aboriginal people, CALD communities and young people as well as those with co-occurring mental health issues and more complex needs is discussed in further detail in Section 2 of this Report.

The specific concerns related to telephone based assessment included that the system may now be perceived as less friendly and less responsive with fewer opportunities for face-to-face engagement. It was noted that a telephone based service may pose some clinical challenges in terms of assessing level of intoxication and state of withdrawal which, at least in part, rely on clinical observation of physical signs and symptoms. There was concern that the physical observation of a client is an important component of an assessment.

It appears that some clients continue to present directly to AOD services seeking immediate assessment for their AOD concerns. Respondents expressed concern that capacity for provision of face-to-face assessments appears to have reduced across the AOD system as a whole.

This appears to be of particular concern in more geographically isolated locations. Some felt that service users preferred a model where they could present face-to-face or 'drop-in' to a service. A number of respondents, particularly those in rural and regional areas, noted that a 'walk-in' model had existed at their service prior to recommissioning and they now had limited capacity to provide that service.[3] These issues were seen to be exacerbated in some areas where telephone based screening and assessment was the only option available.

[3] While this may have been available in some services, VAADA does not have figures on the number of agencies who provided direct 'walk in' assessments prior to recommissioning.

Some respondents felt that this was less responsive to client needs. There was a belief among numerous respondents that some clients who are re-directed to Catchment Based Intake & Assessment providers will not follow-up and may therefore be 'lost' from the system.

The view was expressed that some people may not follow-up with a service provider until their AOD issues escalate, become more problematic or reach a crisis point. Therefore opportunities for brief and early intervention may be lost.

"[I] could imagine that people will fall through the gaps and won't engage until they're in crisis. Seems to have become too bureaucratic, cumbersome and anything but client-centred" – survey respondent

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Related to this were concerns expressed around wait-times associated with the new Intake & Assessment model. The new process was seen as requiring more steps of a potential service user than had previously been required of service users.

"Service system [is] difficult to navigate, few face to face contacts with intake, too many steps involved, too much time lapse between intake and service, no relationship with service. We like to conduct assessment here as this builds a better relationship with the client" – survey respondent

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Prior to recommissioning, clients had been able to present directly to any service and be seen for an assessment, or get an appointment in a relatively short period of time. Within the new arrangements, clients generally had to be directed to a telephone-based intake service, go through a formal screening process and then potentially wait up to several weeks for an assessment appointment. In an extreme circumstance documented by one survey respondent, the wait-time for an assessment in the early months post-recommissioning peaked at eight weeks, although things were noted to have improved in recent months.

Some respondents were concerned that people then get "lost" in the system or drop out completely, either feeling unwilling or unable to make a follow-up telephone call to an unfamiliar service provider. It was reported, that even if they do, the wait-time between initial contact and an assessment appointment was seen as a barrier.

"Severe disadvantage in rural area. Drastic reduction in clients accessing services through centralised model. Timeliness of engagement and follow up severely impacted" – survey respondent

"Opportunity to have face to face contact with workers at the time the client is ready and willing to attend was an integral part of clients engaging in treatment" – survey respondent

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Limited promotion and advertising of the new system

The limited promotion and advertising of the new system, particularly the new Intake & Assessment services, was identified by respondents as a significant challenge and as a potential barrier to access. Some respondents suggested this had impacted on demand, as it had contributed to confusion among service users and broader health and community service providers about how to access the new system.

Not only does it appear that the new entry process is difficult for potential service users to navigate but respondents described the new system as "invisible" to traditional referral sources, in particular General Practitioners (GPs) who appear to be experiencing ongoing challenges with referral pathways into the system. Some respondents noted providers in the child and family, homelessness, mental health and justice sectors have also experienced difficulties with accessing the new system.

There appears to be a need for further information, education and promotion of the changes to the AOD system and in particular the introduction of the new intake and assessment models.

"Major referrers like GPs are confused" – survey respondent

Some respondents noted that GPs are referring at lower-levels due to the difficulties they are having with access.

"Previously [our service] received referrals directly from GP's. They now report they are unable to get their clients into the service system" – survey respondent

"It has been a challenge for GPs in our region as they have found it extremely difficult to contact [the Intake & Assessment provider] directly in making a referral" – survey respondent

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Others pointed out how they have supported GPs to make referrals into the new system in the absence of formal supports.

"Because GPs and Acute Health do not have information about the reform and the central Intake and Assessment - so they refer to agencies they know - such as ours" – survey respondent

"We have spent considerable time and resources supporting and educating GPs, other service providers, and clients to engage in the new referral pathway" – survey respondent

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"GPs are not referring via intake as much they previously referred to AOD directly, due to process of intake and time of phone tags. They prefer to refer direct and then we support the client through the intake process. This is double dealing but it has kept the GPs linked in" – survey respondent

Opportunities to adequately promote the changes associated with recommissioning and advertise central intake details and processes to the broader health and community sectors was identified by respondents as a solution to this issue. More specifically, it appears that promotion is needed to GPs, and allied health and community staff.

"Targeted and coordinated approach to educating GPs about the new service system" – survey respondent

A number of respondents suggested greater leadership was needed from DHHS to ensure the changes to the AOD system broadly and more specifically the new centralised Intake & Assessment services were adequately advertised and promoted, particularly to GPs.

"In regional Victoria we have lower demand. One reason… is agencies doing direct intake themselves others have been GPs, community health etc not using the new system, in part some of this was down to the choke points at the beginning. We are seeing numbers increase but we need to continue to work on promotion as a sector" – survey respondent

"Marketing for new Intake & Assessment providers has been variable, and could be much better supported by the DHHS" – survey respondent

Changes to service user demand

Participants were asked a number of questions about how demand for AOD services had changed at their agency since recommissioning. There was a strong view that demand for AOD services had changed with many respondents indicating a perceived reduction in demand.

"It is difficult to pinpoint why there has been a drop in clients accessing AOD treatment, there are varying possibilities. However from speaking with other AOD services this is not limited to our local area it is across the state which would indicate that it is reform related. However, ascertaining if this is a positive outcome ie. Clients are contacting I&A services however being referred to primary health services, GPs who are meeting the clients' needs by providing brief interventions and education or if it is a negative ie. The catchment based I&A system is not working and clients are not contacting I&A service due to the process in place" – survey respondent

However for some respondents there was the belief that community demand has remained stable, but the recommissioned system is making it more difficult for people to access AOD treatment and thereby demand on treatment services appears reduced.

Respondents acknowledged the reliance on anecdotal evidence at the current time:

"Anecdotally, a lot of clients have reported great difficulty accessing services and are confused by the multiple different intake numbers and pathways; many say they found it difficult to access treatment post sector reform" – survey respondent

"This is difficult to say exactly as a lot of information is anecdotal. From discussions with other local services and GP's the process of referral is now a hindrance for clients and workers in referring client for treatment" – survey respondent

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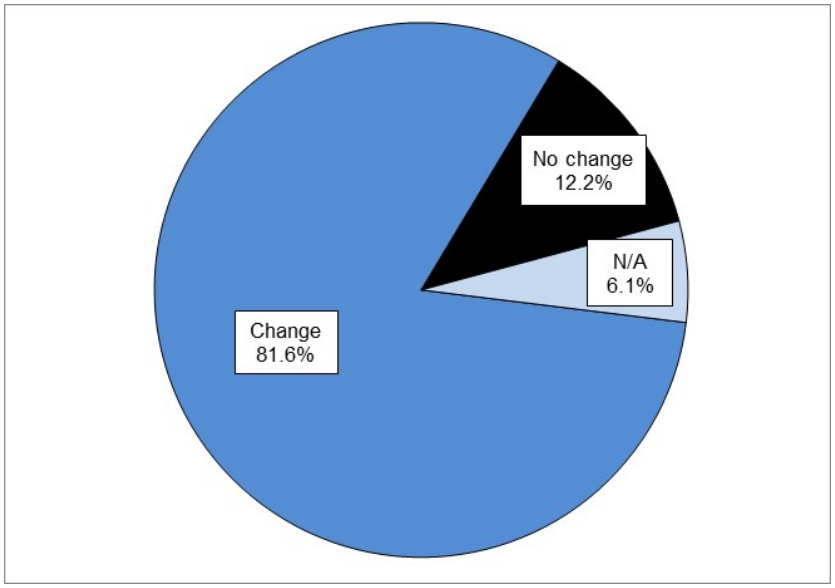
Figure 3 shows that the majority felt demand for AOD services had changed since recommissioning. A total of 81.6% (n=40) reported a change to service user demand.

Figure 3: Percentage of respondents reporting a change to service user demand



NOTE TO THE READER ON MEASURING DEMAND:

VAADA acknowledges there are inherent challenges in accurately measuring changes to demand in the absence of clear baseline data on demand prior to recommissioning. This is further complicated by the limited publicly available data post-recommissioning. Respondents have provided their view and estimates on changes to demand based on their experience, observations, expertise and available agency data.

It is also important to note that a number of respondents stressed the difficulty in making an assessment of how demand has changed, given that a lot of information is anecdotal and that there is variability across different locations and service types.

The findings of this survey must be interpreted with an appreciation of the complexities of mapping demand. VAADA welcomes the release of official data from the Department of Health and Human Services that would provide greater insight into any changes to demand for AOD services since recommissioning. Matching official data about demand against these survey responses would help elucidate these complexities around demand. VAADA believes mapping demand in a more complete way would require analysis of waiting lists & times, an assessment of current treatment utilisation across AOD services and an assessment of those who have unsuccessfully sought treatment (ie. intended to seek treatment but could not access) (see Ritter et al 2013 for a further detail on estimating unmet need and demand for treatment).

Furthermore, to gain a true picture of demand, an analysis of demand for the full suite of treatment types available would be needed. This survey did seek feedback on perceived changes to demand across a number of treatment types but it did not consider demand for newly introduced services such as the Centralised Intake & Assessment model and Care & Recovery Coordination. VAADA believes mapping of demand in these areas could be useful and worthwhile.

When asked *how* service user demand had changed, almost 60% (57.2% or n=24) of respondents indicated demand had **decreased,** as highlighted in Figure 4 below.

Figure 4: Changes to service user demand

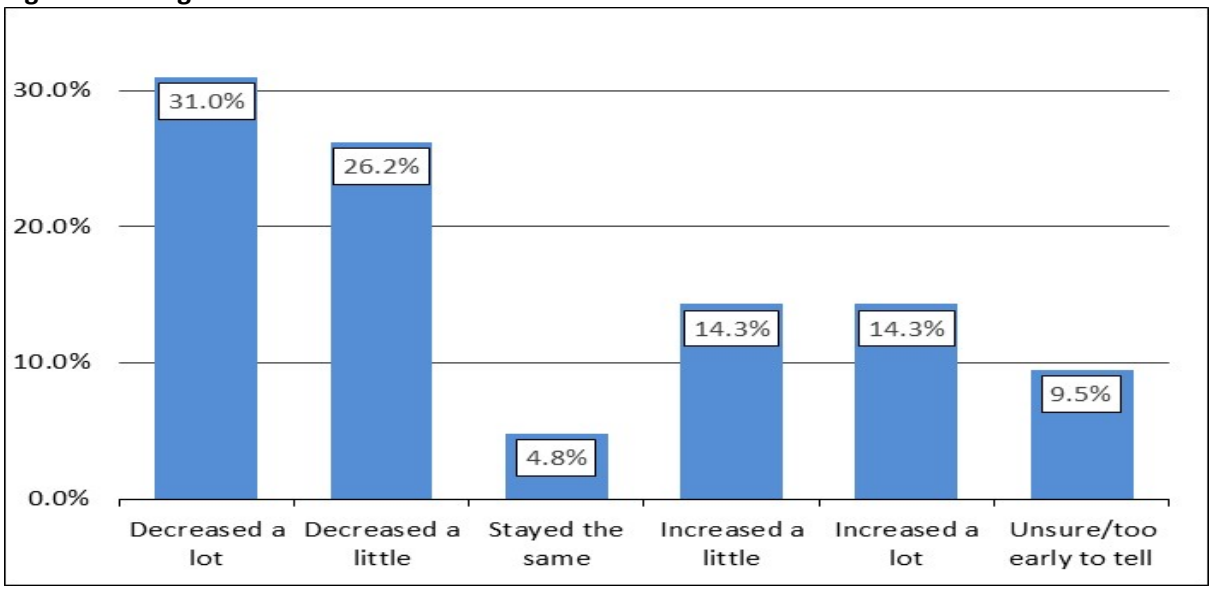


Figure 4 shows that 26.2% (n=11) of respondents reported demand has 'decreased a little'. Further 31% (n=13) of respondents noted that demand has 'decreased a lot' – a combined total of 57.2% of respondents. However, this experience is not universal with 28.6% of respondents noting an increase in demand (n=11). While a further 9.5% (n=4) of responses noted they were unsure or felt it was too early to tell if demand had changed.

Various reasons were identified for a drop in service user demand, among those who responded to the questions. Commentary in relation to reductions in demand pointed to issues already highlighted around barriers created by the new system design:

"I do not believe there are now fewer clients, but feel that many clients have had difficulty accessing services or have stopped trying to access service after initial difficulties" – survey respondent

"Demand is very low in areas where there is not a dedicated AOD Intake & Assessment…Demand could also be impacted by the new way I&A is being done, which creates barriers for some clients who either just want some brief support, or who are complex and often intoxicated, and need some help before they can even engage in an assessment" – survey respondent

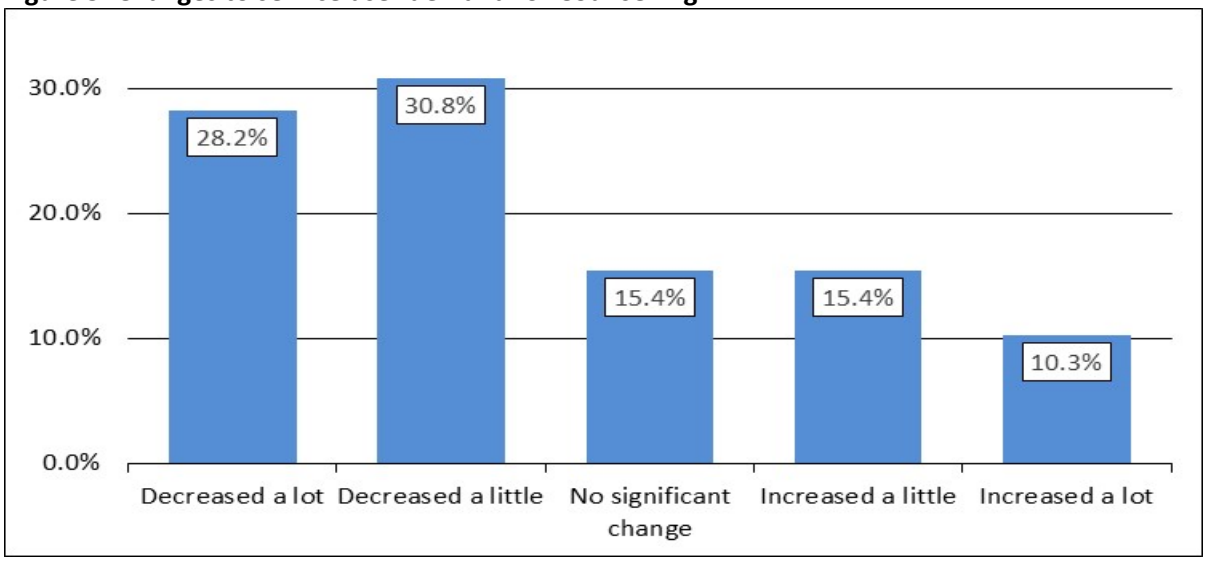
"We are seeing numbers increase but we need to continue to work on promotionas a sector" – survey respondent

"Where have all the clients gone?" – survey respondent

Changes to service user demand across different treatment types

The survey sought to explore if demand had changed across different treatment streams, with findings suggesting that demand is variable across different treatment types. It appears demand may have decreased for counselling and non-residential services, among those who responded to the survey, but appears more stable for residential services.

Figure 5: Changes to service user demand for Counselling



Results suggest Counselling may be an area of where services are noticing reductions in demand with 59% (n=23) of respondents indicating their AOD agency has experienced a decrease in demand.

> *"Referrals to counselling are not coming from Intake & Assessment"* – survey respondent

However, just over one quarter of respondents to the question (25.7% n=10) reported an increase in demand for counselling services. Some of those who identified an increase, noted this was due to expansion of counselling services they now deliver:

> *"This has mainly been as a result of the acquisition of counselling in certain catchment areas where we were not previously operating"* – survey respondent

Respondents were also asked about changes to demand for non-residential withdrawal services. These results are shown in Figure 6 below.

Figure 6: Changes to service user demand for non-residential services

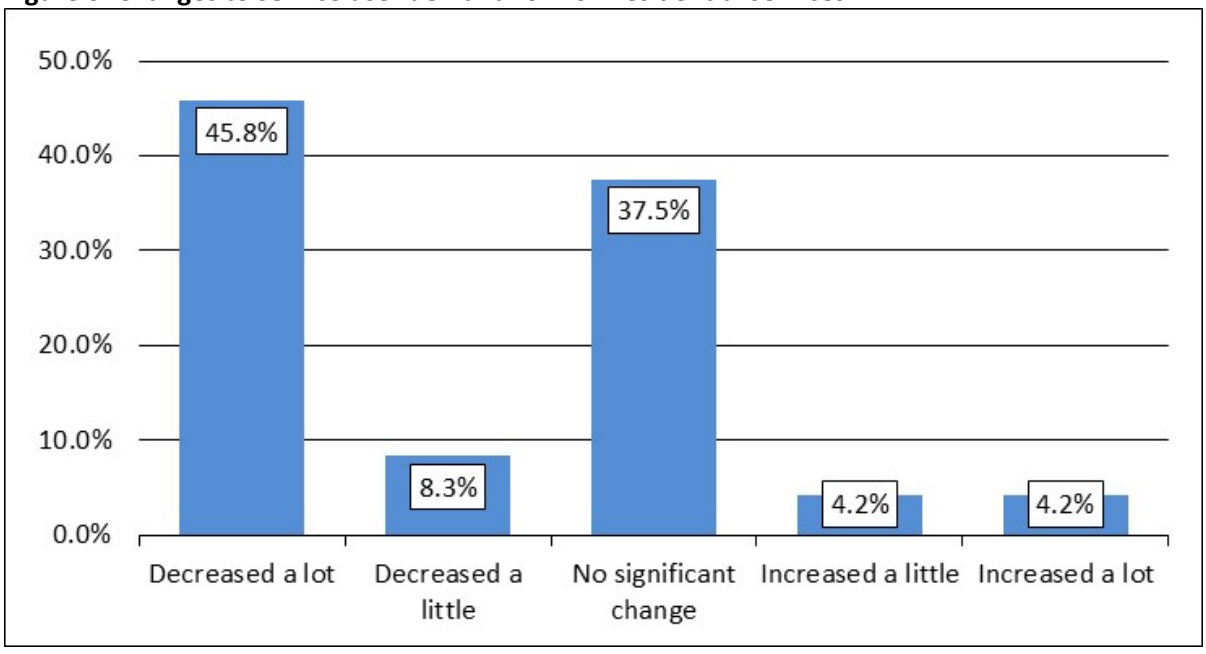


Figure 6 (above) highlights that 45.8% (n=13) of respondents to the question felt demand for non-residential withdrawal had 'decreased a lot', while 37.5% (n=9) felt there had not been a significant change since recommissioning.

In discussing challenges with providing non-residential withdrawal in the recommissioned system, one respondent noted:

"Non-resi withdrawal has significantly decreased. Pre reform, we operated as rural withdrawal, where a client wanting to undergo any form of withdrawal would attend the rural withdrawal service. We are unsure now if many of the withdrawal clients are being referred direct to residential withdrawal and supported via the I&A service until they access a bed, or if they are just not coming through the system as the current I&A system is not conducive to the needs of clients wanting to access withdrawal. This is mainly due to the time and steps taken to get to the treatment service, then the need for further medical assessment and assessment of the client against agency criteria to ensure the safest and most appropriate treatment plan is developed for the client in line with the treatment modalities the agency provides" – survey respondent

Others suggested there were mechanisms in place to try and ensure non-residential services remain an option for people seeking withdrawal:

"Ongoing dialogue within and across Consortia and resi and non-resi services to find solutions to ensure consumers are not being disadvantaged by new models" – survey respondent

Client flow through the system

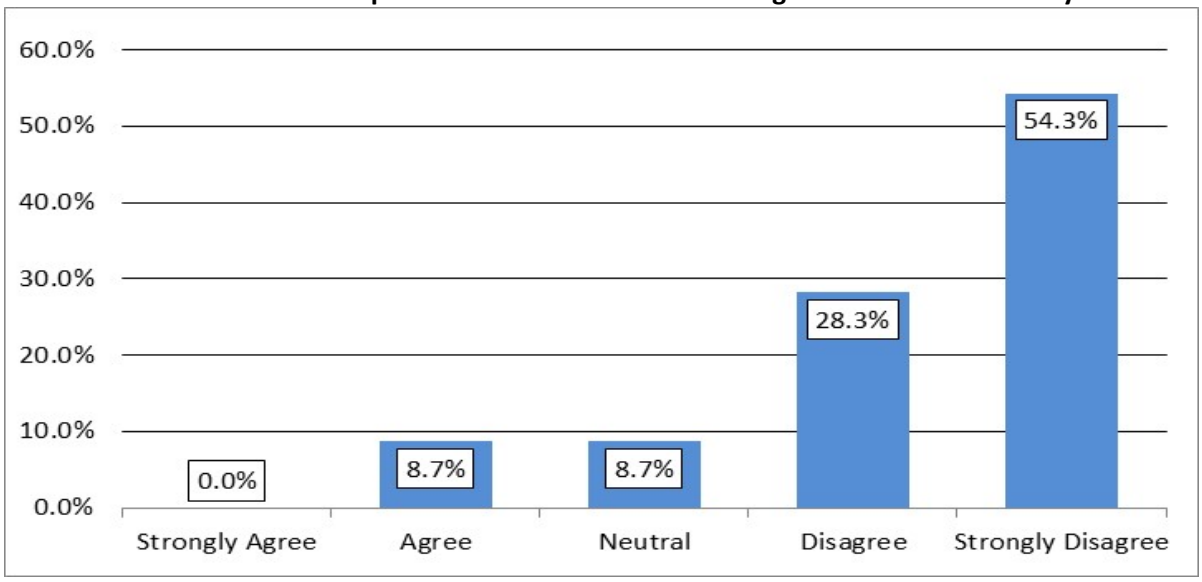
There were mixed views about how referral pathways and client 'flow' was working in the recommissioned AOD service system, as of April 2015.

Some respondents noted that it was too early to comment or adequately assess client pathways due to the substantial changes to how services operate and in recognition of the time needed to establish referral processes and sort out 'teething' problems.

"Referral pathways have been established but it is too soon to measure their success in relation to client flow" – survey respondent

The survey asked respondents specifically how they felt the introduction of Catchment Based Intake & Assessment had improved client 'flow' of clients through the AOD treatment system. The question triggered responses weighted heavily in the negative, as shown in Figure 7 below.

Figure 7: Extent to which respondents agree or disagree with the statement "Catchment Based Intake and Assessment has improved the 'flow' of clients through the AOD treatment system"



Under ten per cent of respondents to this question (8.7% n=4) felt the introduction of Catchment Based Intake & Assessment had improved client journeys through the system.

> *"We are very fortunate in our catchment area. We have excellent links with all of the Catchment [sic] Intake staff and find this helps the flow through for the client and for scheduling appointments in a timely manner"* – survey respondent

Yet the majority felt the introduction of the new Catchment Based Intake & Assessment had not improved the client journey, with 82.6% (n=38) of respondents disagreeing with this statement.

A range of reasons were suggested as to why client flow may be impacted, including the design of the new system having perverse outcomes on referral pathways. Rather than improving client flow, it was seen by some as inhibiting good referral processes and service linkages.

> *"Flow of client - taking clients longer to get into service section than previously. Client disengaging [due to] time to get referral, appointment and the client changes their mind in the interim. Client loses faith in service ability to help because they have waited too long (and AOD specialists cop the wrath of the client)"* – survey respondent

A number of respondents noted the challenges of being reliant on another service provider for referrals and that referrals are not always received in a timely manner, leaving clients waiting for periods of time before they can commence treatment and then requiring further assessment or an update to their initial assessment by the time they reach treatment.

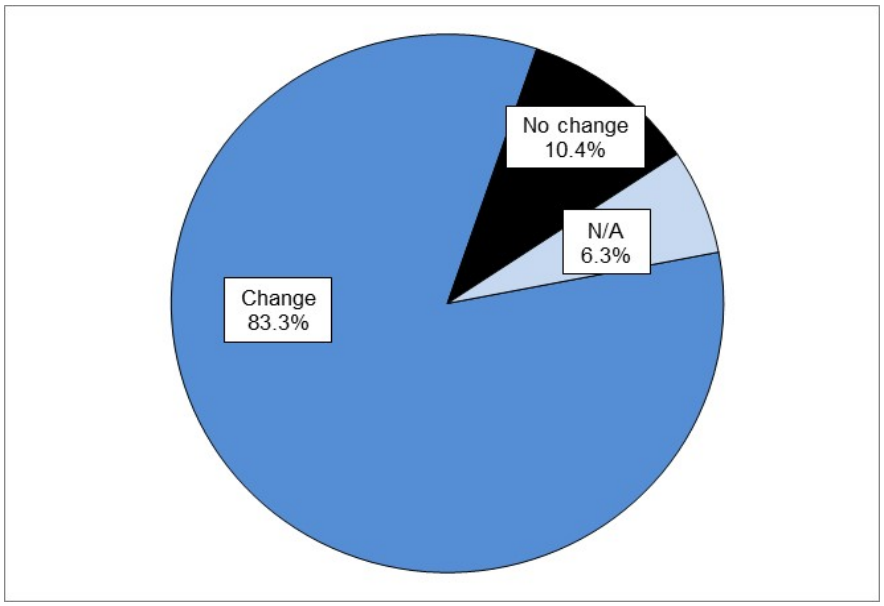
"We no longer do our own assessments and intake and are reliant on an external agency to provide suitable client flow" – survey respondent

Some pointed to the difficulties faced by Intake & Assessment providers needing to ensure adequate numbers of referrals are distributed throughout consortium. It was noted that clients may prefer to undertake treatment with the Intake & Assessment providers' own service, rather than engage with a new and unknown treatment provider. Others suggested Intake & Assessment providers may inadvertently be more likely to refer to their own agency.

Numbers in AOD treatment

Survey respondents were asked if their agency had experienced any changes to the number of service users engaged in treatment since recommissioning. A total of 83.3% of participants (n=40) noted there had been a change, as illustrated in Figure 8.

Figure 8: Percentage of respondents reporting a change to the number of people in treatment since recommissioning



Respondents were also asked *how* the number of service users engaged in AOD treatment had changed:

Figure 9: Changes to the number of people in treatment

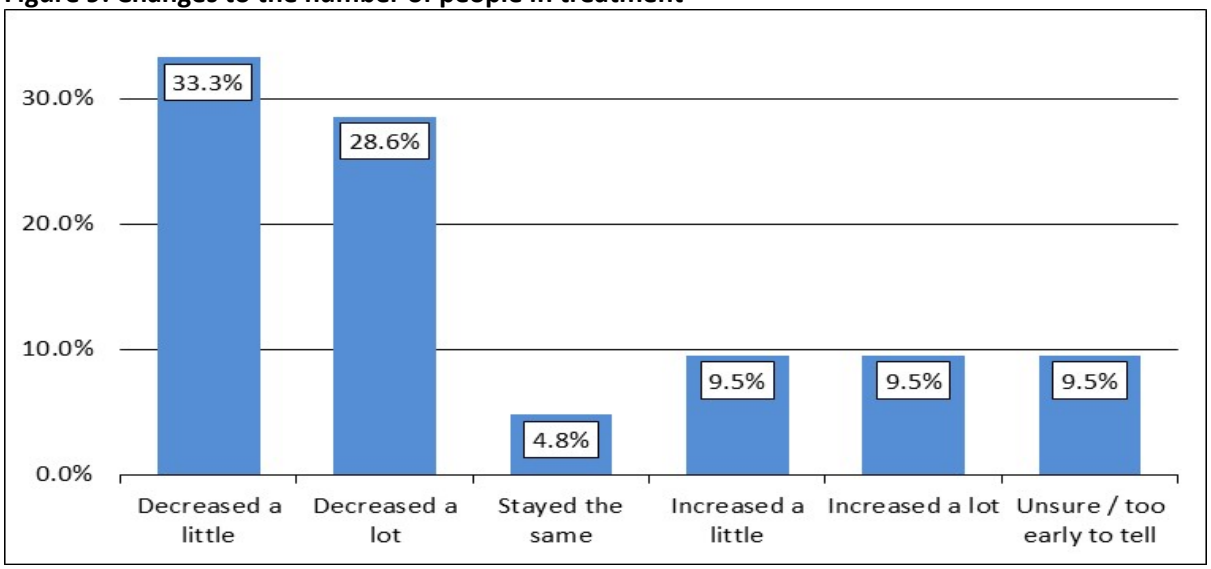


Figure 9 illustrates just over 60% (n=26) of respondents felt they had experienced a decrease in the number of people engaged in AOD treatment at their agency with 33.3% (n=14) indicating the number of clients had 'decreased a little' and a further 28.6% (n=12) suggesting the number of clients at their agency had 'decreased a lot'.

Whereas, 19% of responses (n=8) indicated an increase in the number of people engaged in treatment with equal numbers stating the numbers of people in treatment had 'increased a little' (9.5% n=4) and 'increased a lot' (9.5% n=4)

Respondents were provided with a list of options to choose from in identifying why the number of people in treatment had changed. They could select as many responses as applicable to their situation.

Some of the key reasons identified for changes in the number of people in treatment included:

- Clients having difficulty navigating the new Catchment Based Intake & Assessment system (76.1% n=35)
- Fewer people eligible for specialist AOD treatment with the introduction of the new demand modelling complexity & severity of dependence tool (54.3% n=25)
- A decrease in referrals since the introduction of the Catchment based Intake & Assessment system (47.8% n=25)

These issues are discussed in detail throughout this report.

Section 2: Person-centred, family-inclusive, recovery-oriented treatment

Key points:

- **The recommissioned AOD service system was seen as less person-centred & family-inclusive overall**
- **Respondents felt that capacity to work with families has been significantly reduced as a result of recommissioning**
- **Very few respondents indicated that there had been any improvements to services' capacity to meet the needs of diverse populations and that this may have diminished in some instances**
- **The Catchment Based Intake & Assessment model was seen by some respondents as impersonal, inflexible and not always culturally sensitive or age appropriate**
- **In particular, respondents expressed concern about the appropriateness of telephone based assessment and screening processes for Aboriginal, CALD, youth and dual diagnosis consumers**

The survey considered issues related to the extent to which the recommissioned service system is person-centred, family-inclusive and recovery-oriented. It also considered issues related to cultural inclusiveness and appropriateness as well as capacity to work with younger people.

Survey responses placed a clear spotlight on the diminished capacity to offer family support and interventions, despite this being highlighted in the *Framework document* as a key feature of the redeveloped service system. Responses received to this survey articulated that incorporating families into AOD treatment, or providing direct support to individual families, is increasingly difficult in the recommissioned AOD system. Where respondents indicated they continue to deliver family work, they pointed out that this was largely through unfunded means and agencies had no way of accurately recording and reporting this work to the Department.

Figure 10: Extent to which respondents agree or disagree that the new AOD system is more "person-centred, family and culturally inclusive, recovery-orientated treatment"

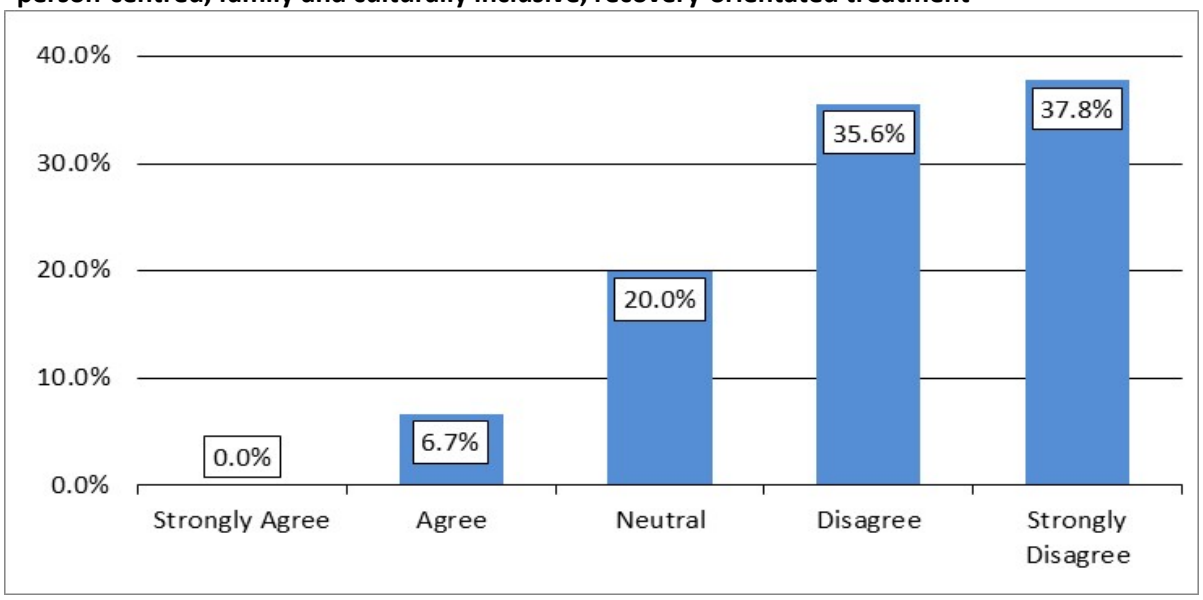


Figure 10 illustrates that the majority of participants (73.4% or n=33) disagreed that the new AOD system is realising the goal of being more 'person-centred, family & culturally inclusive, recovery oriented treatment'. A significant proportion though selected 'neutral' in response to the statement, while only 6.7% (n=3) agreed that it was.

A number of respondents provided additional feedback for this question. They highlighted concerns that the recommissioned system lacks a person-centred and recovery-oriented focus by, at least at times, emphasising program parameters such as the use of the tiered model and the screening tool. Issues related to the screening tool and application of the tiered model are outlined in greater detail in Section 3 of this Report.

"If [the system] was person centred, referrals would turn over quickly to allow for rapid engagement. If the model was recovery oriented, it would include prioritising those at risk of relapse…" – survey respondent

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There was also a view that clients feel uncertain about the new system:

"Less links and supports with this model. Clients have a sense of uncertainty and services are unclear" – survey respondent

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Responding to families

Respondents extensively highlighted that capacity to work with families is limited in the recommissioned system. They revealed a common view that families have been excluded and capacity to engage and support families has been diminished, particularly as to how this complex work can be accounted for within current funding arrangements and reporting mechanisms.

Alongside this, there appears to be some confusion and uncertainty about service provision for families[4]

"The new system is apparently supposed to provide counselling services for families of people experiencing AOD misuse - and yet there is no family-inclusive or family-specific intake and assessment process! This means that if a family member wants to access services they are required to ring a centralised intake service and complete the initial screening tool which asks a multitude of questions about the substance user - this is clearly NOT family-inclusive or best practice" – survey respondent

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[4] VAADA acknowledges that the Intake & Assessment guide states that the screening tool does not apply to families, Yet, this guide was not available until April 2015 and a number of respondents may not have been aware of this when participating in the VAADA survey.

Figure 11: Extent to which respondents agree with the statement " The recommissioned AOD system has improved capacity to meet the needs of families"

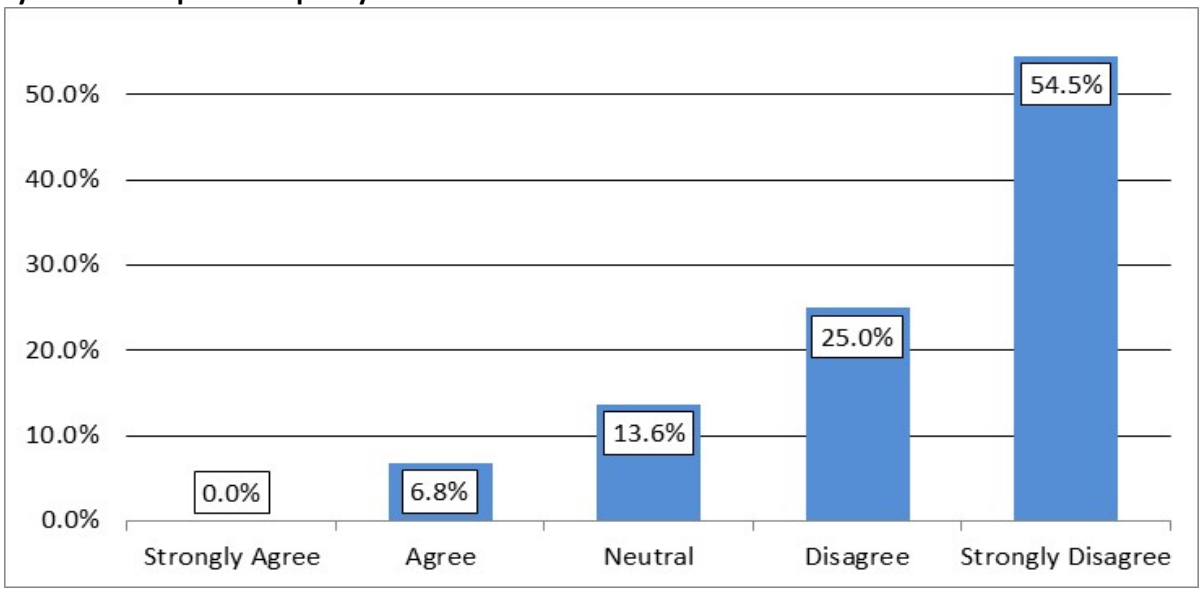


Figure 11 shows nearly 80% (n=35) of responses either 'disagreed' or 'strongly disagreed' with the statement 'The recommissioned AOD system has improved capacity to meet the needs of families'. Over half of respondents to this question 'strongly disagreed' with the statement (n=24).

It appears that providers across the system continue to respond to calls and enquiries from family members; providing information and support and assisting family members to navigate the AOD service system, or find family supports outside of the AOD system. The reduced capacity to work with families, both as a brief intervention, and over the longer-term was another theme identified in responses to this question but also throughout the survey responses more broadly:

> *The capacity for services to provide holistic intake to families that address a number of issues, including AoD has been removed. The identification of AoD issues cannot occur through a centralised intake (holistically understanding the family story) to best understand the services that are required and ensure access is available - I have not seen any family work or support to families to increase their access or improve their capacity to access services under the recommissioning-* survey respondent

Another respondent noted:

> *"We used to provide face-to-face counselling for a number of families, who are now limited to groups (e.g. FDH, FDS) or a private practitioner who might not have experience with AOD"* – survey respondent

The same respondent, proposed the following solution to the problems they had identified regarding family work:

"Funding for families and early intervention (why park the ambulance at the bottom of the cliff??)" – survey respondent

Nonetheless there were some responses which showed that family work continues to be delivered by some AOD services, despite significant constraints on its provision.

"Local families want the help of local services and they want it when they walk through our front door or call us. We often spend up to 60 minutes discussing the issues with them because they need our help. Referral to Catchment Based Intake & Assessment in these cases is futile and works against the principle of service provision in a timely & streamlined approach" – survey respondent

"The recommissioning has eroded the capacity to provide effective support for families. There is no allowance in the system to intake families in small rural centers where there is no alternatives for these families. We of course work to find a path around this for our clients, but once again providing unfunded service to this cohort of people" – survey respondent

While respondents highlighted the challenges with providing family support and interventions; there was recognition that this work is expected to be delivered. Concern was evident in a small number of responses that family interventions were expected to be provided without an adequate baseline of training and workforce development across the AOD sector.

Despite the substantial concern about reduced capacity for supporting families in the recommissioned system, there was some degree of optimism about improvement following the early months of transition.

"I think things are improving more recently but he AOD reform seemed to create a situation of excluding families initially" – survey respondent

Responding to diversity & complexity

Part of the vision for a 'redeveloped' or recommissioned system, as outlined in the *Framework* document was for AOD services to be responsive to diversity (DHHS 2013). Respondents were asked about the extent to which they felt the recommissioned AOD service system has improved capacity to respond to the needs of diverse groups such as Aboriginal people; Culturally & Linguistically Diverse communities; Gay, Lesbian, Bisexual, Transgender, Intersex & Queer communities; young people, families & people with co-occurring mental health concerns.

A few were optimistic about their services' capacity to respond to community needs.

"We have been fortunate to retain most of our skilled and competent workforce, thus we can see this service can be responsive to community needs. With a little tweaking it can also be sustainable" – survey respondent

Others noted overall the challenges in meeting diverse and complex needs:

"Difficulty in engaging young people, Aboriginal clients, and vulnerable [&] intoxicated people in the process" – survey respondent

Some respondents held grave concerns that people with multiple and complex needs, who may need the most support, may find the new processes most difficult to negotiate. There was the suggestion that those who are most complex and require additional support to engage with AOD services, are struggling with the new processes:

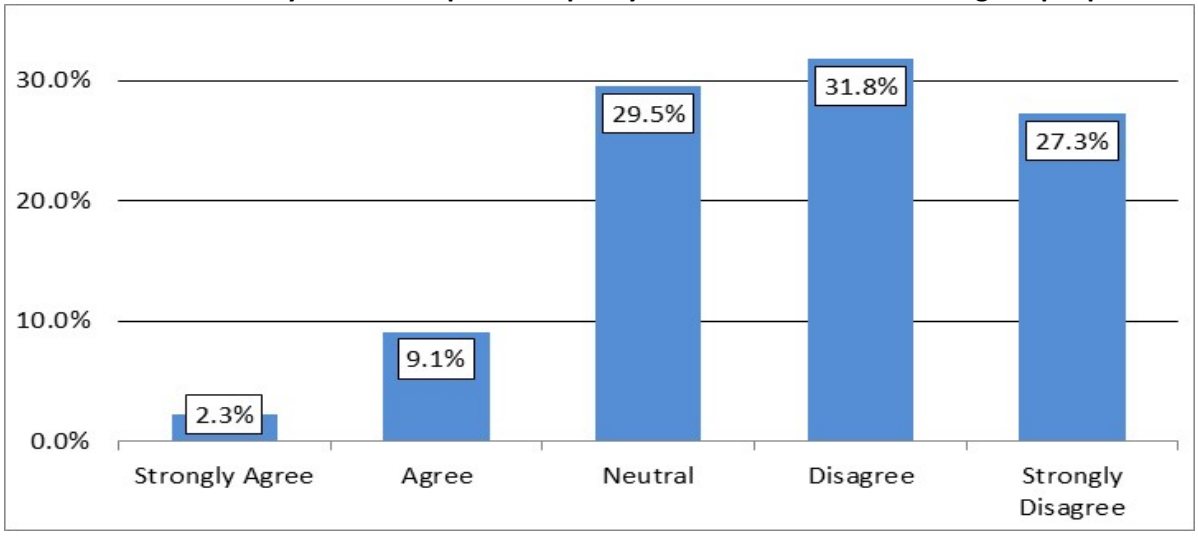
"I believe that there is a role for [intake services] for clients who are comfortable accessing services by phone however there needs to be flexibility and funding to drug treatment services to provide assessments to clients who are reluctant to phone or are vulnerable" – survey respondent

"Our AOD [services] are still seeing and hearing about clients that find the process very difficult without help, often these are the ones that need the services the most" – survey respondent

Aboriginal people

Responses were varied in relation to whether the recommissioned service system is more or less responsive to the needs of Aboriginal people, as shown in Figure 12.

Figure 12: Extent to which respondents agree or disagree with the statement "The recommissioned AOD system has improved capacity to meet the needs of Aboriginal people"



Nearly 60% (n=26) of respondents indicated they either 'disagreed' or 'strongly disagreed' that the new AOD service system has improved capacity to meet the needs of Aboriginal people with a further 30% of responses neutral about the statement, as shown in Figure 12 above.

A number of respondents noted that very little has changed in relation to meeting the needs of Aboriginal clients. In particular, it was noted that where things were previously working well, they continue to work well.

Some respondents noted that there is flexibility for Aboriginal clients in their local area enabling Aboriginal clients to bypass the Central Intake & Assessment service due to long-standing relationships and existing referral pathways. There is also the option for Aboriginal people to directly access community controlled health organisations if they choose to.

However, where Aboriginal clients were required to utilise the new Catchment Based Intake & Assessment services, it was seen as an inflexible process which was not always culturally appropriate:

"Inflexible process, reduced front doors, paperwork very white man oriented. Some Assessment staff and intake staff green and new to the sector [and] not culturally trained"– survey respondent

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Another respondent pointed to the difficulty for Catchment Based Intake & Assessment providers to work in a culturally appropriate manner with Aboriginal clients:

"Engaging Aboriginal [people in] treatment can be more difficult to achieve and building trust can be even more important with this client group. The centralised I&A teams do not have the capacity to do this" – survey respondent

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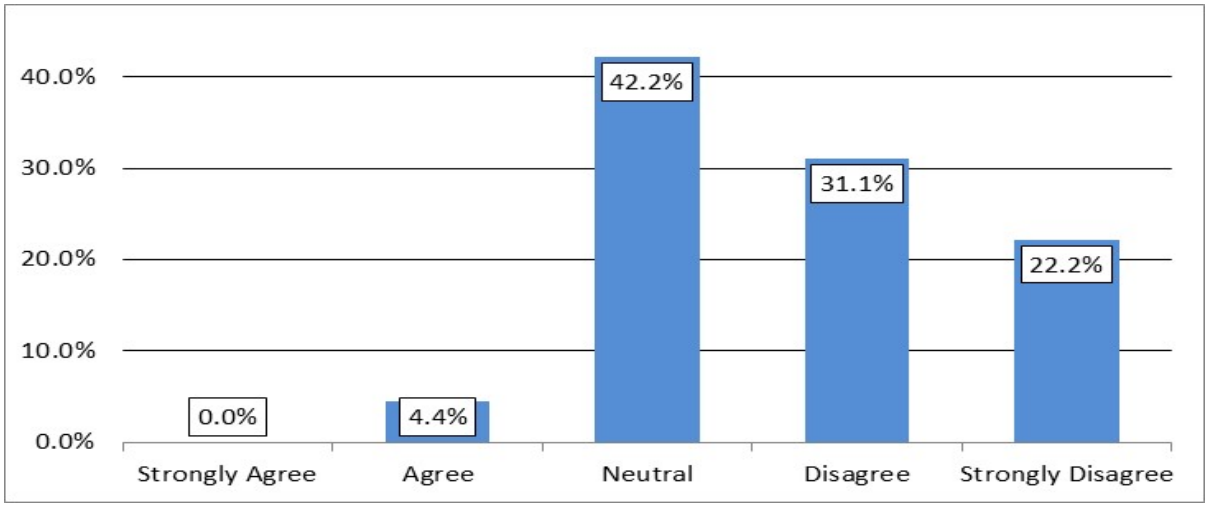
Culturally and Linguistically Diverse Communities

The survey asked respondents to identify if they felt the recommissioned system has improved capacity to meet the needs of Culturally & Linguistically Diverse communities. Their responses are illustrated in Figure 13 below:

Figure 13: Extent to which respondents agree or disagree with the statement "The recommissioned AOD system has improved capacity to meet the needs of Culturally and Linguistically Diverse Communities"



Respondents identified that the needs of CALD communities are not being met in the recommissioned system and that new Intake & Assessment process is a particular barrier for CALD communities in accessing treatment. The difficulties faced by people with low English language proficiency or those unfamiliar with the Australian health system were highlighted as major challenges facing CALD communities.

"Nothing available in other languages to explain process, self-assessment in English. Staff not CALD capable" – survey respondent

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There was also acknowledgement that the low levels of engagement from CALD communities prior to recommissioning make it difficult to determine if things have improved.

"Once again, this is a rural agency, so all rather new learnings with the CALD population and how we can best service these clients, getting an interpreter can be a mission in itself" – survey respondent

"Unfortunately we have not had a high number of clients who come through the service pre reform to gauge the system has improved or not for those seeking treatment. However considering the process of having to phone, many would not be able to access the I&A service without a support worker, especially if requiring an interpreter. The questions are not sensitive to those from CALD backgrounds" – survey respondent

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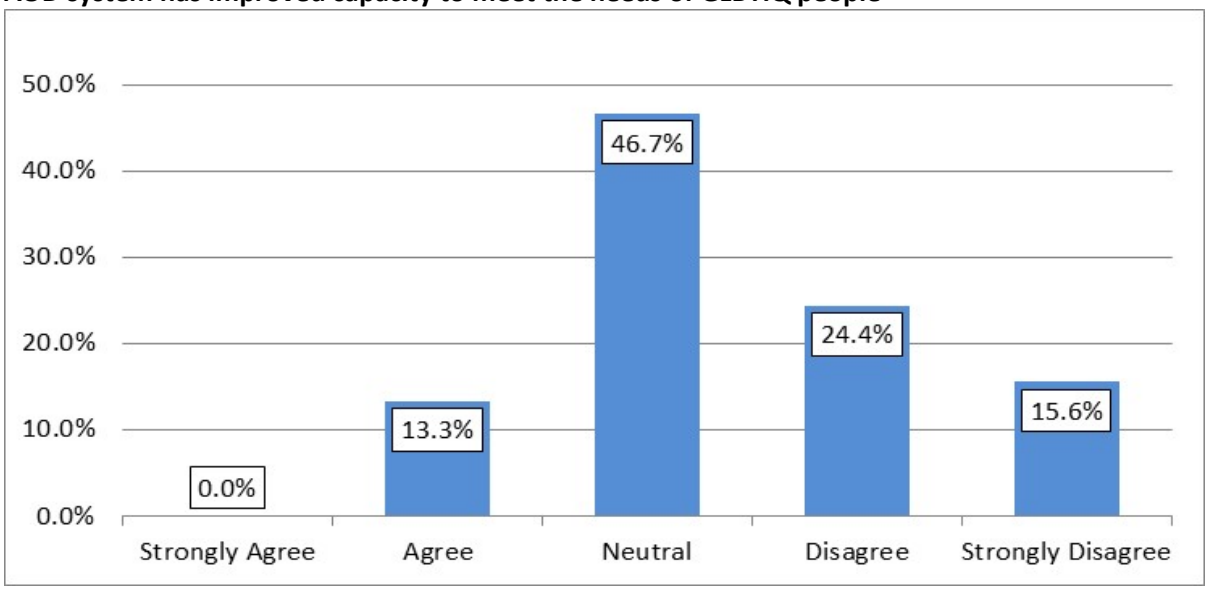
Gay, Lesbian, Bi-sexual, Transgender, Intersex and Queer Communities

Almost half of all responses were neutral in relation to the statement 'The recommissioned system has improved capacity to meet the needs of GLBTIQ communities', as shown in Figure 14. While 13.3% (n=6) of respondents agreed that capacity has been improved and 40% (n=18) either disagreed or strongly disagreed that capacity had been improved.

Figure 14: Extent to which respondents agree or disagree with the statement "The recommissioned AOD system has improved capacity to meet the needs of GLBTIQ people"



Qualitative feedback on this question suggested there had been no change in capacity to meet the needs of people who identify as GLBTIQ, or that the responding service receive few referrals where the client identifies as GLBTIQ.

Some respondents indicated the recommissioned system is not sensitive or responsive to the needs of GLBTIQ communities although, one respondent thoughtfully pointed out:

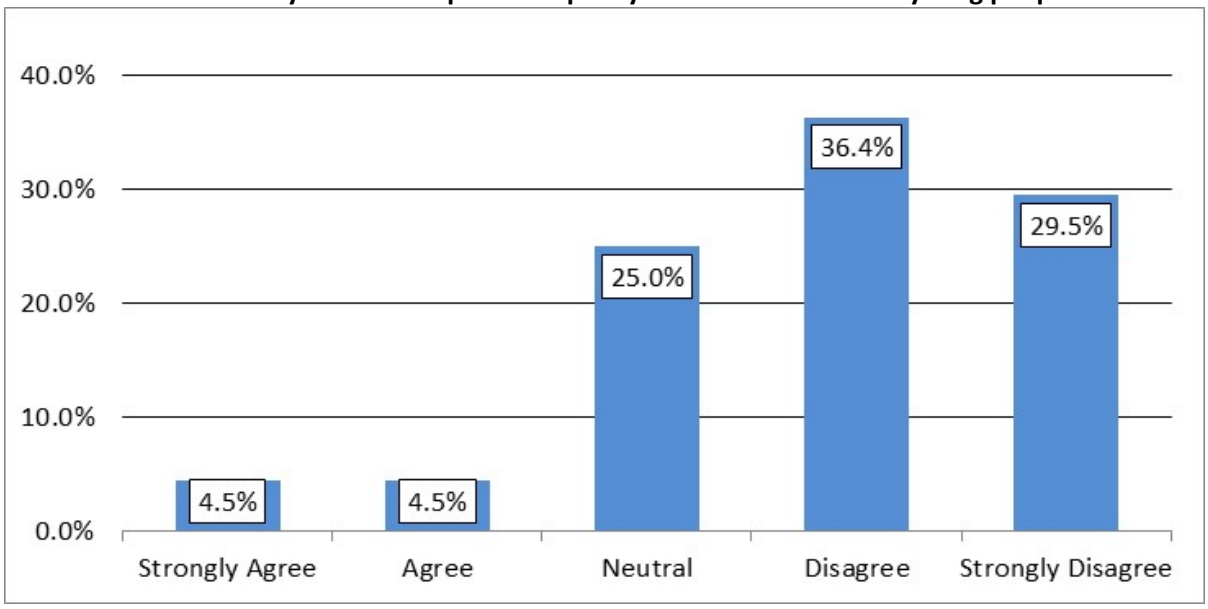
> *"I don't believe the new system is particularly sensitive or responsive to the GLBTI community, however unsure if this has really changed much since the old system"*
> – survey respondent

A small number of responses suggested that it is difficult to meet the needs of diverse groups in general within the recommissioned system, while a small number mentioned the new referral pathways and connection to the statewide organisation working specifically with GLBTIQ communities is a positive of recommissioning.

Young people

Figure 15 shows that 65.9% (n=29) of respondents either disagree or strongly disagree with the statement that the recommissioned AOD system has improved capacity to meet the needs of young people.

Figure 15: Extent to which respondents agree or disagree with the statement "The recommissioned AOD system has improved capacity to meet the needs of young people"



The main themes to emerge from the additional qualitative commentary related to young people was that there has been a reduction in the capacity to assess and treat young people, including a limited number of workers who are appropriately qualified and experienced to work with youth. The new definition of 'adults' as anyone over the age of 16 years was seen by some as inappropriate and unresponsive to the specific developmental needs of young people throughout adolescence.

There has also been confusion about age-related criteria and access for young people with multiple systems and entry points for young people, without appropriate integration. There was a view that a "simpler and more engaging process for youth" is required. Rural services seemed particularly hard-hit by changes in funding to youth CCCC services and other youth specific roles, with several respondents noting the absence of youth specific services as a result of recommissioning.

"There are no youth specific services funded in this area" – survey respondent

"…as a result of the absorption of youth positions into generalist adult services, there is no youth specific AoD services. Furthermore, the decision not to fund [federally funded youth positions] has meant there are no youth-focused positions left in the [local area] at all" – survey respondent

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Others noted the lack of attention to young people under the age of 16 years and the possibility of lost opportunities to work with young people with less severe AOD issues.

"Young people under the age of 16 years were not taken into account with the reform, resulting in agencies having to intake and assess this age group using the 20% flexibility in DTAU's where there is not a specific youth AOD agency. Young people aged 16yrs and over are required to go through an I&A system designed for adults using adult screening and assessment tools. Also concerns regarding the

importance of early intervention with young people and even if they do not rate high on the tier system, the long-term benefits of them attending AOD treatment services are important" – survey respondent

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People with co-occurring mental health issues

There was some consensus among respondents that clients with greater life complexities, including those with co-occurring mental health issues, may be disadvantaged by the changes associated with recommissioning and more specifically by new Intake & Assessment processes particularly telephone-based processes.

Figure 16: Extent to which respondents agree or disagree with the statement "The recommissioned AOD system has improved capacity to meet the needs of people with co-occurring mental health concerns"

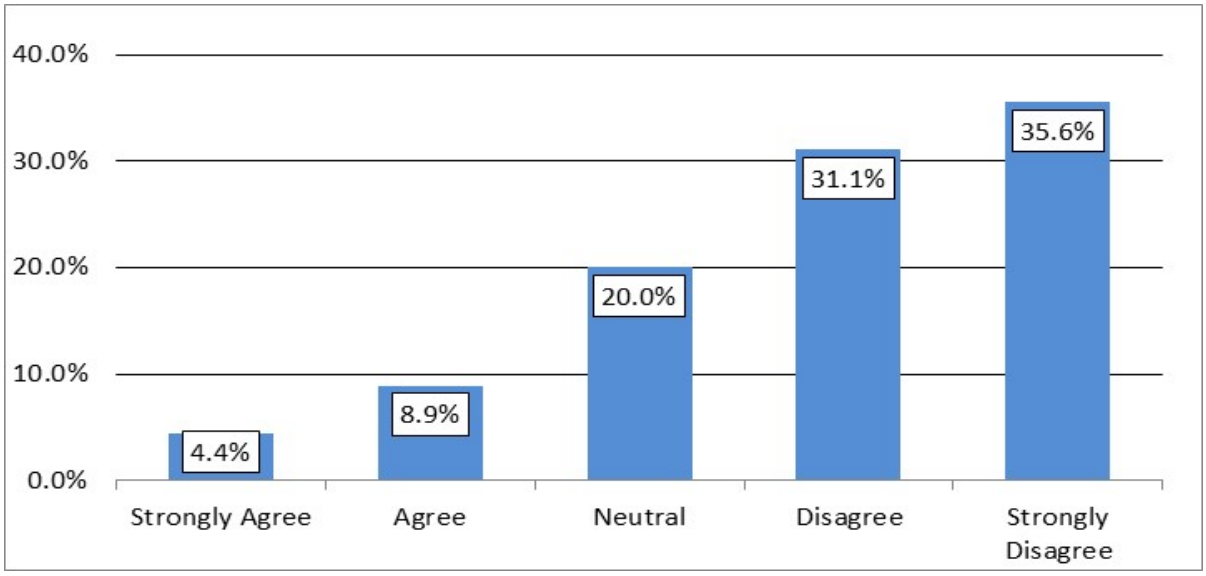

Figure 16 again illustrates variability in respondents' views about the extent to which the recommissioned system has improved capacity to meet the needs of this cohort. It shows that 66.7% (n=30) of respondents either disagreed or strongly disagreed while 13.3% (n=6) agreed or strongly agreed with the statement. Twenty percent of respondents to this question were neutral (n=9) on whether the recommissioning had improved responses.

When examining the qualitative commentary related to this question, a number of themes emerged. A number of responses argued that people with co-occurring mental health concerns are faced with specific barriers in the recommissioned system, particularly around appropriate access. Telephone based Intake & Assessment was seen by a few as a particular challenge and the screening tool was seen as problematic, particularly for those who try to access services without a support worker or advocate.

A few responses noted a decline in referral pathways and collaboration between AOD and Mental Health services following recommissioning of both sectors; while others remarked on the improved collaboration and integration of the two systems particularly in catchments were services are co-located and assessment is integrated.

One respondent noted that the Care & Recovery Coordination role has seen some improved response for people with co-occurring mental health issues. Yet in response to other questions in the survey,

the funding available for the delivery of Care & Recovery Coordination was seen as a barrier to the potential of this treatment intervention for the most vulnerable and complex service users.

Another respondent highlighted the impacts of the changes to Counselling service delivery on service users with complex needs:

"The standard and complex criteria is disrespectful and inaccurate. Four sessions and 15 sessions is not treating addiction - what is it treating? What can be achieved in this framework? What works in treatment is relationship - 4 sessions is what it takes to assess comprehensively and in a person centred way. The system is rigid and inflexible. Traumatised clients and clients with co-occurring conditions are the expectation not the exception so why do we have a system of care that expects standard?" – survey respondent

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While the survey failed to ask explicitly about the needs of homeless people, one respondent highlighted this omission of homeless populations as a group for consideration in the survey and by the AOD system more generally:

"Given there is no consideration of homeless populations I will include it in here given the high rates of mental health within the homeless population. The system is set up for those that have the ability to self-advocate, those that have social supports and family, and those that are connected to a local community (through stable accommodation at the least). The recommissioned service system does not service populations that are transient" – survey respondent

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Section 3: High-quality, evidence-based treatment

KEY POINTS

- **Where respondents reported concerns around quality, they were generally cautious to note that there is variability in quality and there are examples of excellent practice, as well as areas that need further work**
- **There were mixed views of the utility of the statewide screening and assessment tools with some respondents noting they had improved quality and consistency across the AOD service system, while others were concerned about variability in quality of assessments**
- **There were concerns about the application of the screening tool and the tiered model had introduced a more rigid approach to determining someone's eligibility for AOD treatment and there needed to be greater emphasis on clinical judgement as a key factor in decision making**

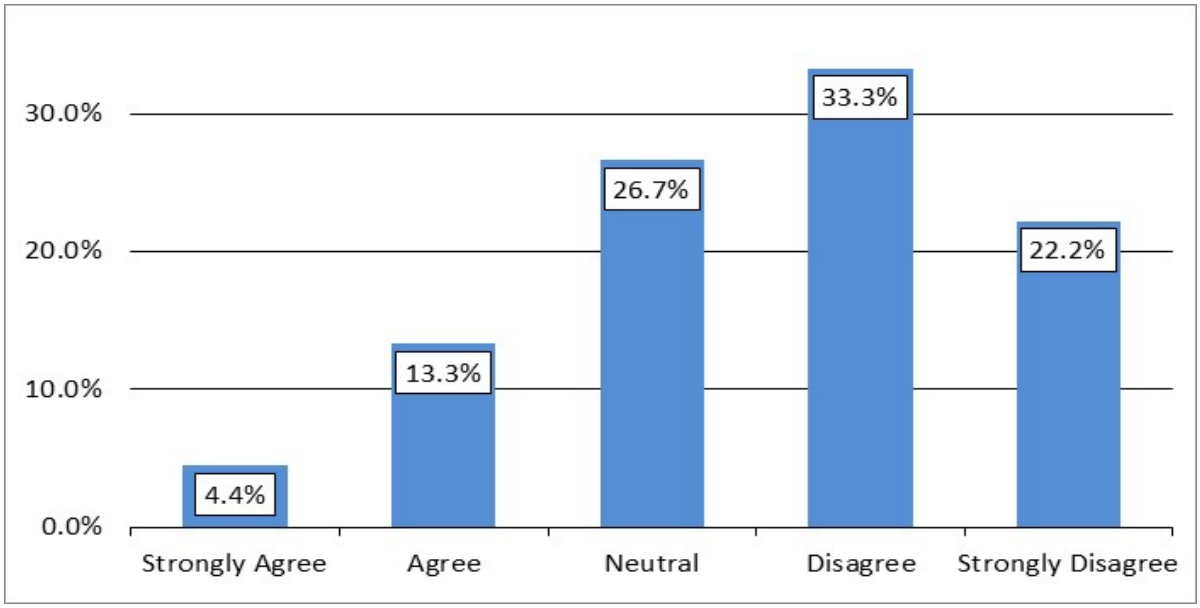
One of the features of a redeveloped system, according to the DHHS in both the *Roadmap* and *Framework* documents (DHHS 2012 & DHHS 2013) was a system that delivers high quality and evidenced based treatment and where there is consistency in quality of treatment across programs and services (DHHS 2013, p.4.). Alongside this, was the desire for service providers to meet clearly defined standards and for service design to be informed by best available evidence (DHHS 2013, p.4).

A number of respondents expressed the view that services continue to deliver high-quality treatment yet there are some serious limitations on capacity to continue work in a number of important areas such as brief interventions and family work (the specific issues in relation to responding to families have been discussed in section 2).

Where respondents reported concerns around quality, they were generally cautious to note that there is variability in quality and there are examples of excellent practice, as well as areas that need further work.

Respondents to the survey were asked the extent to which they agree or disagree that the new AOD system is 'High quality and evidence based treatment' given this was outlined as one of the features of a redeveloped system in the *Framework* document. The findings shown in Figure 17 below.

Figure 17: Extent to which respondents felt that the recommissioned system is more "high quality and evidence based"



Around 18% (n=8) of respondents to this question either agreed or strongly agreed that the recommissioned service system is achieving the goal of being high quality and evidence-based. Some felt quality continues to be delivered across their region and may have improved:

> *"High quality evidence based work delivered by a multidisciplinary team eager to professionally develop. The reporting system assists us with future planning. A team keen to innovate and respond to client and catchment need"* – survey respondent

However, over half of respondents to this question (55.5%, n=25), felt there was room for improvement in providing high quality and evidence-based services.

When considering the qualitative feedback in relation to quality, there was concern that the screening tool, and to a lesser extent, assessments were identified as areas requiring improvement. It is important to note that these two areas may have received such attention because they are the more visible components of service delivery at the present time.

> *"Assessment and Demand Management Tools are problematic and used variously across the sector with quality variance high"* – survey respondent

It appears to be more difficult for respondents to possess a global view of the quality of counselling or Care & Recovery given the system has only been in operation for a limited period. Monitoring of system performance and consideration of applying an outcomes framework may be useful tools to determine how various treatment modalities are meeting the identified objectives of funding models. A small number of respondents supported this by highlighting their desire to see the release of a performance management framework.

Adding to this, the survey itself had a number of questions focused on the new Intake & Assessment model which provided opportunity for respondents to note areas of improvement as well as areas that are working well.

A significant proportion of respondents were neutral with some suggesting it is difficult to answer questions about impact and meeting overall objectives and goals, at such an early stage:

> *"Too broad to answer overall. There are examples of good and bad practice, and it does have the potential to make services more accessible"* – survey respondent

Others saw potential in the new system, although offered the caveat that clinical guidelines and clear benchmarking is needed:

> *"While we see that the reform process has the potential to meet the reform agenda, it certainly needs 'tweaking'! In particular, we believe there is inadequate benchmarking, especially against clinical practice. Stronger guidelines need to be developed in this area"* – survey respondent

The introduction of statewide screening and assessment tools

The introduction of a statewide screening and assessment tool was designed to improve consistency across the AOD treatment system in how people are assessed for AOD related concerns.

There were mixed views on the utility and quality of the tools and a small number of respondents felt they had improved quality and consistency in their region:

> *"The quality of assessments, formulations and treatment plans has increased significantly with senior staff being employed as assessment clinicians. The implementation of the screening tool has provided opportunities for PD among non-AOD service providers. The new model means that people with acute issues get a much quicker service"* – survey respondent

A larger number felt there was potential for improving both consistency and quality of assessments through the introduction of a statewide assessment tool.

> *"Standardised assessment tool across state aspirational in telling story once and getting access to various services eg withdrawal, rehab, counselling etc. This is not however working as intended but has potential to"* – survey respondent

> *"More consistent assessments which have the potential to assess for and refer to the full range of services. Ability to share assessments more easily"* – survey respondent

Yet there were numerous respondents who indicated there exists variability in the quality and consistency of assessments and treatment planning:

> *"Assessments are of varying quality and quality of communication between services and I&A varies across the board. Care plans vary in quality (and sometimes are not developed by I&A)"* – survey respondent

> *"Quality of assessments is generally poor. Inappropriate referrals received by resi services i.e. suitability inadequately considered .eg. medical contraindication"* – survey respondent

Some Intake & Assessment providers highlighted the challenges in using the Optional Modules[5] as part of the comprehensive assessment

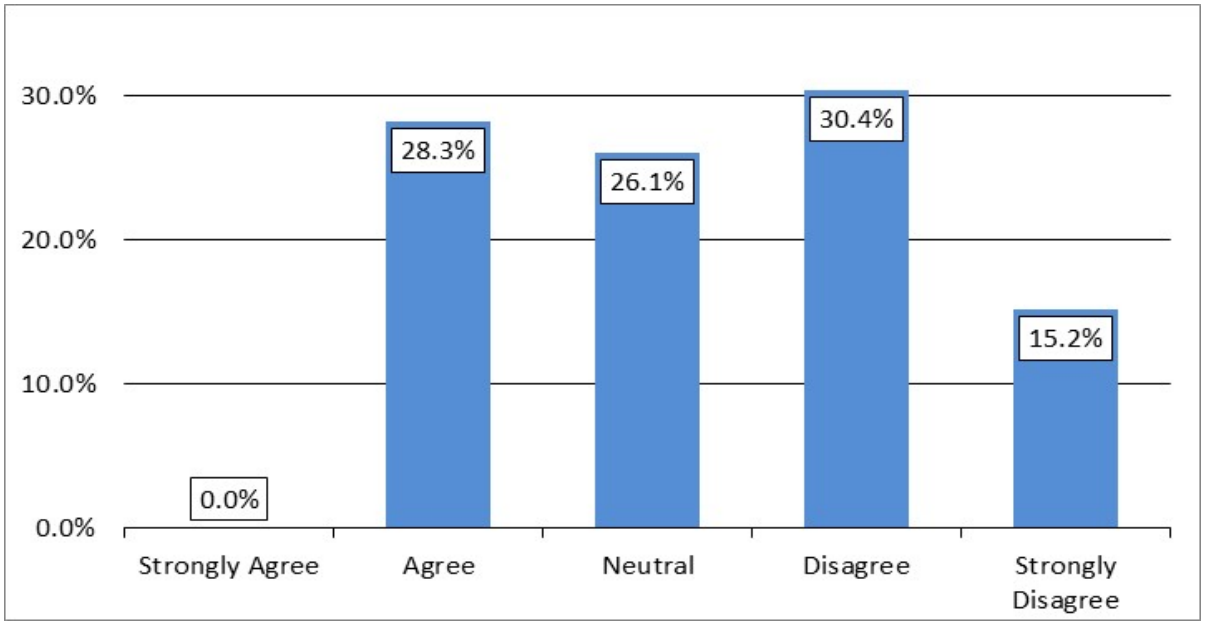
> *"Nobody appears to be using the additional modules of the assessment tool because the 3.5 hours allocated to assessment is grossly inadequate to complete the basic assessment"* – survey respondent

The screening tool itself received a great deal of attention from respondents. The survey included a specific question on the challenges of its introduction yet it received considerable mention across a broad range of survey questions.

When asked the extent to which respondents agreed that the 'common AOD screening tool is a useful tool to assist in determining whether someone is eligible for comprehensive AOD assessment' there was a divergence of opinions. As shown in Figure 18, roughly equal numbers of respondent agreed and disagreed with the statement. Only marginally fewer reported feeling neutral about the statement.

[5] The Comprehensive AOD Assessment for Adults contains 11 Optional Modules. These can be found at: http://www.health.vic.gov.au/aod/pubs/

Figure 18: Extent to which respondents agreed with the statement "the common AOD screening tool is a useful tool to assist in determining whether someone is eligible for comprehensive AOD assessment"



There was concern that the screening tool, while having an evidence-base itself, was being utilised and applied in a manner that was not consistent with the original purpose of its design. Key concerns around 'quality' of the screening tool focused on its application. They included concern that it may be resulting in some people in need of AOD treatment being screened as ineligible and being diverted away from the AOD treatment system. This includes those that may not have used substances recently but who are at risk of relapse. There was specific concern with the tool being applied too rigidly, rather than utilising it as a mechanism to support informed clinical judgement.

While much criticism was leveled at the screening tool and the way in which it had been applied, this criticism was not exclusive to those services outside of the Central Intake & Assessment Providers. Central Intake & Assessment Providers also acknowledged the constraints of the tool and the tiered model:

> *"Introduction of the screening tool is a major barrier for some clients"* – survey respondent

It was seen as a barrier to access for many clients groups, and in some instances, respondents felt that the most vulnerable clients were disadvantaged by the rigid adherence to the screening process.

> *"Use of screening tool when assessment is already clearly indicated. This needs to be reviewed"* – survey respondent

> *"The AUDIT and DUDIT are designed as screening tools only and should not be used to decide whether or not a client requires a comprehensive assessment - The tool does not identify many different types of complexity (e.g. pregnancy, intellectual disability, ABI, etc)"* – survey respondent

There was a strong view among respondents that clinical decision making is crucial to a high-quality AOD intervention and that the screening tool has done little to enhance this. In fact it appears that in some instances it has actually hindered and reduced clinical decision making:

> *"The Tier tool does not assist clinical decision making and has introduced a rigidity into the system"* – survey respondent

VAADA notes the DHHS Catchment Based Intake and Assessment Guide was released in April 2015. It states: "The tiers provide a standardised way of understanding which client groups may require further assessment for face to face treatment and which groups are suitable for lower intensity telephone and online supports. ***Clinical judgement is a critical factor in allocating a person's tier*****"** (emphasis added). In the absence of these formal guidelines for the first 7 months of the new AOD system, it appears there were instances where clinical judgement was not a 'critical factor' in determining a person's tier, or at least there was confusion among those using the tool about the extent to which clinical judgement about need could override the tool itself.

A small number of respondents noted that the introduction of a Centralised Intake & Assessment model lacked a clear evidence base and was introduced without sufficient consultation in its development or and without a trial prior to statewide implementation.

> *"In time I think the sector will be high quality and evidence based, however this could have occurred without the reform also. I think that the reform was implemented before the foundations were laid, and if more time was taken in preparing the primary health service e.g. providing training on brief interventions, education about substances and their effects etc., then the tier system could work better. More time taken to review evaluations on how catchment based intake and assessment services were operating in areas outside AOD and Mental Health to see if this would be the best fit for AOD clients"* – survey respondent

It was also noted that some new Intake & Assessment providers had insufficient time to be appropriately oriented to the local area and that this was impacting on the quality of treatment planning and matching of clients to appropriate treatment and support:

"The operators [of Intake & Assessment] are often unaware of the geography / service system that operates in each community. The response of operators has been at times (inappropriate) - ie refusal to take referrals from a GP as 'we don't take referrals from professionals' - another who advised that they didn't know much about the AoD sector as previously" – survey respondent

"Some I&A services do not seem to have a coherent understanding of services across catchment areas (we need to work on this in a number of areas but in other cases communication seems to have been in vane). Sometimes treatment types have been poorly matched to clients" – survey respondent

A number of respondents remarked on what they felt was a flawed and rushed implementation process, contributing to unintended reductions in quality of service provision:

"Implementation processes … were very poor with no appropriate data collection or referral processes in place when the new system began. Unintended consequences, including issues of safety and quality, adequate assessment, lack of support for people needing to access out of region services and supported accommodation have not been addressed. Implementation proceeded by workarounds, and only because of the goodwill of local agencies and staff who found ways to still work with clients in spite of the system, and because of their commitment to clients" – survey respondent

Section 4: A responsive and sustainable system

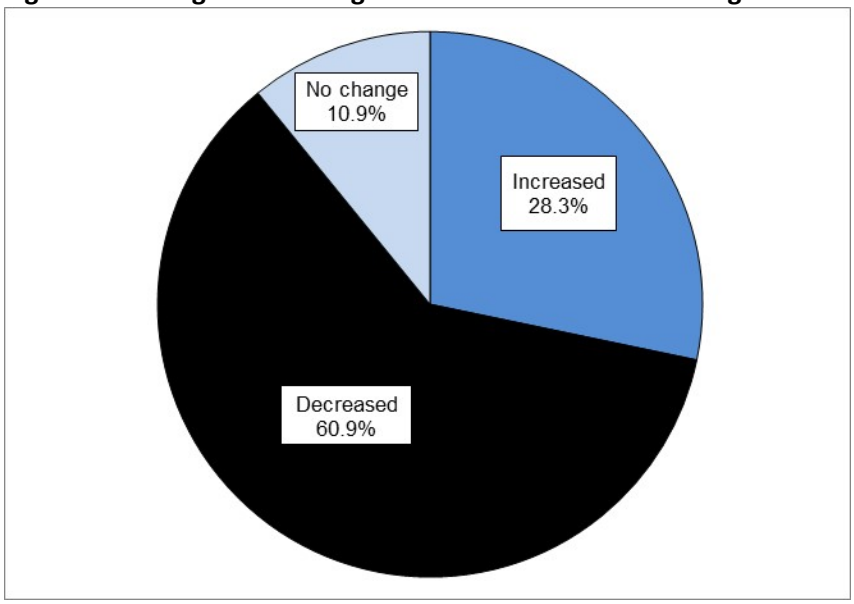
Key points

- **Over half of survey respondents reported a decrease in funding as a result of recommissioning**
- **Reductions in funding appeared to be connected to reductions in AOD services delivered and reduced numbers of employed staff**
- **The product pricing for many treatment types is viewed as inadequate, but particularly for Care & Recovery Coordination & Complex Counselling**

This section considers a number of issues related to funding and the new activity based product pricing, in recognition that a sustainable system requires adequate resourcing. Issues related to responsiveness, in particular around diversity have been covered in Section 2 of this Report.

Respondents were asked about changes to funding as a result of recommissioning. Results are shown below in Figure 19.

Figure 19: Changes to funding as a result of recommissioning



Around 61% of respondents (n=28) reported they have experienced a decrease in overall funding as a result of recommissioning as shown above. Whereas just under 30% (28.3% n=13) reported an increase in funding resultant from recommissioning.

The commentary provided by respondents in relation to changes to funding, included issues such as:

- Reductions in funding connected to reductions in FTE staffing
- Significant changes to funding across catchments for some involved in multiple consortia
- Funding uncertainty and reliance on other sources of funding to ensure comprehensive services are delivered

Participants were also asked their view on the adequacy of the product pricing for the new treatment types. There was variability in responses, but the findings suggest there is a need to investigate the appropriateness of the product pricing across treatment types and to monitor this over time with adjustments as required. In particular the pricing for Care & Recovery Coordination was seen by respondents as inadequate to deliver a holistic service to the most complex AOD clients.

The following graphs outline respondents' views on the adequacy of product pricing across different treatment types.

Figure 20: Respondent views on the adequacy of product pricing across Intake and Assessment treatment types

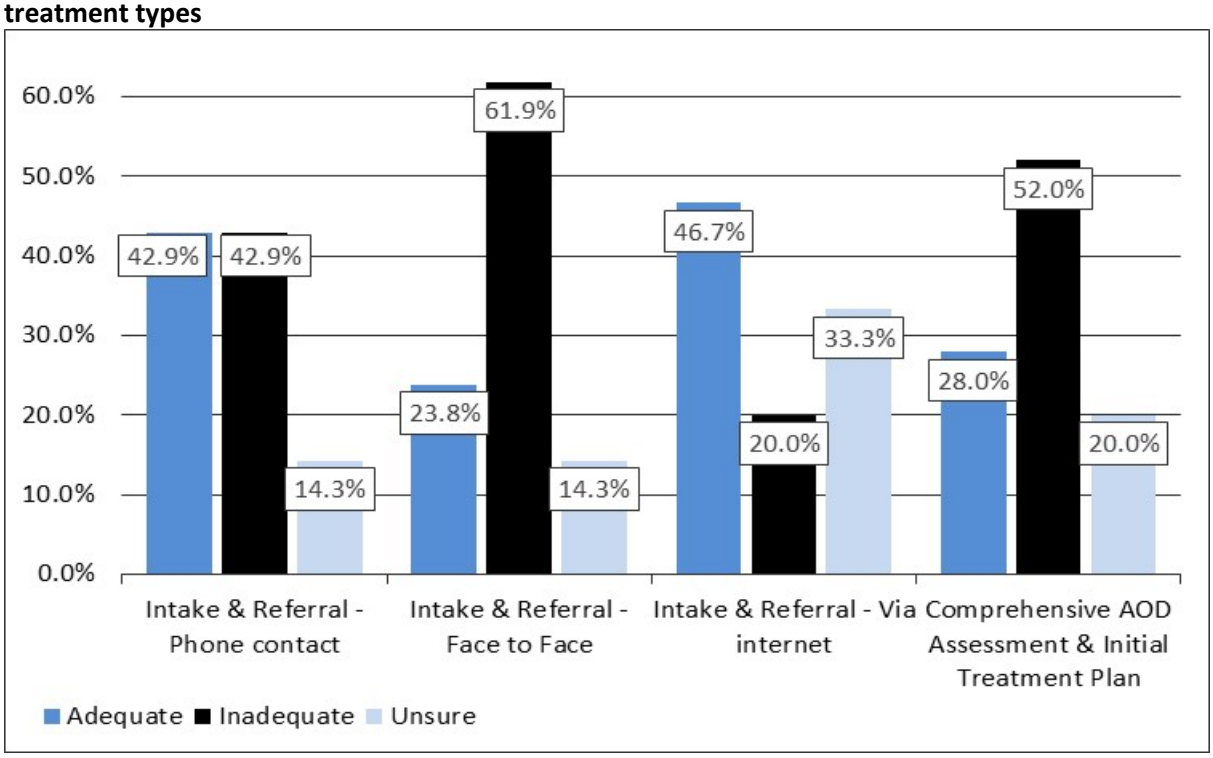


Figure 20 above compares views on the adequacy of the three available means of undertaking Intake & Referral, as well as views on the adequacy of a Comprehensive AOD Assessment. It shows that over 60% of respondents (n=13) believe Intake & Referral when completed face to face is inadequately funded as an activity. In contrast, only 23.8% (n= 7) felt it was adequately funded.

Interestingly, equal numbers of respondents felt that phone based Intake & Referral was adequately funded, as compared to those who think it is not. Some Catchment Based Intake & Assessment providers who responded to the survey observed that the screening process can take up to 40minutes to complete whereas the funding is allocated on a much shorter period of activity.

Almost half of respondents who commented on the adequacy of internet based Intake & Referral felt this was adequate (46.7% n=7) while 33.3% (n=5) felt unsure of its adequacy and some 20% (n=3) felt it was inadequate. It is important to note relatively small numbers of respondents answered these questions.

In considering the adequacy of product pricing for a Comprehensive AOD Assessment and Initial Treatment Plan, just over half of respondents' felt it was not adequately priced for the activity undertaken (52% n=13).

Figure 21: Respondent views on adequacy of product pricing for Care and Recovery Coordination and Counselling services

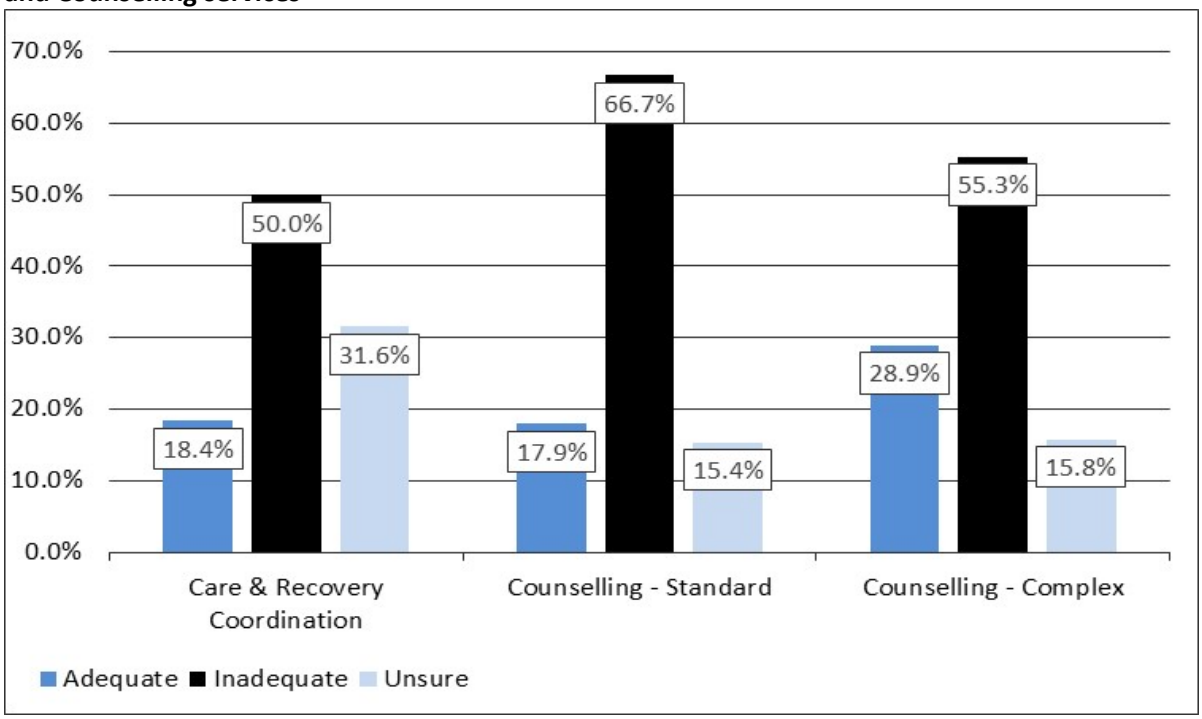


Figure 21 above highlights respondent views on the adequacy of Care & Recovery Coordination and Counselling (both standard and complex). It illustrates that in each instance, over half of respondents felt that product pricing was inadequate.

Over 65% (n=26) of respondents to the question felt that the product pricing for Standard Counselling was inadequate while some 55.3% (n=21) of respondents felt product pricing for Complex Counselling was also insufficient.

A small number of respondents provided further qualitative commentary on the pricing for Care & Recovery suggesting that the potential of the Care & Recovery treatment type is hindered by financial constraints:

> *"Care & Recovery Coordination is viewed as a service innovation however resourcing is meagre and Care & Recovery Coordination responses are therefore limited by funding limitations"* – survey respondent

Figure 22: Respondents view on the adequacy of product pricing for withdrawal (non-residential and residential) and residential rehabilitation services

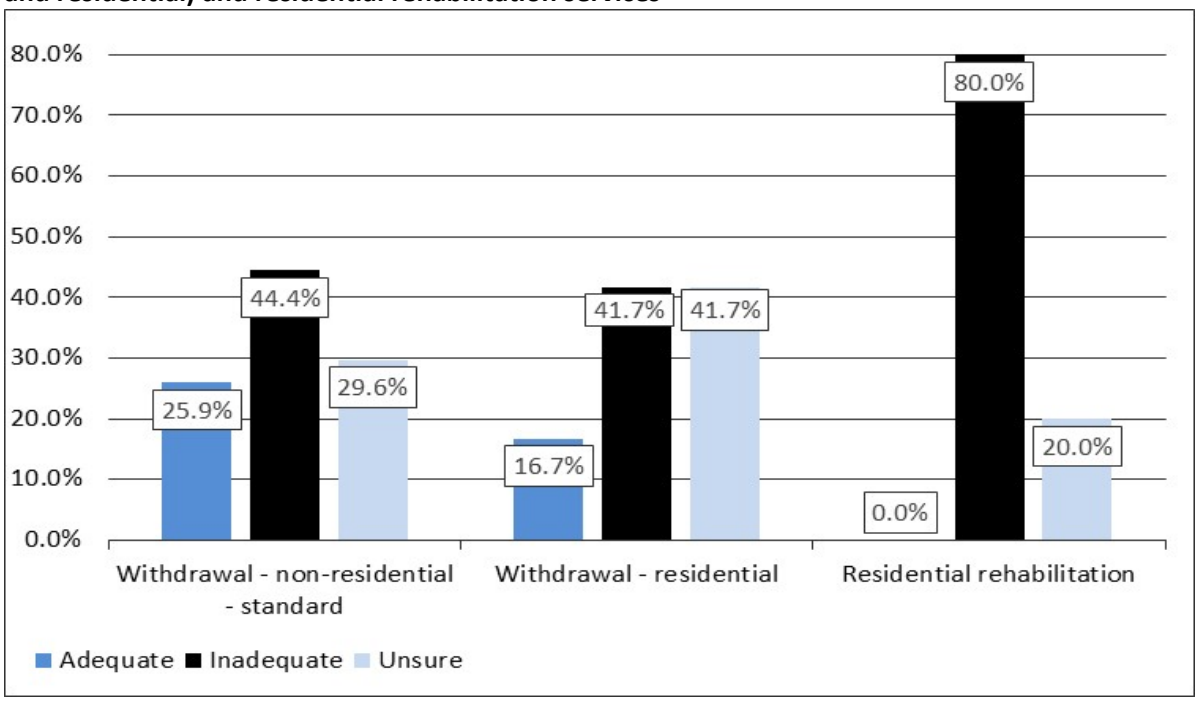


Figure 22 above shows respondents' views on the adequacy of product pricing for withdrawal and residential rehabilitation services. It is important to note that residential services (both withdrawal and rehabilitation) are 'out-of-scope' services, that is, they were not part of the recommissioning. It shows that of the small number of respondents to the question of whether residential rehabilitation had an adequate product pricing, around 80% (n=8) felt this was not the case.

Whereas equal numbers of respondents were unsure or felt residential withdrawal services were inadequately priced (41.7% n=5) and nearly 45% of respondents to the question of whether non-residential withdrawal was adequately priced felt it was not (n=12). Around one quarter of respondents (n=7) to that same question however, felt product pricing for non-residential withdrawal services was adequate.

A number of respondents argued for a review of the adequacy of the DTAU and alongside this, recommended a flexible funding unit be introduced to allow for adequate payment for a range of interventions currently being delivered. This includes activities such as brief interventions; wait-list support; family support and interventions and development of written reports such as court reports.

The significant administrative burden associated with recommissioning alongside the view that there are a range of activities that are not accounted for with the DTAU allocations, became apparent:

> *"The price may be adequate, however it does not take account of the significant administrative burden in the new arrangements. In addition there is an inadequate quantum of DTAUs allocated. There is no allowance or remuneration for many essential activities, for example, work in engaging referred clients. Also the work required to support clients to access out of region residential services is completely unfunded"* – survey respondent

The relationship between numbers of referrals and meeting targets was also highlighted:

> *"There are set costs for delivery of a service however the AOD reform is activity based and if there are not an appropriate number of referrals [the] service delivery cost may not be met. This is a great concern for agencies, staff and community. Rural isolation impacts on staff recruitment and retention [and] is a further concern"* – survey respondent

VAADA provided respondents with the opportunity to contribute additional feedback on the adequacy of the DTAU, including any comment in relation to the loading for forensic and Aboriginal clients. A significant proportion of respondents chose to provide feedback. They highlighted issues related to the forensic loading, rural concerns and general concerns related to the administrative burden associated with new funding arrangements as well as the limited flexibility in funding.

There was some confusion among respondents about the 20 per cent forensic allocation[6] including when and how agencies can commence delivery of fee-for-service activity. The cessation of payments for Did-Not-Attends for forensic clients was raised as well. Additionally, some respondents noted that there are a number of activities for which agencies are not paid when working with forensic clients. These include: non-attendance of clients, court reports and general time spent communicating and liaising with Department of Justice. With regard to forensic clients and part-payments if a client does not meet the required number of hours or contacts, one respondent noted:

> *"I feel the work product is not necessarily being measured appropriately via the DTAU pricing and does not take into account the skill and experience of the clinician that is applied to meet the client outcomes"* – survey respondent

Some respondents felt quite strongly that a rural loading was needed which takes into account costs associated with traveling long distances to provide outreach, even in cases where the client may not attend or attends appointments on an intermittent basis.

> *"In our regional service, no provision is considered for the expense to provide much needed (in some areas) outreach for counselling, Care & Recovery and non-residential withdrawal"* – survey respondent

[6] The forensic allocation for Intake & Assessment is 10% and for AOD treatment is 20%.

Section 5: Integrated services & earlier intervention

Key Points

- **Effective referral pathways exist in some catchments and some agencies report recommissioning has improved referral pathways and relationships between agencies at a local level**
- **However other respondents reported serious impacts on pre-existing referral pathways and collaborative linkages and working relationships between services**
- **There are challenges with the provision of integrated and coordinated care in the recommissioned system**
- **There appear to be reduced opportunities for the provision of early and brief interventions**

Integration

Respondents to this survey made numerous comments in relation to the extent they felt the recommissioned service system had enhanced integration both between AOD service providers and across AOD and related health and community service systems.

Some respondents felt that the new system had created fragmentation rather than supporting integration and coordinated care. It was noted that having a different clinician provide services at intake, then assessment and then again in the treatment response can reduce continuity of care:

> *"There is no connection between the initial responder and the clinician providing the ongoing treatment"* – survey respondent

A key theme to emerge from respondents was that the separation of the intake & assessment function from the broader treatment system has reduced continuity of care and created challenges for the delivery of integrated and coordinated AOD treatment. It was seen as creating fragmentation within the AOD system. Some viewed the process as an additional layer or an 'overlay', rather than an integrated component of service delivery.

> *"There is not a seamless service experience for our shared clients due to multiple and confusing processes"* – survey respondent

> *"The fragmentation of Intake and Assessment is restrictive to referral pathways, and the Central Intake agency has not prioritised understanding the local context and service system or challenges for a rural environment. We also need to continually help other service providers to get AOD outcomes for their clients who are not able to access the system"* – survey respondent

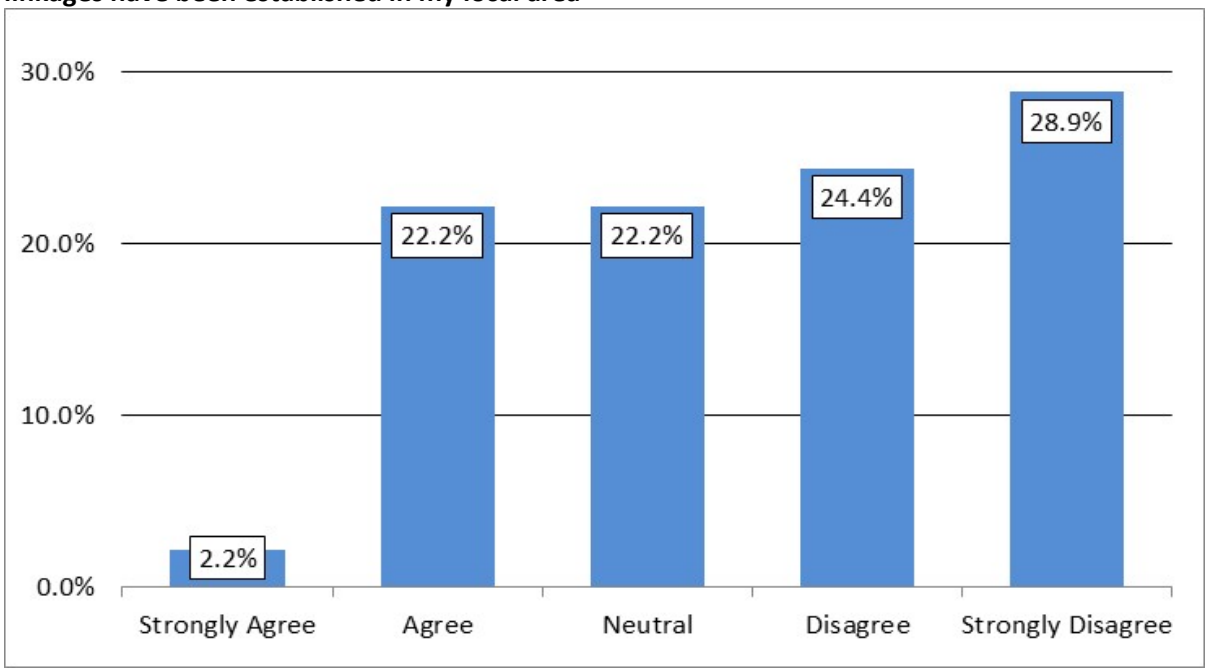
Some pointed to challenges with communication between agencies and fractured relationships within consortia:

"Pre-reform there already existed strong integration of services. Reform has not assisted these existing relationships but rather frustrated other agencies. Informal relationships between services is a powerful tool for person centred care" – survey respondent

"Lack of communication from I&A agency with AOD agencies outside its consortium" – survey respondent

"The sector is crying out for improved communication between agencies, consortia and the Department - there was a great deal of damage caused by the recommissioning, and it will take a great deal of time and trust to repair. Agency relationships were damaged and more importantly, we appear to have experienced a sector-wide 'therapeutic rupture' with our clients" – survey respondent

Figure 23: Extent to which respondents agree or disagree that "effective referral pathways and linkages have been established in my local area"



In relation to whether effective referral pathways had been established in the local area, responses were varied as shown in Figure 23 above.

Some respondents indicated improved relationships and referrals pathways, with a number of others identifying the establishment of good relationships within consortia as a benefit of the recommissioning process. Some noted they have developed stronger partnerships, although there was also some suggestion that partnerships and 'working better together' was required to overcome some of the challenges posed by the new system design and to try and ensure clients continue to have access to appropriate AOD treatment.

"We have significantly positive relationships in this catchment between treatment providers so the distribution of referrals from assessment is equitable and monitored through monthly meetings" – survey respondent

The same respondent noted:

"There is a great deal of activity occurring to bed down the reform and address issues as they present. We have broad multi-sectoral contribution to … working groups and had some additional resources to undertake activity to address some of the early challenges such as referral pathways, consumer access, capacity building in primary and allied health etc. Without this resourcing I imagine it would be extremely challenging to try and bed down the reformed service system whilst managing relationships and referral pathways" – survey respondent

Another provider commented on improved linkages:

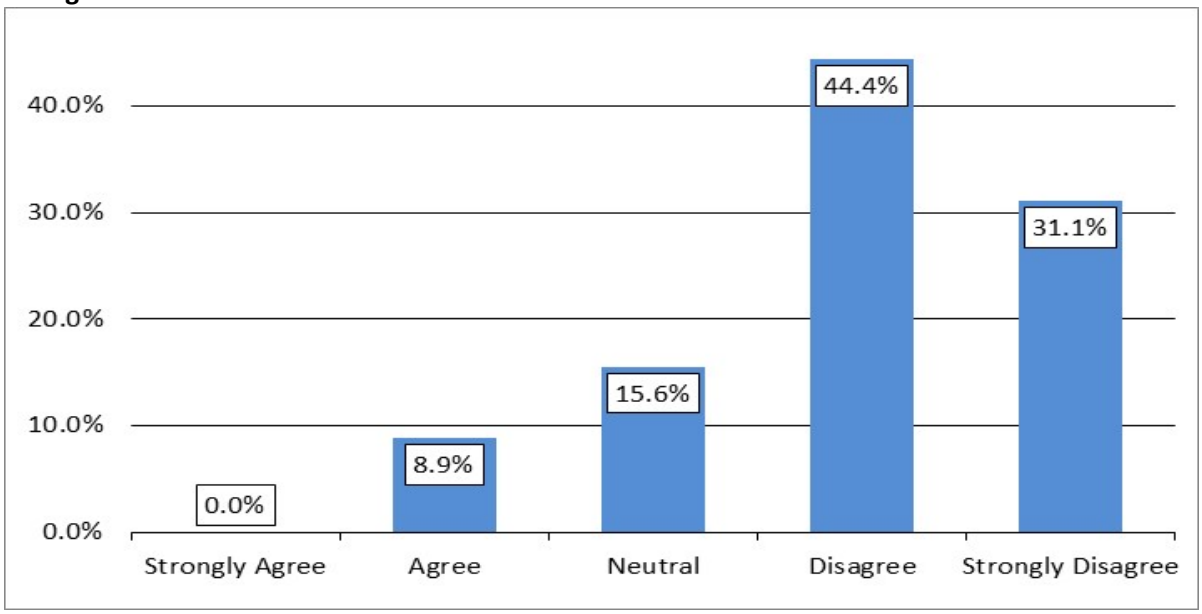
"We have been able to strengthen links with other consortium members that were tenuous at best prior to [recommissioning]. We have been able to enjoy mentoring within the AOD services…and from a governance perspective, I feel that this has been a valuable learning experience with good outcomes to date" – survey respondent

A small number of responses also stated that the recommissioning process had given them the opportunity to re-align their services and better match service delivery to the needs of clients:

"Shaken up the system and opportunity to look at other ways of working in the system" – survey respondent

In relation to how the recommissioned system is integrated with other health and human services, Figure 24 shows the majority of respondents felt this was not occurring at the present time.

Figure 24: Extent to which participants agree or disagree that the new AOD system is more "Integrated with other health and human services"



A significant proportion of respondents (75.5% n=34) either disagreed or strongly disagreed that the new service system is more integrated with other health and human services, as shown in Figure 24.

Some respondents provided additional feedback about the extent to which they felt the new AOD system was integrated with other health and human services. Some of the themes in relation to the issue of integration included comments that the system is now more fragmented than before and that reform has undermined some pre-existing strong relationships and integration between services at a local level.

One respondent referred to the progress made in responding to dual diagnosis in the last decade and felt that had been lost to some extent through fragmentation, loss of experienced staff and division and hostility across the sector.

Another pointed to new challenges with referral pathways as both systems have been recommissioned:

> *"AOD services formerly did the comorbid work as part of normal business. Referral pathways between AOD and MH services are now more tricky as both systems have centralised intake. Informal referral pathways no longer operate"* – survey respondent

Early intervention

Respondents felt strongly that opportunities to provide early intervention had been reduced by recommissioning. The view that there is reduced capacity to provide early intervention has been highlighted throughout this report.

There was an expressed view that early intervention appears to have been forgotten in the recommissioning process:

"Leaving out prevention and early intervention which would help plan for pending trends, hot spots and supporting people before they become complex" – survey respondent

Another respondent noted that the new arrangements are not meeting the demand for early intervention:

"Numbers are improving but the early intervention demand is not met and thus this leads to relapse and chaos" – survey respondent

Providing early intervention to individuals, as well as broader community engagement was now more of a challenge:

"A significant challenge in this catchment (and I imagine others) is the limited capacity for early intervention programs and projects. With the re-commissioning agencies cannot afford to work in this space or the space of community development and in this catchment we do not have a great deal of services able to do this work" – survey respondent

"Simply put, evidence tells us early intervention and prevention are the essential characteristics for avoiding the greater harm from substance use, yet there is no room for this in the Intake and Assessment criteria" – survey respondent

Section 6: A capable and high quality workforce

Key points

- **The retention and recruitment of highly skilled and experienced staff has been challenging – this was particularly evident with rural and regional agencies**
- **A large portion noted uncertainty regarding job security following the recommissioning**
- **Some respondents indicated that there were new roles for senior staff brought about by recommissioning**

Figure 25 below illustrates the proportion of agencies that have lost staff or redeployed staff since recommissioning (69.2% n=27)

Figure 25: The overall impact of recommissioning on AOD staffing

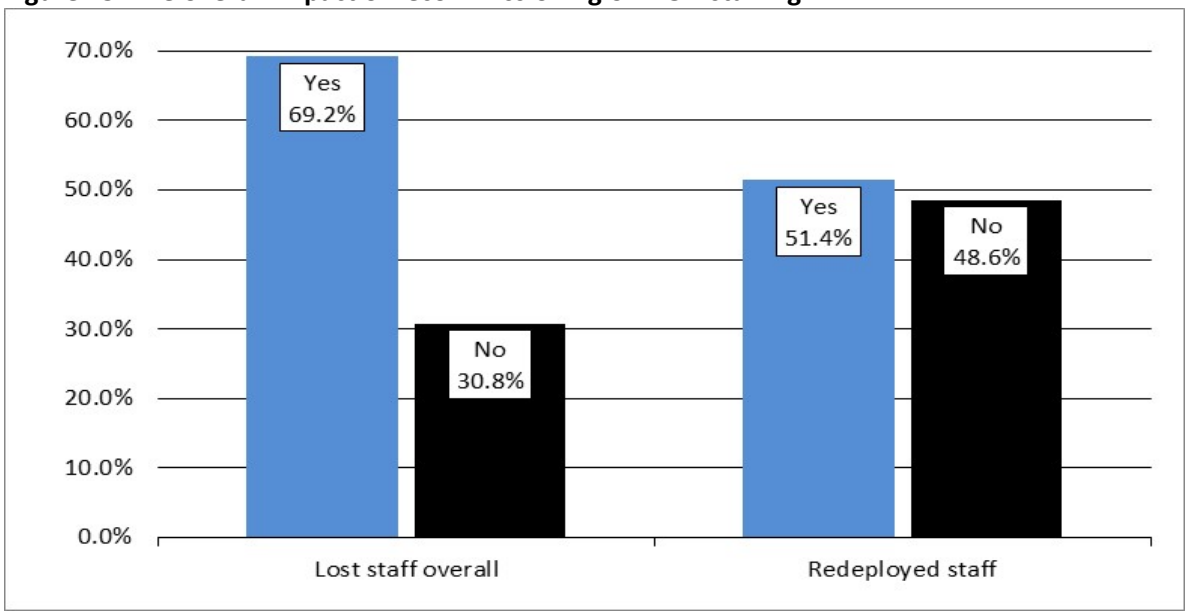
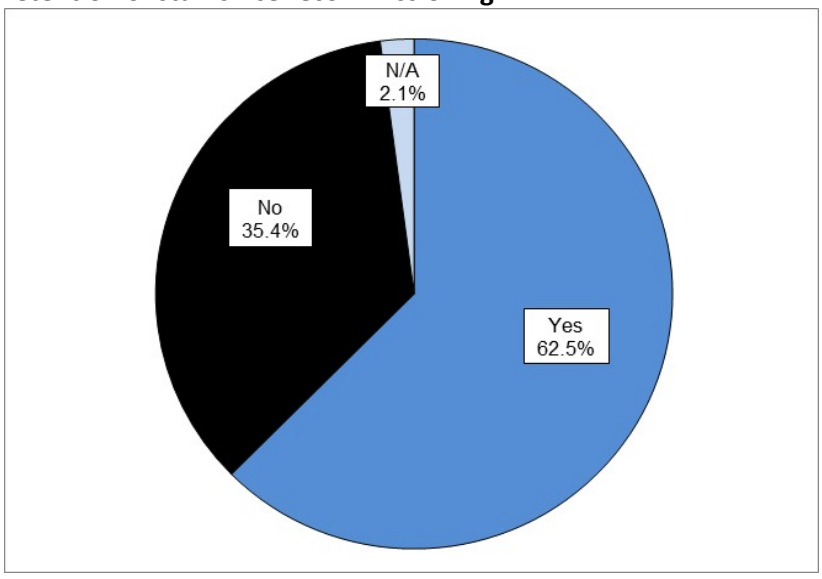


Figure 26: Percentage of respondents who have experienced challenges with recruitment and retention of staff since recommissioning



As shown in Figure 26, over 60% of respondents reported they have experienced challenges with the recruitment and retention of staff since recommissioning.

Some respondents identified the uncertainty with the reform process as having impacted on retention. Many went on to state that staff sought alternate employment which was perceived as more secure.

"The uncertainty of the AOD reform process resulted in several staff leaving to find more secure employment" – survey respondent

"Several staff left prior to the commencement of the new services and it has been difficult to recruit to all positions, some still remain vacant"– survey respondent

"… exit interviews recording staff fears about possibly not having a job if the service was unsuccessful" – survey respondent

---

Uncertainty among staff was a common theme within responses to the question 'has , with many indicating that the overall change process, the availability of 12 month funding agreements and the uncertainty regarding stage two of recommissioning impacted adversely on staff morale.

For those agencies which were successful, the perceived limited duration of current contractual arrangements led to further uncertainty and impacted on morale:

"People only have job security for a 12 month period before the uncertainty sets in again" – survey respondent

Highly experienced AOD counsellors being "lost" and staff morale is "wobbly" no one is sure any more of their jobs security – survey respondent

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Some respondents also noted the significant challenges in retaining and recruiting highly skilled staff and that this exacerbated complications in transitioning to the new arrangements.

"… there appeared to have been a departure of experienced workers from the sector" – survey respondent

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Respondents highlighted the need for the recruitment of senior staff who could '*hit the ground running'* and '*work independently and often autonomously'*. This is particularly evident within rural and regional agencies, where some agencies undertook numerous recruitment activities, consuming scarce resources and at times with minimal success.

"In rural areas, it has been especially difficult to find sufficiently skilled people" – survey respondent

Numerous people highlighted how the way changes were implemented are impacting on staff morale and attitudes towards their chosen careers.

"… there has been a significant impact on current staff after the recommissioning process, moral is extremely low, concerned regarding future of drug treatment services due to lack of referrals, frustration knowing their are clients that aren't accessing treatment due to the complex treatment service or clients wanting treatment however are referred out due to the tier system" – survey respondent

"The AOD workforce… is feeling pretty bruised" – survey respondent

A number of respondents indicated that many staff were redeployed in line with the necessary changes brought about by recommissioning. This resulted in a number of staff working reduced hours and often taking on a wider range of duties.

For many agencies, this required the provision of additional training, however a number of respondents indicated that limitations in resourcing created complexities in the delivery of the necessary training to upskill staff.

"This funding model leaves almost no room for training/upskilling" – survey respondent

A smaller number of respondents highlighted the challenges in developing an expanded service. These people cited issues in recruiting senior staff to supervise the growing number of less experienced staff.

"Main challenge has been recruiting more senior staff who can mentor and supervise newer staff. Some staff have left the sector because they see themselves as counsellors and not happy to do multiple screenings and assessments. I think burn out will be an issue in the future" - survey respondent

Figure 27: Percentage of respondents who reported recommissioning had provided opportunities to staff in relation to progression and advancements

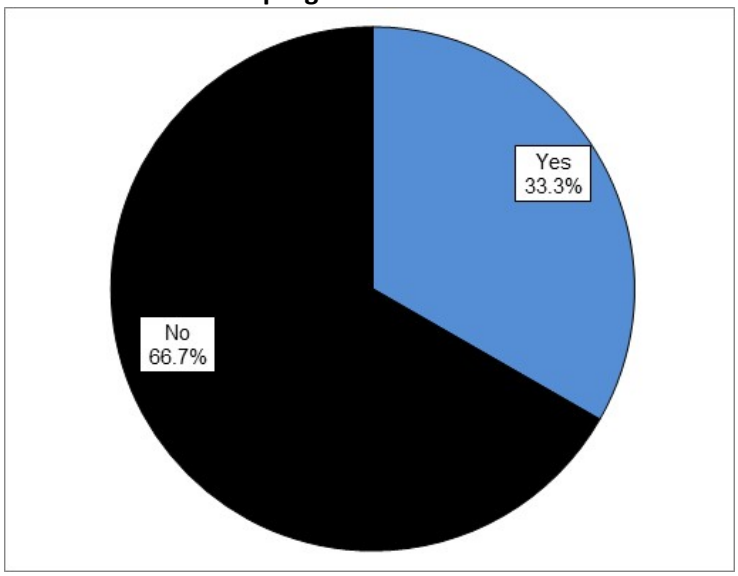

Figure 27 highlights that approximately 33% (n=16) of survey respondents indicated that recommissioning has provided opportunities for progression and advancement of staff at their agency. However 66% (n=32) could not identify opportunities for workforce progression bought about by recommissioning.

Again, respondents were asked to provide any further explanation on any opportunities afforded by recommissioning for staff progression and advancement.

"A number of staff have progressed to more senior roles" – survey respondent

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However it is interesting, considering the chart above, that the majority of respondents noted that recommissioning necessitated the development of new senior positions within some agencies. Respondents indicated that a number of senior roles were available following the recommissioning, some being newly created roles, and others becoming vacant through the departure of staff.

A small number of respondents indicated that the recommissioning had provided the impetus to employ staff based on profession rather than as generic workers. This has resulted in some senior staff progressing to higher classifications and some non-AOD qualified staff being required to undertake additional study.

These people indicated that there were increased opportunities for professional development, particularly with a greater emphasis on higher level qualifications and increased availability of clinical supervision.

Provided an opportunity to review skills and expertise against current best practice and plan for professional development – survey respondent

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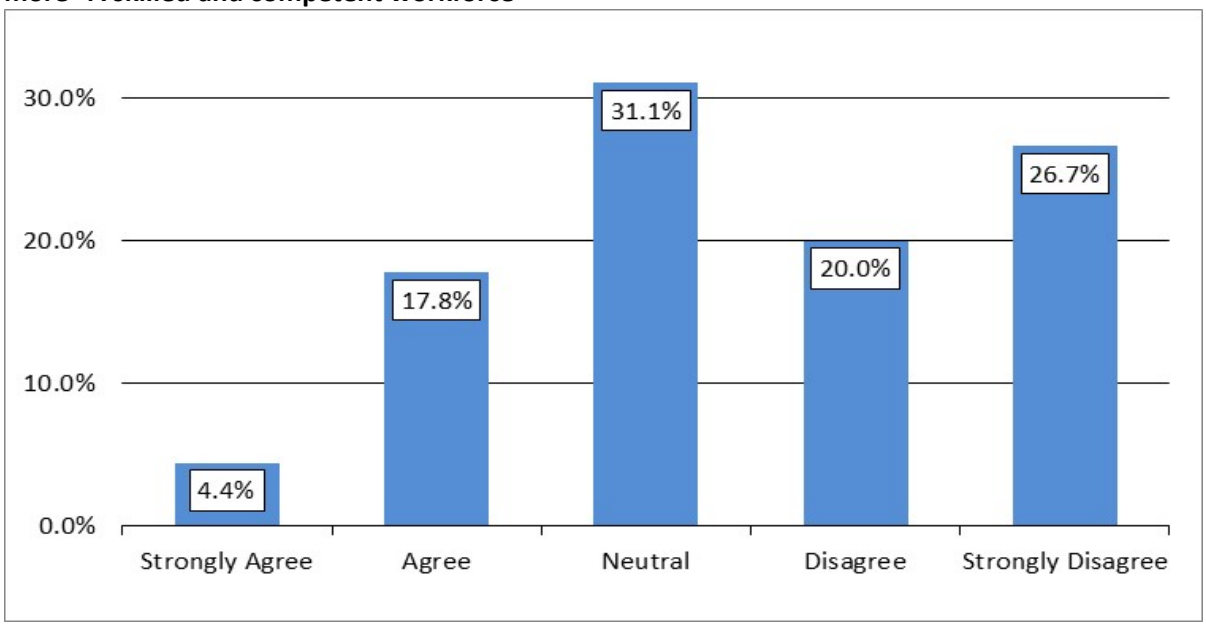
Figure 28: Extent to which respondents agree or disagree that the new AOD system features a more "A skilled and competent workforce"



Responses to the question of whether the recommissioned system features a 'skilled and competent workforce' were varied and may point to the loss of experienced staff from across AOD services through the reform process. While a substantial proportion of respondents were neutral about this statement; it also elicited some agreement from respondents with 22.2% (n=10) either agreeing or strongly agreeing that the new AOD system features a more 'a skilled and competent workforce'.

Others pointed to the gaps left behind by the departure of experienced staff and the need for mentoring of younger staff. The following quote appears to typify many of the respondents who either disagreed or strongly disagreed with the notion of a competent workforce.

> *"In relation to having a skilled and competent workforce, unfortunately there have been many experienced AOD workers leave the sector due to lack of job security, lack of funding [and being] unable to work in the new system…although new people are entering into the sector, it will take some time, support and mentoring to develop some of the expertise in AOD that has been lost as a result of the reform"* – survey respondent

Discussion

The survey, while not intended as an evaluation of the impacts of recommissioning, points to some serious challenges with both the design and operation of the recommissioned AOD service system.

An accessible system

The survey has found evidence of reduced access and additional barriers for service users and families who attempt to access AOD treatment. It also found that health and community sector professionals have experienced difficulty understanding the changes to the AOD service system and making effective referrals for their patients and clients.

VAADA believes efforts to address barriers to access must be prioritised. It is VAADA's view that, at the time of this survey's distribution, recommissioning had not resulted in a more user-friendly or accessible treatment system. Pathways into, through and out of treatment remain a challenge for many, and referral pathways both within and external to the system require significant attention.

Respondents to this survey proposed a number of solutions to the current difficulties with access. These included increasing capacity for local agencies to deliver Intake & Assessment alongside the Centralised Intake & Assessment providers; advertising and promotion of the new AOD system; and changes in the application of the screening tool to allow for a more holistic approach to intake that focuses on the person's needs, rather than their score on the limited spectrums of complexity in the current tool. VAADA acknowledges that a second version of the screening tool has been developed which considers five other life complexity factors in addition to the current three,[7] in determining a person's needs. However, at the time of writing this report, an updated version of the screening tool was not in widespread use across the state.

Importantly though, the survey also found examples where access appears to be more streamlined and service users are able to navigate the system in what looks like an effective manner.

The findings of this survey point to a clear need for examination of official data sources such as wait-times, numbers in treatment and numbers of people who have sought treatment but who have not been able to access it to help pinpoint how demand has changed in the recommissioned service system.

VAADA understands that the Department of Health & Human Services has run a snapshot of wait-times across services in March 2015 and again in early July 2015. The results of these wait-time surveys had not been released as of writing this report. This data may prove useful in providing further insight into issues of accessibility in the recommissioned AOD system.

Other official data sources that may provide further evidence of any change in accessibility across the AOD service system include the National Minimum Data Set when it is released. This study may show differences in the number of completed treatment episodes across Victoria and therefore provide indication as to the impact recent changes have had on accessibility. Issues of access and equity will be difficult to determine if we continue to be plagued by inadequate data collection systems and rely on anecdotal feedback from AOD service providers about their experiences alongside other forms of indicative data.

[7] These include factors such as whether the person care of children, pregnancy, gambling, physical health & legal issues. The current 3 complexity factors include the person's score on the K10, whether they are employed or in formal study and housing issues (homeless or in unstable housing).

Importantly too, mechanisms to seek feedback from service users themselves on access issues are critical to understanding if the recommissioned system has improved access to treatment; made no difference or created new barriers to access as this survey suggests has occurred. VAADA did not seek feedback directly from service users in this survey but understands that the Association of Participating Service Users (APSU) is undertaking a survey to seek feedback directly from consumers about their experiences of the new service system. This will provide critical insight into how the system is meeting the needs of those seeking and accessing treatment.

Person-centered, family-inclusive, recovery-orientated treatment

The survey found evidence of a worrying reduction in AOD services capacity to work appropriately and meaningfully with families. VAADA understands that many services had made progress in the delivery of family-inclusive practice in the years preceding recommissioning, yet it appears recommissioning has undone some of this important progress.

VAADA notes that many agencies continue to offer high-quality family counselling and support programs, but note that these initiatives are often supported through additional funding mechanisms. Furthermore, there is strong evidence to suggest that AOD services are undertaking interventions and providing support to family members that is not able to be adequately recorded or accounted for. It is critical that this be addressed as soon as is practicable to ensure that funded services are able to respond to local need. VAADA notes that the Department of Health & Human Services is exploring to options for the development of sub categories within existing DTAU structures which may offer some solution to this particular issue by allowing agencies to be able to capture family interventions.

VAADA also acknowledges the recent announcement of additional funding for working with families but note that these monies were directed to a number of specific agencies for particular programs.[8] VAADA believes there is a range of family support and brief interventions for family members being undertaken across the state on a daily basis that is not adequately resourced or able to be appropriately recorded on current data collection systems.

VAADA is troubled by findings which suggest the recommissioned AOD system is impersonal, inflexible and not always culturally sensitive or age appropriate. The survey found evidence that there remains confusion about the integration between in-scope and out-of-scope services, particularly in relation to young people. It is critical that young people receive an age appropriate service that is developmentally matched to their needs.

Barriers remain for Aboriginal clients and CALD communities in accessing mainstream AOD treatment services, and findings from this survey suggest the new arrangements may be exacerbating these difficulties in some areas. Evidence provided by respondents which highlighted cases of the most vulnerable and complex clients struggling to negotiate entry into the system is deeply concerning to VAADA. Immediate action is needed by DHHS to determine how these clients can be better supported within the recommissioned service system.

High quality & evidence based

VAADA believes AOD services continue to strive for excellence in the delivery of AOD treatment and are committed to working in partnership with other AOD and related services to provide high quality and evidence based treatment. Furthermore, we believe there are many AOD staff who are highly skilled and continue to deliver quality clinical interventions.

[8] This funding was announced as part of the *Ice Action Plan*. Please see www.ice.vic.gov.au for details

Yet, there is little doubt that recommissioning has brought with it some significant challenges and substantial issues that have to be overcome.

The evidence of a weakening role of clinical judgement and the prescriptive use of the screening tool and tiered complexity model throughout the early months of the recommissioned system raised a number of issues. VAADA acknowledges the release of the Catchment Based Intake & Assessment Guide that was published in April 2015, however it appears that a more timely release of such an important document may have encouraged earlier dialogue as to how the complexity tool was being implemented. This, at least in part, contributed to what was described by numerous respondents as a 'rigid' and 'inflexible' approach to screening all potential service users in the early months.

It is unclear how many potential service users were, and continue to be, diverted out of the AOD treatment system as this data has not been made publicly available. Official data sources are needed to provide insight into this issue. There is a strong view that some people requiring AOD intervention have been turned away through the new system, but data is needed to determine if this is the case. While some people may have been screened and diverted out of the system, without any study of this group of people we cannot know if they received an appropriate service response.

A responsive & sustainable system

Findings from this survey suggest that agencies have experienced changes to funding associated with recommissioning and there are concerns about the adequacy of product pricing for various treatment types, in particular for the new treatment type of Care & Recovery Coordination.

VAADA has continually communicated that a responsive and sustainable service system requires an adequate baseline of funding and as such we call for the product pricing and modelling underpinning the new arrangements to be monitored and evaluated to determine if any changes are required. A number of respondents argued for a review of the DTAU and called for flexible funding for a range of activities that are not adequately funded at the current time including brief interventions, family support and wait-list support. VAADA agrees with these views and believes that this also extends to activities related to community development, health promotion and education. These were always considered integral components to building cross sectoral capacities that are no longer able to be undertaken in many environments.

The survey also found a general need for improved communication flows between AOD services and the Department of Health and Human Services.

Integrated services & earlier intervention

Findings from this survey suggest that overall, the recommissioned system has less capacity for early intervention. There is also evidence to suggest that the degree to which effective referral pathways have been established and integrated care is available is variable. Some catchments appear to be doing well in this area, yet others are struggling with fragmented relationships and referral pathways.

The introduction of a separate assessment process appears to have made integrated care a bigger challenge than previously. VAADA continues to be troubled by the feedback that relationships between AOD services are fragmented and that there are difficulties with providing coordinated care and treatment for service users.

VAADA was particularly troubled by feedback which suggested the substantial progress made in responding to clients with coexisting AOD and mental health issues has been interrupted by the recommissioning process. This may be, at least in part, due to the recommissioning of community

mental health services during the same period. VAADA believes this requires ongoing monitoring and planning to ensure progress is not lost.

The AOD workforce

Finally, it appears the AOD workforce has experienced some substantial changes as a result of recommissioning. There was evidence in this survey of a loss of experienced staff from the sector and some challenges with staff morale, particularly in the earlier months following transition to the new arrangements.

The impacts of losing a substantial proportion of the experienced AOD workforce is worrying, though further investigation is needed to determine the extent to which significant workforce shifts have resulted from recommissioning. VAADA believes that some of these changes in workforce may be evident in the results of the next AOD workforce study planned for distribution in late 2015. This will offer greater insight into the shifts within the AOD workforce that have resulted from recommissioning.

Any significant changes to the AOD workforce composition will likely have flow-on effects to service delivery while new staff orient themselves to roles, organisational structures and policies and broader AOD system frameworks and approaches. While agencies may be adept at managing staffing changes on a smaller scale; the substantial shifts in staffing that appear to have resulted from recommissioning may pose unique and largely unprecedented challenges for agencies in relation to supporting new staff to develop knowledge, clinical skill and experience while also managing a broader change process.

Next steps for VAADA

VAADA notes the Minister has commissioned a review of the new arrangements for the delivery of Mental Health Community Support and Alcohol and Drug Treatment services. The aim of this review is to “examine outstanding issues with the current measures and potential opportunities to address these”. The review is being undertaken by Aspex Consulting with stakeholder forums to be held with service providers from both AOD and community mental health sectors, as well as consumers and family members.

VAADA is currently planning a statewide *Regional Voices* project to build on the findings of this survey and, more importantly, to provide opportunity for AOD service providers to come together within local catchments and determine solutions to locally identified needs. This, along with future surveys and consultations seeking to monitor system functioning from the service provider perspective, are considered integral aspects to ensuring that government is held to account for decisions made that have the potential to impact on a much marginalized group of individuals, their families and the broader communities in which they reside.

Appendices

Appendix 1: Demographics of respondents

Participating AOD agencies were asked to provide some basic background information on their agency including the geographic locations in which they operate, whether they operate in a consortium or within multiple consortia and the AOD treatment services they currently provide.

Figure 29: Percentage of participating AOD agencies in consortium arrangements

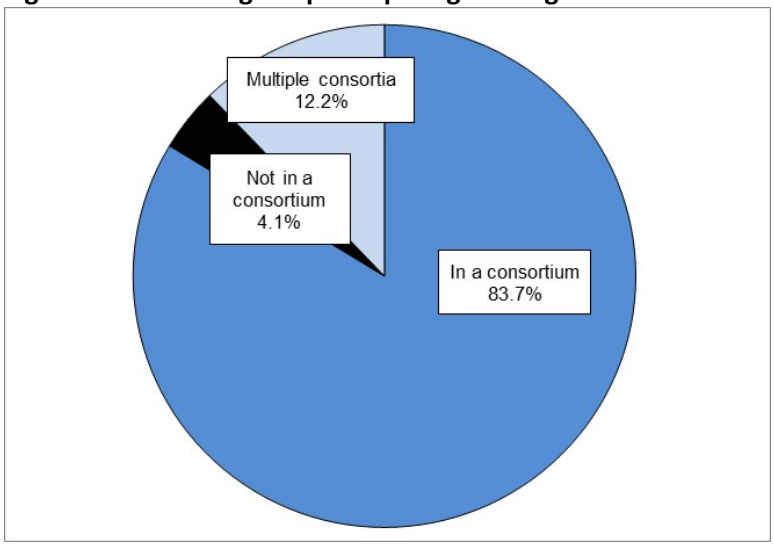


Figure 29 shows the majority of participating AOD agencies identified as consortium members (95.9% n=47) while 4.1% (n=2) of participating agencies indicated they operated outside of consortia arrangements

Figure 30 shows 61.2% of participating AOD agencies (n=30) were general consortia members or stand-alone agencies while nearly 39% (n=19) indicated they were a lead agency.

Figure 30: Percentage of participating AOD agencies that are a lead agency

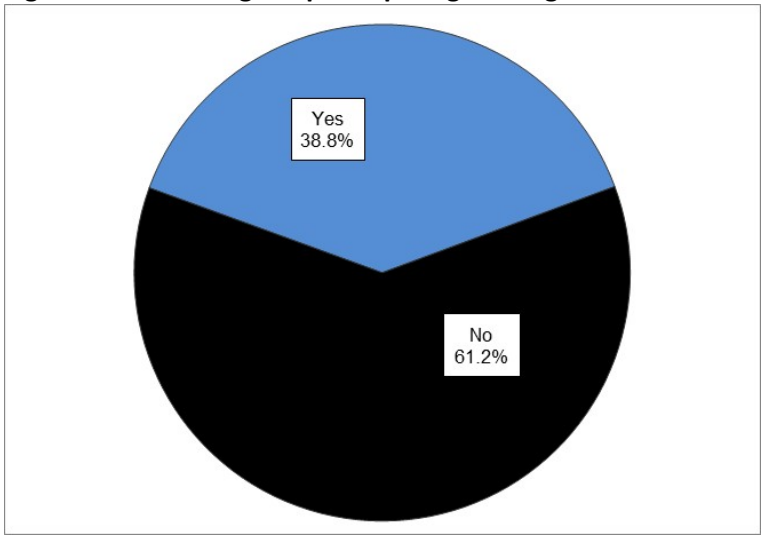


Figure 31: DHHS Regions from which participating AOD agencies operate

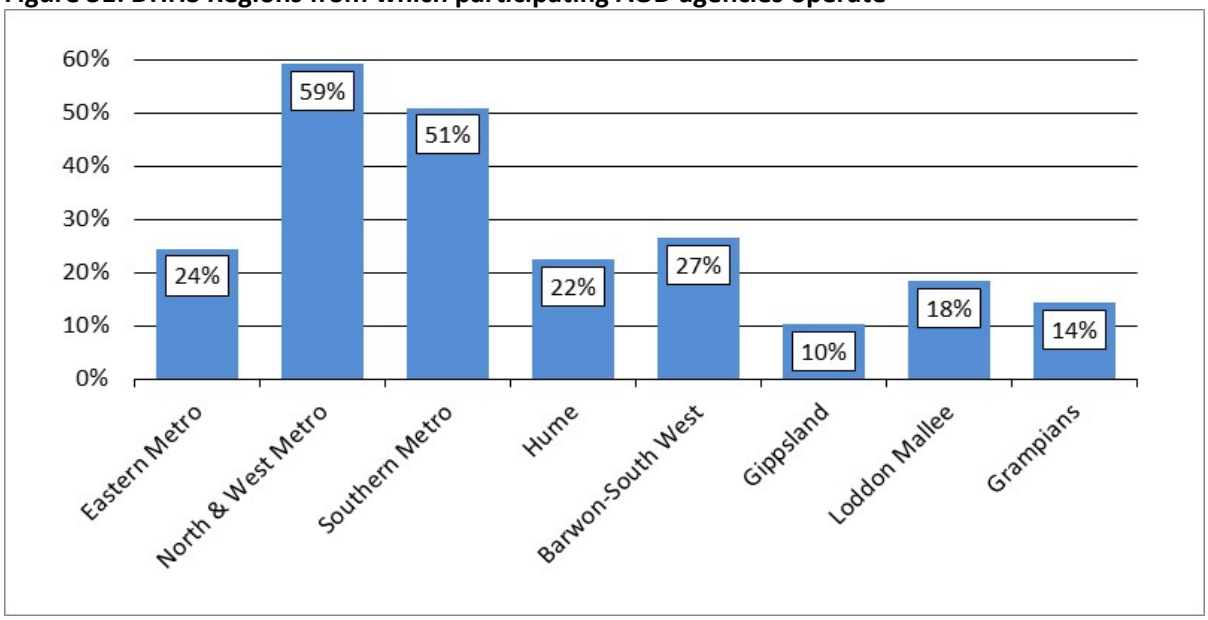


Figure 31 shows participating AOD agencies represented a mix of metropolitan and regional services and areas

Figure 32: Alcohol and Other Drug (AOD) service provided

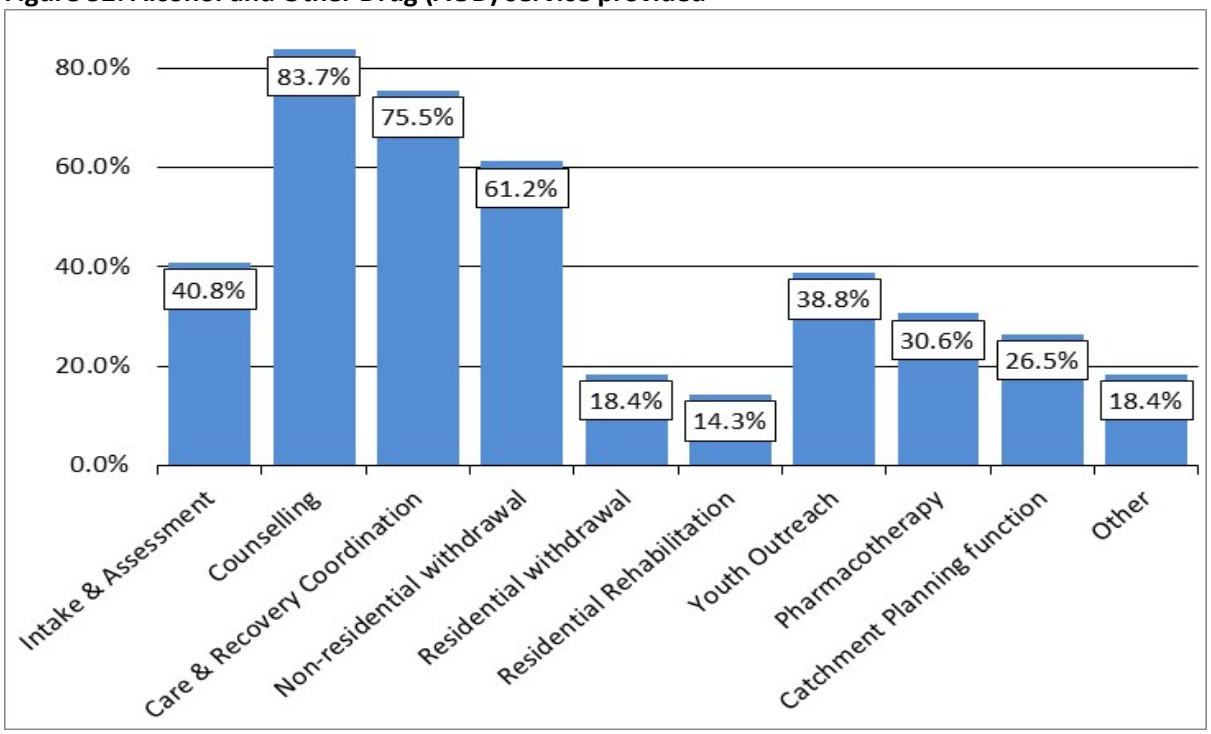


Figure 32 illustrates the range of AOD treatment types are being delivered by survey participants including Intake & Assessment, Counselling, non-residential withdrawal, residential services and Care & Recovery Coordination

A proportion of respondents indicated they deliver 'other' services, including Needle & Syringe Programs, Youth home-based withdrawal, Rural withdrawal and mobile drug safety services to name a few examples.

Appendix 2: Survey questions

SECTION 1: CONTACT & ORGANISATION DETAILS

1. Name

2. Position

3. Agency name

Email

Phone

6. Are you in a consortia? (Please note: we are seeking your responses in relation to your individual organisation)

☐ Yes

☐ No

☐ Multiple consortia

7. Are you a lead agency?

☐ Yes

☐ No

8. Catchment area

☐ Inner East Metro	☐ South East Metro	☐ Great South Coast
☐ Inner North Metro	☐ Eastern Metro	☐ Goulburn Valley
☐ North Metro	☐ Frankston-Mornington	☐ Loddon Mallee
☐ North West Metro	☐ Barwon	☐ Gippsland
☐ South West Metro	☐ Hume	
☐ Bayside	☐ Grampians	

9. Which of the following AOD services does your agency currently provide? (select all that apply)

- ☐ Intake & Assessment
- ☐ Counselling
- ☐ Care & Recovery Coordination
- ☐ Non-residential withdrawal
- ☐ Residential withdrawal
- ☐ Residential Rehabilitation
- ☐ Youth Outreach
- ☐ Pharmacotherapy
- ☐ Catchment Planning function
- ☐ Other

If other, please specify:

SECTION 2: DEMAND, ACCESS & AVAILABILTY

Since recommissioning, has service user demand for AOD services at your agency changed:

☐ Yes

☐ No

☐ N/A - Agency not delivering AOD treatment services pre recommissioning

If you answered yes to the previous question, has service user demand for AOD services at your agency:

☐ Increased a little

☐ Increased a lot

☐ Stayed the same

☐ Decreased a little

☐ Decreased a lot

☐ Unsure/too early to tell

☐ N/A - Agency not delivering AOD treatment services pre-recommissioning

How has service user demand changed across different AOD treatment types?

	Increased a lot	Increased a little	No significant change	Decreased a little	Decreased a lot	N/A Agency not delivery service
Counselling	☐	☐	☐	☐	☐	☐
Residential withdrawal	☐	☐	☐	☐	☐	☐
Non residential	☐	☐	☐	☐	☐	☐
Residential rehabilitation	☐	☐	☐	☐	☐	☐
Youth Outreach	☐	☐	☐	☐	☐	☐

Further comment:

If your agency has experienced a change in demand, what (in your view) are the factors driving this?

(Please comment)

Numbers in treatment

Has your agency experienced any change to the number of service users engaged in AOD treatment since recommissioning?

☐ Yes

☐ No

☐ N/A - Agency not delivering services pre recommissioning

If you answered yes to the previous question, has the number of service users engaged in AOD treatment:

☐ Increased a little

☐ Increased a lot

☐ Stayed the same

☐ Decreased a little

☐ Decreased a lot

☐ Unsure / Too early to tell

☐ N/A – Agency did not deliver service pre-recommissioning

Further comment:

If there has been a change **in the number of people in treatment** at your agency, what (in your view) are the reasons for this change? (Select all that apply)

☐ No change in number of people in AOD treatment

☐ Delivering fewer services since recommissioning

☐ Delivering greater number of services since recommissioning

☐ Clients having difficulty navigating the new Catchment based I&A system

☐ Fewer people eligible for specialist AOD treatment with the introduction of the new complexity and severity tool (ie. the tier model)

☐ Increase in referrals since the introduction of the Catchment based I&A system

☐ Decrease in referrals since the introduction of the Catchment based I&A system

☐ Unsure

☐ Other

Further comment:

SECTION 3: FUNDING & PRODUCT PRICING

In aggregate terms, has your agency experienced a change to funding as a result of recommissioning?

☐ Increase

☐ Decrease

☐ Stayed the same

Further comment:

The new treatment types are listed below. Please indicate your view on the adequacy of the product pricing for each:

	Adequate	Inadequate	Unsure	Service not provided
Intake & Referral – Phone contact	☐	☐	☐	☐
Intake & Referral – Face to Face	☐	☐	☐	☐
Intake & Referral – via Internet	☐	☐	☐	☐
Comprehensive AOD Assess & Treatment Plan	☐	☐	☐	☐
Care and Recover Coordination	☐	☐	☐	☐
Counselling – Standard	☐	☐	☐	☐
Counselling – Complex	☐	☐	☐	☐
Withdrawal – Non-residential – standard	☐	☐	☐	☐
Withdrawal – Residential	☐	☐	☐	☐
Residential rehabilitation	☐	☐	☐	☐

Further comment, including any comment on the forensic and Aboriginal loading:

SECTION 4: STAFFING & WORKFORCE

What has been the overall impact of recommissioning on AOD staffing at your agency?

	Yes/No	EFT
Gained staff overall?		
Lost staff overall?		
Redeployed staff?		

Has your agency experienced any challenges with the recruitment and retention of staff since the recommissioning of AOD services?

☐ Yes

☐ No

☐ N/A - Agency not delivering services pre-recommissioning

If you answered **yes** to the previous question, please provide a brief outline of the main challenges your agency has encountered with recruitment and retention since recommissioning:

Has recommissioning provided any opportunities to staff in relation to progression and advancement?

☐ Yes

☐ No

☐ N/A - Agency not delivering AOD services pre-recommissioning

If you answered **yes** to the previous question, please provide a brief outline of the opportunities provided by the recommissioning in relation to progression and advancement for staff:

SECTION 5: THE RECOMMISSIONED SYSTEM

Catchment Based Intake & Assessment

Please describe the benefits of the Catchment Based Intake & Assessment model?

In your view, what, if any, are the current challenges with the operation of the Catchment Based Intake & Assessment model?

How can the challenges you have identified be addressed?

What, if any, are the current challenges with the application of the Screening Tool 'Self Complete Initial Screen for Alcohol and Other Drug Problems'

PLEASE INDICATE THE EXTENT TO WHICH YOU AGREE OR DISAGREE WITH THE FOLLOWING STATEMENTS

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Catchment based Intake & Assessment has improved access to treatment for service users generally	☐	☐	☐	☐	☐
The common AOD screening tool, known as 'Self Complete Initial Screen for AOD problems' is a useful tool to assist in determining whether someone is eligible for comprehensive AOD treatment	☐	☐	☐	☐	☐
Catchment based Intake & Assessment has improved the 'flow' of clients through the AOD treatment system	☐	☐	☐	☐	☐
Effective referral pathways and linkages have been established in my local area	☐	☐	☐	☐	☐

Further comment (optional):

Diversity

29. PLEASE INDICATE THE EXTENT TO WHICH YOU AGREE OR DISAGREE WITH THE FOLLOWING STATEMENTS :

The recommissioned AOD system has improved capacity to meet the needs of diverse groups such as:

	Strongly Agree	Agree	Neutral	Disagree	Strong Disagree
Aboriginal People	☐	☐	☐	☐	☐
Culturally & Linguistically Diverse Communities	☐	☐	☐	☐	☐
People with co-occurring mental health issues	☐	☐	☐	☐	☐
Families	☐	☐	☐	☐	☐
GLBTIQ	☐	☐	☐	☐	☐

Further comment:

30. In your view, is the recommissioned service system more:

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Person-centred, family & culturally inclusive, recovery-orientated treatment	☐	☐	☐	☐	☐
Accessible & easy to navigate	☐	☐	☐	☐	☐
High quality & evidence based	☐	☐	☐	☐	☐
Integrated with other health and human services that people need	☐	☐	☐	☐	☐
Sustainable & responsive to community needs	☐	☐	☐	☐	☐
A skilled and competent workforce	☐	☐	☐	☐	☐

Further comment:

Final thoughts

Please rate, in order of importance, the top 5 challenges facing your agency today

	1	2	3	4	5
Responding to new drug types or changing drug use patterns	☐	☐	☐	☐	☐
Establishment of referral pathways within local catchment	☐	☐	☐	☐	☐
Building relationships and linkages between consortia members	☐	☐	☐	☐	☐
Recruitment of staff	☐	☐	☐	☐	☐
Retention of staff	☐	☐	☐	☐	☐
Meeting demand	☐	☐	☐	☐	☐
Working with client complexity	☐	☐	☐	☐	☐
Assisting clients to access treatment services	☐	☐	☐	☐	☐
Funding	☐	☐	☐	☐	☐
Other issues not identified in this list	☐	☐	☐	☐	☐

Other issues not identified above (please elaborate)

Please describe what you feel has been the most beneficial element of recommissioning of AOD services to date?

33. Any further comments

List of references

Berends, L. & Ritter, A. (2014) *The Processes of Reform in Victoria's Alcohol & Other Drug Sector*, 2011-2014, Drug Policy Modelling Project, National Drug and Alcohol Research Centre, University of New South Wales, with support from Victorian Alcohol & Drug Association (VAADA).

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