Submission by UnitingCare ReGen to the Independent review of new arrangements for the delivery of Mental Health and Drug Treatment Services in Victoria

Summary

This submission focuses on the alcohol and other drug (AOD) reforms only. It reflects UnitingCare ReGen's (ReGen) experience of implementing the new AOD treatment system, feedback collected from consumers and family members and the experiences of other partner treatment providers.

The document's structure has been guided by the questions set out in the Review of new arrangements for the delivery of MHCSS and AOD treatment services in Victoria.

General Statement

We believe that the service model is fundamentally sound. Consolidation of the service types and partnership-based, collaborative, catchment level services are an improvement that will lead to improved client outcomes in the longer term. However, there have been many roll-out issues: some of which were foreseeable, and some that were foreshadowed by the sector during the pre-reform focus group consultations.

It is important to remember that service change of this magnitude will inevitably lead to teething issues that will take time, fine-tuning and goodwill to overcome. There is a very real risk that these issues will be interpreted as insurmountable problems with the model rather than issues that need to be addressed as they arise.

It is also worth noting that some of the current issues relate to non-reform services (such as pressure on residential withdrawal and rehabilitation services), and have arisen due to the partial nature of the reform process and that the operation of 'dual systems' (reformed and non-reformed services) is likely to contribute to ongoing implementation challenges.

This document outlines some of the key issues that have emerged during the first year of implementing the recommissioned services and recommendations on how to improve the current system.

Key Issues

Intake and Assessment

- The new Intake model appears to be working well for many people, but has created new access barriers to people with complex needs, particularly those who are homeless and other vulnerable groups within the Inner North catchment. More resources are required to meet the established high demand in this catchment and increase system capacity for outreach services to vulnerable groups.
- The screening tool is overly cumbersome and time consuming for Intake staff and people seeking treatment or support. It should be replaced by a much shorter set of questions to improve consumer's experience of their likely first contact with treatment services and the efficiency of the new Intake system. AOD clinicians are already experienced in determining treatment eligibility based on a brief telephone

conversation. However evidence based screeners such as the CAGE or CAGE-AID could be utilised (see Appendix 1)

- Despite a view that the sector was over servicing clients pre reform and that a percentage of clients were being serviced that do not meet the criteria for AOD treatment, the Tier system of identifying people at Tiers 1 and 2 who are not suitable for treatment from the AOD sector has not confirmed this view. In fact only a small percentage of people who present at ReGen screen as Tier 1 or 2 and despite that there are often compelling reasons why they would benefit from treatment.

Service Delivery

- There has been significant rewriting of history as government and service providers have tried to respond to issues in the system that don't appear to be working. For example we have moved from only servicing families of clients in treatment to supporting all families of people with AOD issues. This has not necessarily been communicated well across the sector, to other sectors or to families.
- NRW was introduced with rigid service specifications that service providers predicted during the pre- reform forums, did not address the service needs. We have heard verbally that DHHS now consider clinical judgement rather that strict adherence to service specifications should inform treatment. However, until the specifications are revised, Registered Nurses will be reluctant to jeopardise their professional registration by acting outside of the specifications.
- The Care & Recovery Co-ordination service type is under-resourced and poorly defined. The current limits on CRC contact are insufficient to meet the needs of consumers with complex needs and the inclusion of Supported Accommodation within the service type is not working. As a result, entry to CRC is blocked, giving the appearance of low utilisation. This is not a service type that can generate a waiting list to demonstrate demand. Rather, if CRC is not available, clinicians are forced to cobble together some form of often inadequate support for the client.
- The drop-off in harm reduction services delivered in the Inner North is placing already vulnerable groups at increased risk and further reducing the accessibility of treatment services in the catchment. Many of these services were delivered under the guise of counselling pre-reform.

Service Relationships

- The competitive tender process implied that only partnered-up agencies would be successful in tendering for new services and as a result many partnerships have been formed which has enhanced service delivery. These partnerships take time, resources and good will to manage and it is likely that some will struggle from time to time as they compete for other services, manage power relationships and address issues relating to general direction and values.
- With other services outside of the partnerships, the competitive tendering process damaged relationships that will take time and good will to mend. Having said that

it is our view that agencies have come together to try to ensure services are provided to clients where and when needed and that there current communication between services is much better than it was pre reform.
- While concentrating on relationships between AOD services, it would appear that relationships with other providers such as mental health services have been put on the back burner and have suffered as a result.

Catchment Planning

- The establishment of this service type is a welcome addition but has been hampered by lack of reliable data, shifting timelines and poor communication from DHHS.

Workforce

- Recruitment has been a significant issue across the AOD sector since the commencement of the reform process. Anecdotal evidence suggests that a cohort of senior workers has been lost to the sector as a result of the reforms, with increased interest from new graduates.
- Service providers are faced with delivering new services with a less experienced workforce. There is a clear need for investment in professional development across the Victorian AOD sector to develop a new cohort of senior clinicians and promote consistent, evidence based service delivery across the treatment system.

Funding

- Funding models for new service types need to be reconsidered. In particular, resources for Intake and Assessment and Care and Recovery Co-ordination do not take into account the full range of activities associated with these service types, nor the complexity of consumer needs that must be responded to within each service type.

Quality

- There is a considerable challenge to partnered agencies in addressing Clinical Governance across a range of agencies. For example developing common Operating Policies and Procedures, file audit systems, incident management processes. There needs to be a sector wide investment best practice in this area and disseminating information and resources to the sector.

Additional Areas of Concern

- Community awareness of publicly funded AOD treatment services in Victoria remains worryingly low, with key service information (for both recommissioned and non-reform services) too difficult to access and little change in the public perception of a fragmented, impenetrable service system.

Recommendations

Intake and Assessment

- A substantial review of the screening and assessment tools to reduce the amount of time needed to administer them and improve their clinical utility. DHHS to consider replacing the current tools with evidence based alternatives such as the CAGE or CAGE-AID tools
- Establish a single, statewide entry point (1800 number) for treatment enquiries
- That DHHS review the DTAU loading for the Intake & Assessment activities.
- That DHHS define a new flexible treatment activity that can be recorded in blocks of 1 hour, with an associated DTAU, that can be used for a range of eligible activities within defined limits. Examples of these may be pre-assessment support, brief interventions, bridging support, family consultations, completion of additional/complimentary assessments, and extensive written reports (eg. Court reports).
- I&A providers commence and record the intake process for all consumer enquiries as a way to truly reflect demand for service, even if the call does not progress to an assessment appointment being made. (ATODS data set is the trigger for the DTAU allocation)
- A simple data set be agreed to be collected for family members who make contact with intake providers where advice and a brief intervention is provided. This data set would trigger a DTAU allocation for Intake (regardless of whether a screen has been completed or not).
- DHHS limit the current DTAU allocation that providers may use to directly Intake and Assess consumers to those most urgent and complex to the specified 20%, ensuring those most in need and at risk get the quickest access to treatment, whilst those with less complex needs are redirected through centralised I&A.
- DHHS adjust the guidelines to ensure that all treatment services provide Intake and Assessment information back to catchment based I&A providers or Catchment Planners so that a full picture of the regions can be mapped.

Service Delivery

- DHHS demonstrate its commitment to service accessibility by developing clear, consistent messages about Victorian AOD treatment services (as part of an overarching recommissioning communications plan) and improving the accessibility of service information for consumers.
- DHHS urgently address the accessibility of recommissioned services for particularly vulnerable groups with complex needs and ensure system capacity for targetted harm reduction services for this group is returned.
- DHHS reconsiders current service guidelines and funding models for the Intake and Assessment, Care and Recovery Co-ordination and Non-Residential Withdrawal service types.

Service Relationships

- Location of services within catchments needs to be included within the scope of Catchment Planning and specified within funding agreements for individual providers. Any significant changes to established locations within the period of funding agreements should be signed off by DHHS.

Catchment Planning

- Improved systems for service data collection within all catchments and more regular provision of relevant data by DHHS to Catchment Planners
- Establishment of guidelines for future service planning decisions, recognising that resource limitations will restrict catchment services' capacity to respond to emerging community needs without cutting established services.

Workforce

- DHHS recognise the impacts of the reform process on the available experience within the Victorian AOD workforce and the significant impacts that difficulties recruiting (and retaining) sufficiently expert staff has on service providers' capacity to establish new services, maintain service quality and meet service targets.
- DHHS allocate appropriate workforce development resources to enable the rebuilding of senior clinical capacity within the Victorian AOD workforce.
- That the resource allocation take account not only of the cost of work force development activities including training but the requirement for service delivery to continue to be met (e.g. backfill of key roles).
- DHHS recognise the need for professional development in youth-specific practice for clinicians working in recommissioned adult services.

Funding

- That Supported Accommodation management be resourced as a separate service type and not part of CRC.
- Identify key harm reduction activities and fund them as a separate service type

Quality

- There needs to be a sector wide investment resources to support best practice in Clinical Governance (e.g. common Operating Policies and Procedures, file audit systems, incident management processes) and disseminating information and resources to the sector.
- In consultation with catchment service providers, DHHS develop a clear communications plan to improve broad awareness of the reform process and changes to the AOD treatment system within key service sectors.
- DHHS reveal the modelling for the first stage of AOD treatment reforms to inform an open review of current service models and their capacity to support consistent delivery of evidence based treatment services.
- In addition to documenting changes to service guidelines, DHHS should invest in developing and disseminating best practice models for Clinical Governance to

support implementation of evidence based practice and management of potential risk.

Additional Areas of Concern

- DHHS investigate the provision and promotion of one 1800 number across Victoria.
- DHHS develops a range of consistent marketing materials for broad distribution in the community, advertising the new Intake and Assessment function and the new treatment types available
- That we move towards utilising and marketing I&A for all Victorian AOD treatment services (both in and out of scope of the reform process), with some considerations and flexibility for some vulnerable groups such as Aboriginal, Youth or homeless consumers.
- Once the current review process is complete and remedial actions agreed upon, DHHS proceed directly with the second stage of the Victorian AOD reform process.

Response to review questions

1. Intake and Assessment

Consumer experience – importance of first contact to successful engagement

Understanding the changes to the AOD treatment system is still a challenge for professionals working in related service sectors. For community members, the new intake, referral and service allocation processes (with potentially multiple service providers operating under a range of organisational names) can be confusing and disorientating. This is due, in part, to the requirements for consortium/partnership delivery of services. A poor initial experience when seeking support can have a significant impact on subsequent engagement with treatment services.

We need to be careful to explain from the outset, and minimise the impact of multi-service involvement in a course of client treatment. Otherwise confusion and frustration may arise when 3 or more organisations may be involved in a single course of treatment.

The current entry point into drug treatment sees each Intake provider field a large number of enquiries from people seeking information and advice before they make the decision to enter drug treatment programs. These enquiries come from consumers and more often than not from their families. They don't immediately trigger an assessment, nor do many of them want a clinical response such as an assessment. At least 20% of all our triage work includes this cohort.

A well promoted 1800 number as a single statewide entry point would significantly assist consumers.

Screening and Assessment Tools

The inflexibility and lack of clinical utility (prioritising data collection over clinical engagement) of the mandated screening and assessment tools pose a significant barrier to consumer engagement and, in many cases, effectively deter people from further pursuing their treatment enquiries.

Many ReGen clients have become frustrated and confused thinking that the assessment is completed at the end of the screening phase. Duplication between the two tools needs to be removed. Briefer tools with equal validity and reliability could to be introduced to reveal dependent use (particularly relating to the screening component) and serious consideration needs to be given to adapting it to better suit the needs of Aboriginal people and other vulnerable groups. Removing the burden of collecting further information on behalf of the residential withdrawal services has reduced the overall assessment time.

The tools were developed pre-reforms, with little genuine consultation with consumers or service providers. Since their implementation, there has been no review of their effectiveness in clinical settings. They have clearly been developed as a research tool, not a clinical tool, but have not resulted in the collection of any meaningful data on presenting needs (that ReGen has seen).

ReGen's experience (reflecting that of other Intake providers) consistently shows that the time allocation for screening episodes has been significantly underestimated in the original service modelling. Twenty minutes is barely enough time to answer questions in a phone interview – and does not leave time for any therapeutic engagement activity. It is

also our experience that we have had to add resources to screening and assessment functions to meet demand. In ReGen's case this has reduced the availability of staff resources for assessment and counselling.

To ReGen's knowledge no-one is using the optional modules and there is only very limited identification of co-occurring issues e.g. gambling The Strengths & Family Violence forms are more of a referral form than an identification tool , are difficult for clinicians to use, providing a disincentive for their clinical use.

Despite a view that the sector was over servicing clients pre reform and that a percentage of clients were being serviced that do not meet the criteria for AOD treatment, the Tier system of identifying people at Tiers 1 and 2 who are not suitable for treatment from the AOD sector has not confirmed this view. In fact only a small percentage of people who present at ReGen screen as Tier 1 or 2 and despite that there are often compelling reasons why they would benefit from treatment. We also have a view that those well positioned to provide a secondary intervention for people with a developing AOD problem, such as GPs, are often not willing or sufficiently confident to provide these services.

De-centralised Intake and wait-list management

There are currently a number of demands in the sector. In particular, there are long waitlists in Metropolitan catchments and some waitlists starting to grow for voluntary clients in both Metropolitan Melbourne and Regional Victoria. Waiting periods for access to public treatment services is the primary frame of reference for the majority of public discussions of the Victorian AOD treatment system, particularly in reference to treatment for methamphetamine dependence, with local and international for-profit services being presented as 'filling the void'.

Under the current model, treatment providers are able to use up to 20% of their allocated DTAUs, to provide direct treatment access to consumers by providing 'walk-in' assessments. This presents a number of challenges and opportunities for current Intake and Assessment providers:

- Information about the numbers and location of consumers and their level of need (tiers) is not consistently provided to the catchment based Intake & Assessment provider, and as such it is impossible to have a true view of the whole catchment, its trends, demands and any emerging needs. We hope that Catchment Planners will be able to access this data in future.
- No standard data is being collected on support needs and/or referral outcomes for those people with Tier 1 or 2 level needs. This is important information.

Recommendations

- A substantial review of the screening and assessment tools to reduce the amount of time needed to administer them and improve their clinical utility.
- Establish a single, statewide entry point (1800 number) for treatment enquiries
- That DHHS review the DTAU loading for the Intake & Assessment activities.
- That DHHS define a new flexible treatment activity that can be recorded in blocks of 1 hour, with an associated DTAU, that can be used for a range of eligible activities within defined limits. Examples of these may be pre-assessment support,

brief interventions, bridging support, family consultations, completion of additional/complimentary assessments, and extensive written reports (eg. Court reports).

- I&A providers commence and record the intake process for all consumer enquiries as a way to truly reflect demand for service, even if the call does not progress to an assessment appointment being made. (ATODS data set is the trigger for the DTAU allocation)
- A simple data set be agreed to be collected for family members who make contact with intake providers where advice and a brief intervention is provided. This data set would trigger a DTAU allocation for Intake (regardless of whether a screen has been completed or not).
- DHHS limit the current DTAU allocation that providers may use to directly Intake and Assess consumers to those most urgent and complex to the specified 20%, ensuring those most in need and at risk get the quickest access to treatment, whilst those with less complex needs are redirected through centralised I&A.
- DHHS adjust the guidelines to ensure that all treatment services provide Intake and Assessment information back to catchment based I&A providers or Catchment Planners so that a full picture of the regions can be mapped.

2. Service Delivery

Delivering on policy rhetoric?

To date, the new treatment system is not living up to the policy rhetoric of 'client centred' and 'family inclusive' services. Consumers and family members have had too few opportunities to have their voices heard on the impacts of the reform process on people who use AOD treatment and support services.

Accessibility is a key issue: the new Intake system is effective for many, but offers less flexibility for those people with complex needs who need additional support to engage with treatment services.

The new system has been poorly communicated to consumers and family members. The various new partnership arrangements are complex and not easily understood by service providers, let alone people with no previous knowledge of the AOD treatment system. Public awareness of treatment services (particularly in the light of heightened community concern about the impacts of methamphetamine use) remains disturbingly low, with private providers often presented in media and social media discussions as the only option for affected families.

There is only limited awareness of the recommissioning process outside the AOD sector and a clear need for improved communication of the new AOD treatment system, particularly high level promotion to other service sectors.

While individual provider capacity to undertake sustainable community development work to improve awareness of and access to treatment services within target CALD communities has always been limited, the current system has further removed the capacity for services to undertake outreach work with these and other communities not currently accessing treatment services.

At present, it is unclear what commitment there is at a policy level to 'recovery oriented practice' and how this concept is defined by DHHS. ReGen has updated its Recovery Oriented Pracitce Position Statement and Supporting Evidence in the wake of the reform process, but the application of recovery oriented practice across the AOD sector remains unclear.

Meeting complex needs

While not a stated objective of the reforms, the changes in service funding have resulted in a significant decrease in harm reduction services for people who are homeless and other vulnerable groups who are not seeking treatment but at imminent risk of AOD related harm, particularly within the Inner North catchment. The cessation of these services has resulted in a marked failure of the new service system to provide services that are relevant to the needs of this group. As this group typically no longer has a reason to engage with AOD service, the accessibility of treatment services for them has significantly decreased. These services were often provided under the guise of counselling pre reform.

Explicit limitations within the service guidelines for recommissioned service types (particularly Non-Residential Withdrawal and Care and Recovery Co-ordination: see below) have resulted in those services being unable (NRW) or inadequately resourced (CRC) to address the complex and inter-related needs of many people seeking AOD treatment.

Care & Recovery Co-ordination

The Care & Recovery Co-ordination service type is under-resourced and poorly defined. The current limits on CRC contact are insufficient to meet the needs of consumers with complex needs and the inclusion of Supported Accommodation within the service type is not working. As a result entry to CRC is blocked giving the appearance of low utilisation. This is not a service type that can generate a waiting list to demonstrate demand rather if CRC is not available clinicians are forced to cobble together some form of often inadequate support for the client.

There is insufficient client contact time allocated to CRC. When a client is in crisis this time allocation can be exhausted in 2-3 days. The level of CRC support required for complex clients in transitional housing has been seriously underestimated in the modelling for the new service type.

Non-residential withdrawal

The model for this service type was clearly wrong from the outset: targeting people with Tier 1& 2- level needs, even though they would have been deemed ineligible for treatment via screening. The service model needs to be completely re-written to allow for NRW services to return to working with people with complex needs (e.g. supporting access to ReGen's non-residential rehabilitation programs or pre/post residential support for people undertaking methamphetamine withdrawal) and this change needs to be clearly communicated to the AOD and related sectors.

Based on ReGen's experience to date, we are also predicting that the current targets for Non Residential Withdrawal services are excessive.

Counselling

Pathways into counselling and individual treatment appears to be functioning well, although further work needs to be done in combination with catchment planning to ensure counselling services are located in areas of most need. Service limits on numbers of sessions may need to be addressed to cater to complexity of need and potential shortcomings in assessment. Assessment can only provide a partial judgement on a person's suitability for counselling. Typically, this is confirmed during early counselling sessions.

Improving consumers' quality of life

The current restrictions on recommissioned service types limit the capacity of service providers to support the development of consumer's living skills, family relationships and a range of other factors likely to improve the sustainability of treatment outcomes and quality of life.

The ongoing absence of any detail on potential outcomes measures has resulted in only the most limited outcomes data being collected during the first year of recommissioned service delivery. In ReGen's experience, the only meaningful measures of treatment outcomes have come via (funded) evaluations of the agency's Catalyst and Torque non-residential rehabilitation programs.

Recommendations

- DHHS demonstrate its commitment to service accessibility by developing clear, consistent messages about Victorian AOD treatment services (as part of an overarching recommissioning communications plan) and improving the accessibility of service information for consumers.
- DHHS urgently address the accessibility of recommissioned services for particularly vulnerable groups with complex needs and ensure system capacity for targetted harm reduction services for this group is returned.
- DHHS reconsiders current service guidelines and funding models for the Intake and Assessment, Care and Recovery Co-ordination and Non-Residential Withdrawal service types.

3. Service Relationships

Resource implications for service co-ordination

The reform process was supposed to be 'cost-neutral' but partnership requirements impose additional costs for service co-ordination, clinical and organisational governance that were not recognised within the new service funding model. As a result, a greater proportion of service funding is now being spent on co-ordination, less on service delivery. ReGen provided consistent feedback throughout sector consultations and subsequent opportunities, but this issue was not addressed during the reform process.

ReGen and Odyssey House Victoria (together with our other service partners) have undertaken 12-months' preparation before commencing implementation of the joint North and West Metro AOD Service. This work required the identification of service co-ordination as a strategic priority and the allocation of a significant level or resources from both organisations, while maintaining regular service delivery.

Even with, this substantial preparation, there have still been a range of challenges in delivering accessible, consistent services across four catchments. The additional workload this created for senior staff continues to be felt across both organisations.

Current reporting mechanisms take no account of staff resources allocated to support Services Connect operations and there is no clear benefit for the specialist AOD treatment system. ReGen has enabled senior staff to take up Services Connect roles to support the initiative, but Services Connect is not working with complex needs and is not easing demand for specialist services. This is exacerbating recruitment and workforce issues across the sector.

Relationships amongst recommissioned service providers

While catchment staff report consistent benefits from the higher degree of collaboration and co-ordination with non-partner treatment providers (compared to pre-recommissioning), the impact of catchment level co-ordination activities on individual providers' service capacity is not recognised within sector consultations to date.

ReGen understands that some consortia (particularly those which had not done extensive pre-reform preparation) in other areas are experiencing significant difficulties in delivering co-ordinated services within their respective catchments.

There is a clear message for DHHS: developing and maintaining effective service partnerships (either within a consortium/partnership or across all catchment services) to manage complex care arrangements requires a significant commitment of resources. This needs to be addressed within future funding agreements.

Location of catchment services

One role of the catchment Intake and Assessment service is to ensure that clients are referred to other non-partner services, based on individual need, client preference of providers and convenience of access. This is made more difficult if we have no control over the location of those services, changes to those locations or changes to EFT allocation across locations. As lead agencies across the four catchments in the North and West Metro region, ReGen and Odyssey House Victoria have been committed to ensuring a broad spread of service delivery locations to increase accessibility for all catchment residents. However, we have already seen examples of non-partner catchment service providers unilaterally deciding to close locations or relocate services to areas which are already fully serviced by other providers. Such moves place an additional burden on lead agencies and limit the capacity of catchment Intake services to manage an equitable distribution of appropriate referrals to particular providers or within over serviced local areas. It is hoped that localised Catchment Plans will assist with planning resource allocations across catchments.

Management of consumer information

The absence of a standard data collection system is likely to make the collection and comparison of meaningful service data difficult to achieve across all catchments. Each provider (including ReGen and Odyssey House Victoria) has developed their own data collection system at great cost and resource utilisation. ReGen has experienced implementation problems with its own system (including the capacity for secure electronic

transfer of consumer information to non-partner catchment services) and is unlikely to be the only one.

Recommendations

- Location of services within catchments needs to be included within the scope of Catchment Planning and specified within funding agreements for individual providers. Any significant changes to established locations within the period of funding agreements should be signed off by DHHS.

4. Catchment Planning

Improving accountability and local responsiveness

The decentralisation of the Catchment Planning function is a positive development, enabling greater local responsiveness to emerging community needs. However, to date, catchment planners have had very limited access to DHHS data to inform the development of local plans.

Given the various identified issues with the resourcing of recommissioned services, there remains a serious question about the future capacity of catchment services to respond to emerging local issues. Where services are already operating at full capacity, how will providers be able to establish new initiatives, particularly those requiring community development approaches with CALD and other communities?

Recommendations

- Improved systems for service data collection within all catchments and more regular provision of relevant data by DHHS to Catchment Planners
- Establishment of guidelines for future service planning decisions, recognising that resource limitations will restrict catchment services' capacity to respond to emerging community needs without cutting established services.

5. Workforce

Recruitment to recommissioned services

Recruitment has been a significant issue across the AOD sector since the commencement of the reform process. Anecdotal evidence suggests that a cohort of senior workers has been lost to the sector as a result of the reforms, with increased interest from new graduates. The increase in clinical salaries resultant from the introduction of new funding agreements for recommissioned services has provided an insufficient 'pull factor' to retain experienced workers within the AOD treatment system or attract senior staff from other related sectors.

All treatment providers have been forced to recruit from within a less experienced pool of current AOD workers and new graduates. In addition to a collective loss of expertise from within the AOD workforce, services now need to allocate a greater level of resources to

supervision and workforce development to ensure quality of service delivery remains unaffected.

Workforce capacity for early interventions

While ReGen understands the need to focus on the most serious and complex, we are concerned that capacity for early intervention for those experiencing serious non-dependent alcohol and other drug related problems has been seriously diminished due to the tier rating system. If there were widespread alternative referral options we would be less concerned. However we know that frontline workers in other sectors have limited interest or capacity respond. This capacity needs to be developed to provide effective interventions to reduce the likelihood that abuse will escalate to dependence and other more serious problems.

In response to the longstanding reticence of non-AOD services to engage with people affected by AOD dependence (and prior to the reform process), ReGen had invested significant resources in building the capacity of its workers to deliver a range of early interventions with individuals and family members. Since the commencement of the recommissioned services, this capacity has been largely lost. Services Connect services are not working with people with complex needs and the emergence of methamphetamine use has further exposed how unprepared frontline workers are to respond effectively and how unwilling non-AOD services are to engage with a group of people considered to be 'high risk'.

We know that people experiencing Tier 1 & 2 level harms still experience stigmatisation by mainstream service providers, who are now their only source of support. The assumption that generalist services would readily take up the service load with this group has proved ill-founded.

We also know that the cessation of key harm reduction programs has left particularly vulnerable groups with no point of contact with AOD treatment or other related services.

Workforce Development Needs

There are gaps in workforce development directly related to the reforms. For example the adult system now deals with clients 16 years and above and there is a resultant need for training in working with young people.

While the focus has been on getting services up and running, there has not been adequate time or resources for agencies to release staff for training. For example the CAN initiative managed through Turning Point has unrealistic and unsustainable expectations on participants and their employer agencies. This is also true of the service type specific Communities of Practice (COPs).

Recommendations

- DHHS recognise the impacts of the reform process on the available experience within the Victorian AOD workforce and the significant impacts that difficulties recruiting (and retaining) sufficiently expert staff has on service providers' capacity to establish new services, maintain service quality and meet service targets.
- DHHS allocate appropriate workforce development resources to enable the rebuilding of senior clinical capacity within the Victorian AOD workforce.

- That the resource allocation take account not only of the cost of work force development activities including training but the requirement for service delivery to continue to be met (e.g. backfill of key roles).
- DHHS recognise the need for professional development in youth-specific practice for clinicians working in recommissioned adult services.

6. Funding

Intake & Assessment

Following the Intake process, the current funding model allows an average of 3.5 hours per consumer to complete comprehensive assessment, treatment planning and referral into drug treatment programs. It is expected that Tier 5 consumers may take more time due to the complexity of their needs, while Tier 3 may take less time. I&A providers are also required to provide assessments across the full catchment, including some outreach to ensure ease of access, and to also provide some brief interventions. ReGen's analysis to date indicates that these are taking us much longer than the 3.5 hours as detailed below, and that some significant actions that are part of good treatment practice are being missed or are not funded. Current data indicates that:

- A full Intake process (including screening) takes an average of 40 mins to complete;
- The actual comprehensive assessment with a client takes an average of 2.5 to 3 hours to complete (without the use of any optional modules or completion of the ITP);
- It takes an average of 40 mins to refer a consumer into treatment depending on the number of treatment types and wait times for these. Where there are extensive wait times e.g. for residential services, the amount of time managing and following up referrals can exceed 2 hours per person;
- While a person is waiting significant periods of time, referral to other non-residential treatment types is not always appropriate, leaving I&A providers to remain engaged with clients while they wait; &
- Additional activities for some consumers are not factored in to the DTAU modelling such as initial support, crisis management and engagement to prepare a client for an assessment, report writing, family sessions, and brief interventions and waitlist support (see below).Currently, services are struggling to resource these basic elements of good practice.

When a consumer is on a waitlist for treatment after assessment, I&A providers are expected to provide support and brief interventions to keep consumers engaged until they commence treatment. We currently do this in 3 ways:

- Telephone based bridging support
- Face to face brief intervention support
- Group support

Care and Recovery Co-ordination

While the problems with the funding model for Intake and Assessment services stem from a combination of poorly designed clinical tools, inaccurate estimates of the length of time required to undertake service processes and a lack of recognition for additional activities not included in the service guidelines, the issues with the Care and Recover Co-ordination model are much clearer.

From the outset, it was clear that the sheer number of service types being combined within the CRC service model (and required to be carried out by individual CRC workers) was unrealistic, particularly given the limited hours (and DTAUs) allocated to work with consumers with entrenched complex needs.

ReGen has consistently communicated to DHHS that the service model is fundamentally flawed and that, if it is to be effective, it requires a significantly higher level of funding and capacity for longer-term engagement with people throughout their participation in AOD treatment.

The inclusion of Supported Accommodation into CRC is not working. As mentioned previously, it is effectively blocking access to CRC services and needs to be re-established as a separate service type.

Recommendations

- That Supported Accommodation management be resourced as a separate service type and not part of CRC.

7. Quality

Service consistency

A key concern is lack of clarity about the operation of the newly commissioned services and the absence of an agreed current model to inform service providers. Since the publication of service specifications in the original tender documentation, there has been no documentation of proposed changes to individual service types or the system as a whole. This has resulted in a significant breakdown in consistency of service delivery, with individual providers relying on verbal advice provided in meetings with DHHS.

There is a lack of clear understanding of the current guidelines and what flexibility services have for working within them. Latest reports of verbal updates indicate that, in spite of the entire reform process being driven by the need for consistency, individual providers are now being told to ignore the original guidelines and unilaterally exercise 'clinical judgement'. While there was a clear need for increased flexibility within the original specifications, the current advice appears to undermine the impact of the entire reform process.

There is a need for clear communication with current treatment service providers to address apparent shift in service criteria and expectations of providers. With little documentation of the process (and some apparent 're-writing of history' occurring within DHHS), providers have been forced rely on comments made in service planning meetings

to determine how their services are delivered. Clear documentation of the guidelines for the new service types is necessary.

Evidence-based services

Given the lack of sector access to the original scoping project to determine the structure of the new treatment system and the emerging inconsistencies in practice across the sector, providers have limited capacity to comment on the use of 'evidence-based service models and practice'.

The North and West Metro AOD Service has established a Clinical Governance framework (based on ReGen and Odyssey House Victoria's internal framework) to ensure consistency of practice across all partner services and support the partnership's Steering Group in identifying and managing risk. However there is a need for the DHHS to invest in developing & disseminating best practice models of Clinical Governance.

While the introduction of an outcomes-based framework has been much discussed since the commencement of the reform process, service providers are yet to see any detail about the framework and how it may affect service delivery. The ongoing delay in the release of this framework has resulted in little meaningful outcomes data being collected during the first year of delivery for the recommissioned services and is a significant impediment to service providers' development of their own evaluation frameworks for these (and other) services.

Integration with other service sectors

The nature of the reforms and the implications for other sectors need better higher-level explanation/promotion. We have found that there is a general lack of awareness about the reforms at a high level in other sectors (Mental Health, Corrections, Child Protection, Housing Services, Primary Health, including GPs), with obvious implications for the effectiveness of the new AOD treatment system in supporting improved integration of service planning and delivery. ReGen is working hard to inform/promote the reforms at a local level, but this needs to be supported by a higher level, government initiated promotional strategy.

Recommendations

- In consultation with catchment service providers, DHHS develop a clear communications plan to improve broad awareness of the reform process and changes to the AOD treatment system within key service sectors.
- DHHS reveal the modelling for the first stage of AOD treatment reforms to inform an open review of current service models and their capacity to support consistent delivery of evidence based treatment services.
- In addition to documenting changes to service guidelines, DHHS should invest in developing and disseminating best practice models for Clinical Governance to support implementation of evidence based practice and management of potential risk.

8. Additional areas of concern

Enduring lack of public awareness of the Victorian AOD treatment system

Key information about AOD treatment services in Victoria has never been easily accessible to members of the public. This was a key (and often repeated) criticism of the pre-reform sector. However, little appears to have changed under the new system, with service information still difficult to obtain for community members without a detailed understanding of established treatment services.

Currently there are nine providers of Intake and Assessment for drug treatment across Victoria, each offering a different telephone number and entry point into drug treatment. The existence of new consortium/partnership arrangements in most catchments has provided an additional layer of complexity to public communications about the new service system and made it more difficult to provide community members with a clear understanding of the new system.

Service providers, GPs and health services are still confused about how to refer clients into the new system. Consumers themselves have also reported that it is not easy to know who to go to in order to start their drug treatment journey and which provider is likely to be providing different elements of their treatment.

Ongoing uncertainty about 'Stage Two' reforms

In addition to the abovementioned uncertainty about recommissioned services, there are ongoing concerns about the delays to the remainder of the reform process and the effective operation of parallel systems, with Federally (or independently) funded programs sitting further outside the scope of the reforms.

While there is a clear need to reassess and redevelop key elements of the current reforms the ongoing uncertainty about 'Stage Two' reform services is having a significant impact on the capacity of service providers to plan for the future development of their services.

Recommendations

- DHHS investigate the provision and promotion of one 1800 number across Victoria.
- DHHS develops a range of consistent marketing materials for broad distribution in the community, advertising the new Intake and Assessment function and the new treatment types available
- That we move towards utilising and marketing I&A for all Victorian AOD treatment services (both in and out of scope of the reform process), with some considerations and flexibility for some vulnerable groups such as Aboriginal, Youth or homeless consumers.
- Once the current review process is complete and remedial actions agreed upon, DHHS proceed directly with the second stage of the Victorian AOD reform process.

Appendix 1 – CAGE & CAGE-AID Tools

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

CAGE Substance Abuse Screening Tool

Directions: Ask your patients these four questions and use the scoring method described below to determine if substance abuse exists and needs to be addressed.

CAGE Questions

1. Have you ever felt you should cut down on your drinking?
2. Have people annoyed you by criticizing your drinking?
3. Have you ever felt bad or guilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

CAGE Questions Adapted to Include Drug Use (CAGE-AID)

1. Have you ever felt you ought to cut down on your drinking or drug use?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

Scoring: Item responses on the CAGE questions are scored 0 for "no" and 1 for "yes" answers, with a higher score being an indication of alcohol problems. A total score of two or greater is considered clinically significant.

The normal cutoff for the CAGE is two positive answers, however, the Consensus Panel recommends that the primary care clinicians lower the threshold to one positive answer to cast a wider net and identify more patients who may have substance abuse disorders. A number of other screening tools are available.

CAGE is derived from the four questions of the tool: Cut down, Annoyed, Guilty, and Eye-opener

CAGE Source: Ewing 1984