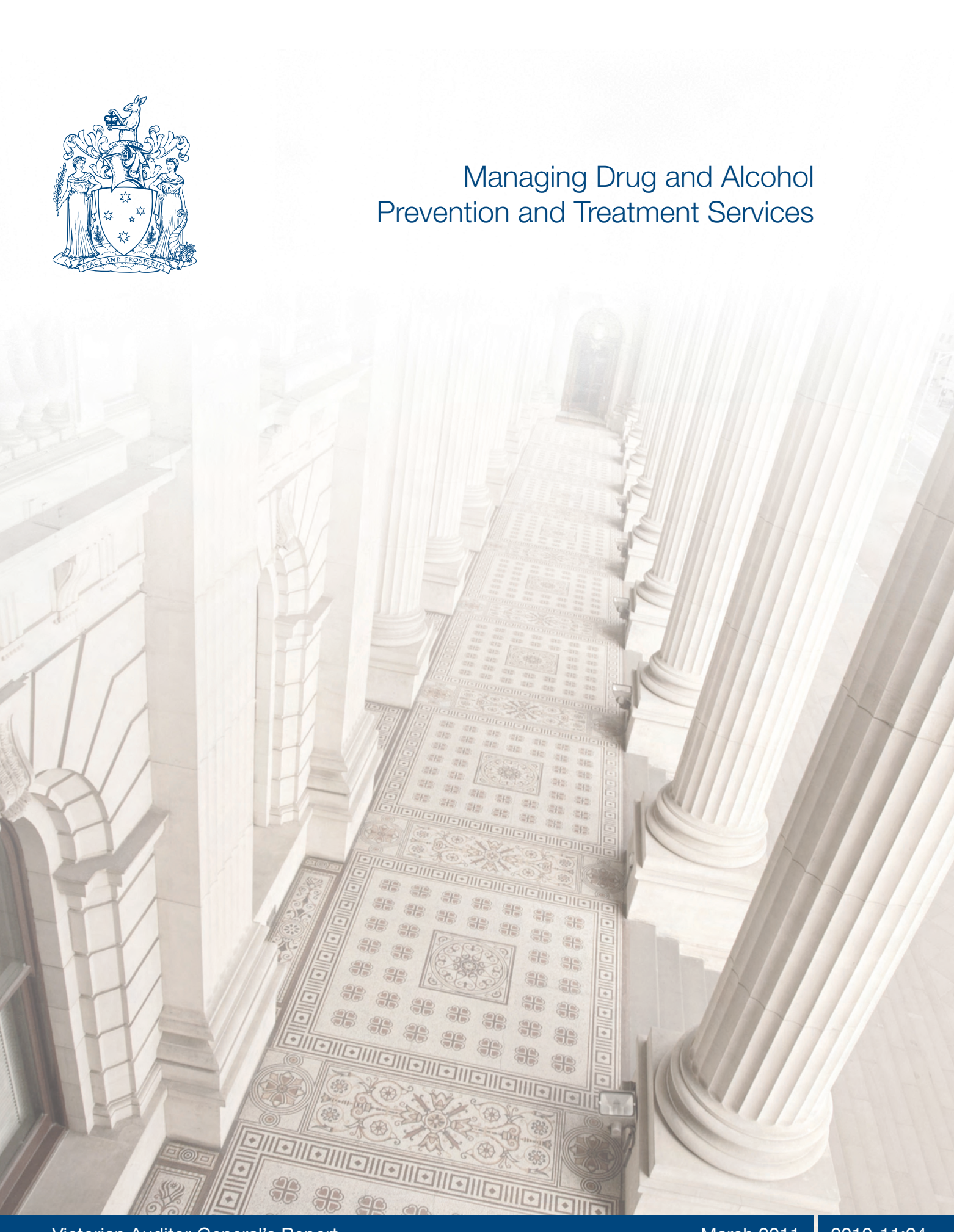
Managing Drug and Alcohol Prevention and Treatment Services



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Managing Drug and Alcohol Prevention and Treatment Services

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Victorian Auditor-General's Office

Auditing in the Public Interest

The Hon. Bruce Atkinson MLC
President
Legislative Council
Parliament House
Melbourne

The Hon. Ken Smith MP
Speaker
Legislative Assembly
Parliament House
Melbourne

Dear Presiding Officers

Under the provisions of section 16AB of the *Audit Act 1994*, I transmit my performance report on *Managing Drug and Alcohol Prevention and Treatment Services.*

Yours faithfully

D D R PEARSON
Auditor-General

2 March 2010

Contents

Audit summary

Background

Harmful drug and alcohol use is a major social issue with an estimated annual cost to the community of $14 billion. More than 77 000 Victorians are hospitalised for alcohol and drug related conditions each year. Around 27 000 enter government-funded specialist alcohol and other drug (AOD) treatment programs.

The current community-based alcohol and drug program guided by harm minimisation principles has operated since 1997. This program funds activities designed to prevent and treat harmful drug and alcohol use. The state allocated $135.7 million for AOD prevention and treatment activities in 2010–11. Of this, $110 million, or 81 per cent is allocated to treatment and 19 per cent to prevention activities.

Typically, prevention initiatives are one-off projects, such as media campaigns, with few prevention services funded on an ongoing basis. In contrast there are 105 services providing treatment services to those who use AODs harmfully.

This audit examines the effectiveness of drug and alcohol prevention and treatment services overseen by the Department of Health (the department), with a particular focus on quality and accessibility of services, and the extent to which interventions work.

Conclusions

Dealing with harmful alcohol and drug use is particularly difficult due to the complexity of addiction, which is a chronic condition where individuals are prone to relapse. A simple ‘cure’ cannot be prescribed. Because of this, prevention and treatment programs need to be reviewed regularly and refined to adapt to changing community needs and to maximise their chances of success.

At its inception the new community-based alcohol and drugs program was innovative in both its service and funding model. However, 13 years later, the problems with treatment services that it was designed to overcome have not been resolved.

The department has no assurance that the service system objectives of effective case management and continuity of care for clients and consistent, high quality services, are being achieved. Treatment services remain difficult for clients to access and navigate, and do not provide seamless pathways to other health and social support services.

This situation has arisen not through a lack of review and awareness, but rather for want of action to address difficult issues. While the treatment system has been refined, this has been at the margins. The episode of care funding and performance measurement model, recognised as flawed since 2000, has not been satisfactorily dealt with; nor has the fragmentation and inconsistency of approach by the relatively large number of service providers.

Thirty-one internal reviews have been conducted since 1999, many on the same theme, and further reviews are currently underway. While these reviews have to some extent informed current strategies for AOD services the great majority of review findings have been subsumed by still further review activity. In this way review has stifled reform rather than being the springboard to improvement.

The poor track record of acting on review findings has resulted in scepticism among service providers about the current suite of reform projects for the program. Despite this, the staff and management of AOD services are a committed workforce who continue to perform a difficult role.

As was the case at the inception of the new AOD program, the service sector continues to face a number of important issues that require a whole-of-system response, including improving access to and quality of services, coordination and integration with other human and health services, demand driven by population growth, prevention strategies, and measuring performance. A real commitment to implement long overdue reforms is required.

Findings

Prevention

Around $25 million is spent each year on prevention. However, there is confusion within the sector about what constitutes prevention in the AOD context. The department's intention would be clearer if it had a prevention strategy to describe to stakeholders the kinds of activities which can lead to prevention outcomes. Despite calls for this since 2000, no such strategy exists.

Further, there is a lack of coherence in what has been funded. Projects are discrete, not complementary and they have not been sustained and integrated.

Treatment

Challenges identified at the establishment of the current AOD service system in 1997 were listed as issues which 10 years later continue to be addressed in the department's latest reform plan, *A new blueprint for alcohol and other drug treatment services 2009–2013.* These include:

- the fragmentation of a treatment response made up of numerous service providers, rather than a coordinated system
- significant access barriers facing those who need the system
- different standards across services and workforce development needs.

The audit confirmed these issues and also found the department's monitoring of services to be poor. In effect, the department cannot show how well services are delivered on the ground.

Funding model and effectiveness of treatment

The funding model for treatment services is based on the department purchasing outputs in the form of a specified target number of client episodes of care (EOC), or completed courses of treatment, from service providers. Each EOC has a set unit price which is historically based. Due to changes over time, unit prices have lost their relationship with the real costs of service delivery.

The EOC-based funding model promotes episodic and fragmented service responses to clients. This is inconsistent with the underlying objectives of the AOD program which focus on continuity of care. The EOC was designed to allow clinicians the discretion to provide multiple episodes of care because of the chronic and relapsing nature of addiction. The department acknowledged that the conceptual confusion within the sector over the use of the EOC as both a performance and funding measure creates uncertainty and ambiguity about its use, resulting in inconsistent outcomes for clients.

The need to achieve EOC targets creates incentives for service providers to manipulate or 'game' the system. There is evidence that service providers 're-episode' clients by closing a course of treatment for a client, recording an EOC and then immediately opening a new course of treatment for the same client in the same service type. There may be clinical considerations for closing and reopening an EOC due to the chronic and relapsing nature of addiction, however, these considerations can be compromised by the imperative for agencies to meet their EOC targets. The under-costing of EOC unit prices may also be a factor.

One result of this manipulation is a system which appears successful because it greatly exceeds its activity targets. In 2009–10 the target of 31 085 for successful courses of treatment was exceeded by nearly 40 per cent. However, up to 70 per cent of clients in the AOD service system at any one time, are repeat clients. While this phenomenon is primarily due to the chronic and relapsing nature of addiction, it is also partly due to the funding model.

A fragmented system

The objectives for the service system focus on effective case management, continuity of care for clients and, where possible, services tailored to a client's specific needs.

Notwithstanding these objectives, there are 19 different funded service types in the AOD service system and 105 funded service providers responsible for delivering treatment, many of whom are small and can only offer a limited number of treatment types. The result is a highly complex and fragmented system, which is difficult for clients to understand and navigate.

The lack of service integration makes it difficult for clients to move between different service providers and types of treatment and also makes it difficult for services to offer responses tailored to individuals.

Ease of getting help

Access can be measured by how easy it is for a prospective client to enter and negotiate the AOD service system and by waiting times. The department's reported waiting times for residential-based treatment have doubled since 2005–06.

The reported waiting times also understate the client's experience of the time it takes to access the system. The department's measure starts from the date a client is first assessed by a service provider. However, from the clients' perspective the wait time commences when they first contact a service seeking treatment.

As the department's allocation of resources for AOD services across the state is largely historically based, it does not align with current demand or address considerations of equity of access. In addition, particular groups, including culturally and linguistically diverse communities, continue to have a low uptake of treatment services.

Service types and mix

The department has not acted on recommendations to change its service mix to reflect available evidence and expert advice on how best to meet community needs. An issue consistently raised by the sector and independent experts during the audit was that the current service system reflects what was put in place in 1997, while client needs, and the complexity and patterns of substance use, have changed significantly since then.

In addition, the AOD budget has been relatively stable since 2003–04. Budget constraints make it critical that the department uses funds in the most effective way to deliver best results. However, the program has changed and grown through a range of small specialised add-on initiatives rather than through strategic decisions about how best to direct program resources as a whole. For example, the 2008–09 and 2009–10 state Budgets included additional funding for the establishment of new programs in relation to specific strategic priorities. There was no funding made available for broader system reforms.

Service quality

The department released service quality standards in 2008, 11 years after the system was established, but service providers' knowledge of these standards is patchy.

The department does not directly assess service quality against the standards in any structured way. As a result, it cannot be assured about the consistency and quality of service provider approaches and practices for key activities such as client assessment, clinical supervision and after care planning.

Having a qualified workforce is a major step towards guaranteeing service quality. The department has successfully promoted the need for sector workers to acquire AOD specific qualifications. Around 67 per cent of workers now hold such qualifications, but this is well short of the department's goal of 100 per cent.

Service performance monitoring

The department has taken steps from mid-2010 to establish a more systematic, strategic and robust approach to the monitoring of service provider performance and the use of data. Prior to this, regular quarterly reports were produced from data collected by service providers but there was little evidence that senior AOD program managers made effective use of this information.

Recommendations

Number	Recommendation	Page

1.	The Department of Health should:
	• implement a whole-of-government alcohol and other drug prevention strategy
	• deliver on the commitment to review unit prices
	• prioritise work on:
	  • the capacity of the alcohol and other drug sector to attract and retain a specialist alcohol and other drug workforce
	  • promoting careers in the alcohol and other drug sector in relevant higher education settings
	• revise its reporting requirements to address weaknesses in the use of the episode of care.
		16

2.	The Department of Health should: • revise the treatment service mix so that services funded align with need • address the inequity of the current distribution of alcohol and other drug resources • address the longstanding fragmentation and inconsistency of service provision across the 105 service providers that make up the treatment service system.	27

Recommendations – *continued*

Number	Recommendation	Page
3.	The Department of Health should: • prioritise replacement of its data collection system • implement data integrity assurance processes for information submitted by service providers • clarify responsibility for monitoring service provider compliance with service quality standards.	38
4.	The Department of Health should: • improve the performance measures used for reporting publicly on the alcohol and other drug program • take definitive action on the wealth of review recommendations.	50

Submissions and comments received

In addition to progressive engagement during the course of the audit, in accordance with section 16(3) of the *Audit Act 1994* a copy of this report was provided to the Department of Health with a request for submissions or comments.

Agency views have been considered in reaching our audit conclusions and are represented to the extent relevant and warranted in preparing this report. Their full section 16(3) submissions and comments however, are included in Appendix F.

1 Background

1.1 Introduction

Harmful drug and alcohol use is a major social issue. Community concern has focused recently on drug and alcohol related crime and violence, and the effects of harmful use, particularly on children and young people. Increased alcohol use among the population generally, and young people in particular, is of concern. Young men and women are now drinking at more dangerous levels through binge behaviour than ever before.

Estimates from 2004–05 suggest that the cost of harmful drug and alcohol use in Victoria is about $14 billion annually. This includes the costs of healthcare, crime, road accidents and injuries, decreased economic participation and lost productivity.

More than 27 000 Victorians enter government-funded specialist alcohol and other drug (AOD) treatment programs each year, and over 77 000 were hospitalised for related conditions in 2006–07. Current treatment philosophy focuses on encouraging behaviour change to reduce the harms from problematic drug use, while recognising that addiction is a chronic condition needing management of episodic relapses.

1.1.1 The basis for government policy

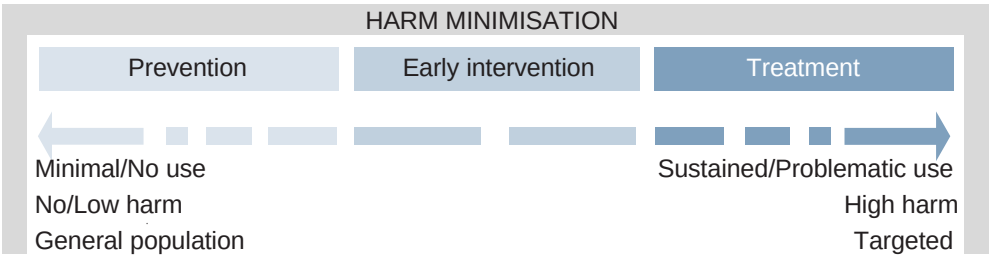
The Department of Health's (the department) goal for AOD services and interventions in Victoria is:

To prevent and reduce the harms to individuals, families and communities associated with alcohol and other drug misuse by providing appropriate, timely, high quality, and integrated services that help people to address their substance use issues and participate fully in the social and economic life of the Victorian community.

The response to AOD use is based on the principle of harm minimisation. Harm minimisation aims to reduce the adverse health, social and economic consequences of misuse of AOD. It assumes that, as AOD use will continue to be part of our society to some extent, the best approach to addressing the associated problems is to identify the harms to individuals and the community and implement strategies to minimise them.

Interventions in the AOD field range from prevention of AOD misuse, through early intervention for those using AOD, to treatment of those who have developed a dependency. Figure 1A sets out the range of AOD interventions within the harm minimisation context.

Figure 1A
Alcohol and drug interventions



Source: Victorian Auditor-General's Office.

1.1.2 Administration and funding

The department is responsible for the management and oversight of the state's AOD program. Its Mental Health, Drugs and Regions division is responsible for policy, planning, strategy and programs. The programs deliver prevention initiatives aimed at the general community as well as early interventions, treatment and support for people experiencing substance misuse and their carers, family members or significant others.

The department's eight regional offices oversee local program delivery by service providers. Service providers are community sector organisations, community health services and health services funded through service agreements with the department.

The department's 2010–11 budget for drug and alcohol prevention and treatment services is $135.7 million, about 1 per cent of the department's total budget. The base funding of the AOD program is $95 million. This is supplemented by $40 million of other funding which is tied to specific initiatives under the Victorian Drug Strategy and the *Victorian Alcohol Action Plan*.

1.2 The service delivery framework

In the late 1980s, a new approach to health and welfare services emerged based on 'deinstitutionalisation' and 'normalisation'. Clinicians and governments here and overseas began to accept that smaller services in community-based settings could be more efficient and improve both patient access and outcomes.

In 1994 the then government began 'deinstitutionalising' and redeveloping the AOD system. Specialist youth services were added to the system in 1996 on the recommendation of the Premier's Drug Advisory Council in its *Drugs and our Community* report that year, now known as the 'Penington Review'.

The redevelopment of the AOD system culminated in 1997 with the release of *Victoria's Alcohol and Drug Treatment Services – The Framework for Service Delivery*. The 1997 framework set out AOD service system components and how they would be funded and managed across the state. Core AOD treatment types included withdrawal, counselling and support, residential rehabilitation and specialist methadone services. Funds previously invested in state-run institutions were used to buy these and other services from service providers through competitive tendering.

The 1997 framework remains the basis for the current service system. A key objective of the framework was to establish a single coherent specialist drug and alcohol service system capable of delivering services to a consistent standard. Yet, given that since 1994, service delivery had shifted to a large number of service providers of varying sizes and philosophies, achieving the aims of the 1997 framework was always going to be inherently challenging.

As heroin related deaths rose in 1999, community concern mounted over the issue, leading to the establishment of the Drug Policy Expert Committee in November 1999. Following this committee's recommendations, the state invested more in prevention and family-related services, established primary health services in known drug 'hotspot' areas in metropolitan Melbourne and increased the number of beds for those withdrawing from addiction.

In 2007, all residential resources and beds, which had originally been allocated on a regional basis were designated as 'statewide' and therefore available to clients from anywhere across the state. This was intended to improve service access and efficiency. Apart from a range of specialised add-on initiatives and service responses, the core AOD service system is largely unchanged since 1997.

The department has developed a number of strategies to guide management of the AOD service system. The most recent is *A new blueprint for alcohol and other drug treatment services 2009–2013* (the Blueprint), which sets out reform priorities and investment decisions for the AOD service system.

1.3 The service system

The AOD program funds service providers to deliver treatments, education and training, research and some prevention activities. Most providers deliver treatments.

1.3.1 Prevention

In the 2010–11 Budget, $25.5 million was allocated to prevention, representing 19 per cent of the overall AOD budget.

Prevention refers to measures that prevent or delay the onset of drug use as well as measures that protect against risk and prevent and reduce harm associated with drug use and supply.

The department describes effective AOD prevention and early interventions in the Blueprint as:

Addressing problematic behaviours before they become entrenched and empowering people to make the necessary changes that will improve their health and wellbeing.

Prevention activities can include project-based social marketing such as media campaigns, drug education, parenting support and activities designed to enhance community awareness and connectedness. Appendix A includes a list of prevention initiatives. Early interventions can include general practitioner (GP) advice or internet and telephone helpline services.

1.3.2 Treatment services

In the 2010–11 Budget, $110.2 million was allocated to drug treatment and rehabilitation, representing 81 per cent of the overall AOD budget.

There are 105 state-funded AOD treatment service providers varying in size and type from large organisations receiving millions of dollars per year to smaller providers receiving a few thousand.

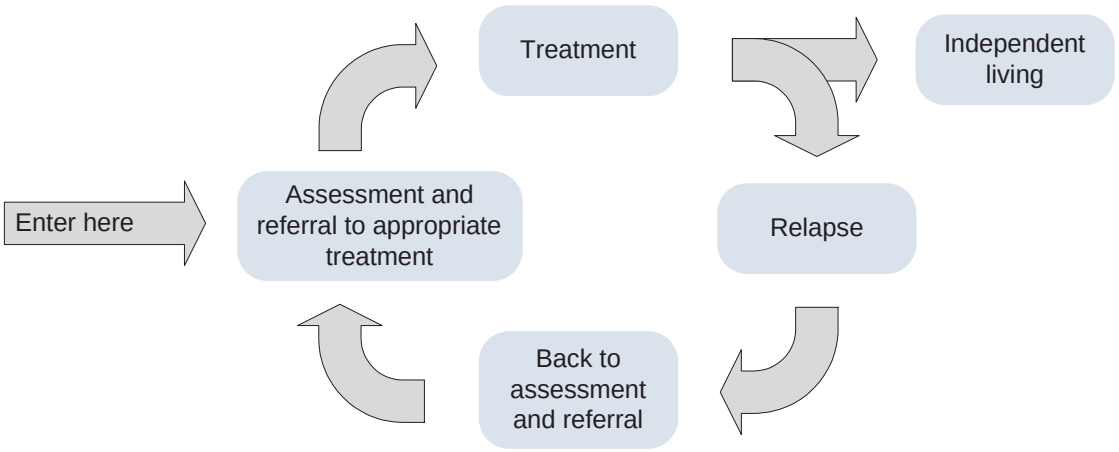
Different service providers have different philosophies. Some believe abstinence is the only successful treatment outcome. Others see minimising harm to the individual as treatment success. There are 19 different types of AOD treatment interventions offered to about 27 000 people each year. There are specialist services for young people, women and Indigenous clients. Appendix B provides a listing and explanation of service treatment types.

AOD treatment covers brief or early interventions and outreach; one-to-one counselling; and short, medium and long residential stays of between seven days and 12 months. The service treatment settings range from rural and metropolitan health services or community health centres, to independent non-government organisations.

New clients access AOD services voluntarily by self-referral or through a referral from another AOD service or a GP. Services also see clients referred from the criminal justice system.

Figure 1B provides an overview of the service system.

Figure 1B
AOD service system



Source: Victorian Auditor-General's Office.

AOD treatment service providers assess each client and develop an individual treatment plan. Following a treatment episode, a client may be referred to other treatments or services or leave the service system. The nature of addiction means that relapse often occurs. However the treatment system is based on the premise that, with effective behaviour interventions, relapses will be less frequent and/or less severe.

Client profile

An understanding of the clients accessing treatment services is important for service planning and for identifying potential gaps in services. Department information from 2009–10 show the following profile for clients of treatment services:

- two-thirds were male
- most clients were between 15 and 39 years
- about one-third had dependent children
- approximately 60 per cent used a service in the metropolitan area
- 78 per cent identified as being Australian, with less than 4 per cent as Indigenous
- 6 per cent were homeless.

The main drugs of dependency reported by clients in the system in the final quarter of 2009–10 were:

- **alcohol**—48.6 per cent
- **cannabis**—22.3 per cent
- **heroin**—13.0 per cent
- **amphetamines**—6.0 per cent.

Over half of all clients reported using multiple drugs, which is referred to as ‘poly drug’ use.

The instance of clients presenting with an addiction and a mental illness, also called co-morbidity or dual diagnosis, is increasingly common. Thirty per cent of clients present with a dual diagnosis. Treatment of clients with a dual diagnosis is generally more complex, often requiring longer treatment times and specially trained clinicians.

Family members and significant others of a drug user can also get support from AOD services through family counselling and online or telephone support. Treatment involving family members has been shown to improve outcomes for the client. Family counselling is a relatively small program receiving $700 000 in funding in 2009–10.

1.4 Audit objective and scope

1.4.1 Audit objective

The objective of the audit was to examine the effectiveness of drug and alcohol prevention and treatment services overseen by the Department of Health. It reviewed the department's planning, coordination and management activities, focusing on whether it has reasonable assurance that:

- the service model is based on sound evidence and is consistent with relevant whole-of-Victorian-government strategies
- services and service providers are delivering a consistent and appropriate level of service quality
- services are accessible to those who need them, when they need them
- services are delivering the desired outcomes.

1.4.2 Audit scope

This audit examined planning and coordination activities carried out by the department, in particular the Mental Health, Drugs and Regions division and its organisational predecessors where applicable. These include the former Department of Human Services.

It examined a cross-section of the department's regional offices and funded service providers. The cross-section of 12 service providers covered:

- large and small providers
- different service types
- metropolitan and regional areas.

The audit also reviewed data collection and reporting requirements for service providers, to assess the efficiency and effectiveness of the department's monitoring and review activities.

Two service user forums with AOD service clients were conducted as part of the audit covering metropolitan and regional clients.

1.5 Structure of report

The rest of this report is structured as follows:

- Part 2 examines resource management
- Part 3 examines the treatment service system
- Part 4 examines the effectiveness of monitoring of treatment service providers
- Part 5 examines performance reporting and review.

1.6 Audit method and cost

The audit was performed in accordance with the Australian Auditing and Assurance Standards. The total cost of the audit was $470 000.

2 Resource management

At a glance

Background

The Department of Health (the department) is responsible for allocating resources for alcohol and other drug (AOD) prevention activities and treatment services. Effective resource management means having the right skills and services in place, doing the right things at the right time.

Conclusions

Available resources have not been actively managed to respond effectively to changes in client needs. The funding model for treatment services emphasises episodic intervention rather than continuity of care which is inconsistent with the underlying objectives of the AOD program.

Findings

- Additional funding received for the AOD program since 2000 has been tied to specific initiatives, constraining the department's ability to re-allocate it to address new or changing needs.
- Unit prices for treatment services have not been regularly reviewed to keep pace with increasing client complexity and costs of service delivery.
- The allocation of prevention funding is not informed by a strategy.
- The proportion of the treatment workforce with AOD specific qualifications has increased to around 67 per cent, but this is well short of the goal for all workers to have such qualifications. Notwithstanding this, 97 per cent of the workforce hold some form of formal qualification.

Recommendation

The Department of Health should:

- implement a whole-of-government alcohol and other drug prevention strategy
- deliver on the commitment to review unit prices
- prioritise work on:
  - the capacity of the AOD sector to attract and retain a specialist AOD workforce
  - promoting careers in the AOD sector in relevant higher education settings
- revise its reporting requirements to address weaknesses in the use of the episode of care.

2.1 Introduction

Allocation of resources in a complex service system, such as the alcohol and other drug (AOD) system, should be guided by policies and planning which are evidence-based and responsive to the needs of the target group.

This part looks at how the Department of Health (the department) manages resource allocation, the funding model for treatment services, and the specialist AOD treatment workforce.

2.2 Conclusions

The relatively stable AOD funding over the last seven years has resulted in minimal direct expansion of the service system, despite a growing population and demand for services. Where additional funding has been provided for the AOD program since 2000, it has been tied to specific initiatives, constraining the department's ability to re-allocate it strategically to address new or changing needs.

There is little assurance that the funding allocations between prevention and treatment options represent an optimal resource mix. The allocation of prevention funding is not guided by a strategy designed to meet prevention objectives.

The funding model for treatment services emphasises episodic intervention. This is inconsistent with the underlying objectives of the AOD program which focus on continuity of care.

Unit prices for treatment are also historically based and need review to reflect changes in client complexity and the costs of service delivery.

While the department has successfully promoted the uptake of AOD qualifications among the sector workforce, it has yet to achieve its aim of a consistent minimum qualification level across the whole AOD workforce. The department's new AOD workforce development strategy needs to move beyond minimum qualifications to professional registration systems and career pathways.

2.3 Resource allocation

State funding for the AOD program is $135.7 million in 2010–11. This includes funding from the Commonwealth for a needle and syringe exchange program, and the diversion of clients from the criminal justice system into drug treatment services.

Departmental analysis indicates that real per capita funding for drug and alcohol services decreased between 2006–07 and 2009–10 from $32 to $29 per head. Additional funding provided as part of the 2010–11 budget reversed this trend.

Additional funding has been provided periodically since 2000, but was tied to specific initiatives.

2.3.1 Allocating new resources

The tied nature of new AOD funding provided periodically, limits the department's ability to distribute these additional resources strategically across the system as a whole, allowing only highly specialised additions to the system.

Tied funding enabled Acquired Brain Injury AOD clinician positions to be created in 2006, and youth-specific dual diagnosis workers in homeless shelters to be introduced in 2009–10.

Of the $37.2 million in total funding committed under the Victorian Alcohol Action Plan, the department was allocated $14.4 million over four years for AOD services. This funding was for specific initiatives including; a community awareness campaign, new online and telephone screening and self-help resources for people at risk of harm from alcohol, and new and additional treatment responses.

Obtaining an additional $14 million in funding over four years in the 2010–11 Budget for counselling teams in metropolitan growth areas was positive. However, the funding was for a specific treatment type in specific areas, limiting the type and location of service response, and constraining the department's ability to re-allocate it to address new or changing needs.

An additional risk facing the department is that approximately $40 million, or 30 per cent, of the 2010–11 budget for AOD services is non-recurrent and due to sunset at the end of 2010–11. This funding was sourced largely from the Community Support Fund as part of the Victorian Government's Drug Initiative launched in 2000.

2.4 Funding prevention

Nineteen per cent of the overall AOD budget, $25.5 million, is allocated to what is described as 'drug prevention and control' activities in 2010–11. The department directs these funds to education and prevention initiatives, early interventions and the regulation of controlled substances and poisons, including pharmacotherapies.

The concept of prevention is understood in different ways by the department and the AOD sector. The department produced *A new blueprint for alcohol and other drug treatment services 2009–2013* (the Blueprint) which describes effective prevention and early intervention as 'addressing problematic behaviours before they become entrenched, and empowering people to make the necessary changes that will improve their health and wellbeing'.

Discussion with departmental staff and service providers reveals differing views on what 'prevention' covers and the extent to which this should be used to deter uptake as opposed to being directed towards people with advanced or established drug use behaviours to prevent further harm.

Public reporting on the performance of prevention activities includes indicators relating to treating and reducing the harm created by advanced drug use—such as the processing of pharmacotherapy permits and participation in peer education for injecting drug users. The reporting lacks indicators relating to activities focused on prevention and early intervention before entrenched drug use becomes established.

To resolve the ambiguity about where prevention activities start and stop implicit in public reporting, a clearer description is needed of where the allocation of prevention resources sits within the context of the AOD program. Greater clarity would be achieved if the department's prevention and early intervention activities were guided by an evidence-based prevention strategy.

Strategic guidance of prevention resource allocation

A central recommendation of the Drug Policy Expert Committee's stage two report in 2000 was that the 'Victorian government introduce a comprehensive drug prevention strategy' to complement and support a broader drug strategy. The report noted the importance of having integrated and sustained interventions and programs, as well as the risks in uncoordinated or short-term initiatives.

The then government committed to the development of a whole-of-government alcohol and drug prevention strategy in 2006 and again in the Blueprint. The department has yet to develop that prevention strategy. Progress to date includes the delivery of the *Whole-of-Government Alcohol and Drug Prevention Framework* to the Minister for Mental Health by the Victorian Drug and Alcohol Prevention Council (VDAPC) in February 2010. The purpose of this framework is to help progress a prevention strategy. The department advised that VDAPC delayed its advice on the prevention framework for around six months to ensure it aligned, where possible, with the National Preventative Health Taskforce's National Prevention Strategy, released in September 2009.

The prevention framework describes a range of possible actions that could be included in a future drug prevention strategy. These include regulatory changes to limit supply and strengthening early interventions in primary health to reduce demand. However VDAPC's role and the actions proposed in the framework take a whole-of-government approach and extend beyond the range of the AOD program. The department has not considered how its prevention resources could be more effectively invested within that context.

2.5 Funding treatment

The department uses a purchaser-provider model to pay for the delivery of AOD services. It purchases outputs from service providers in the form of a specified number of episodes of care (EOC) in defined service types.

2.5.1 EOC funding model for treatment services

The EOC is the primary basis for funding and measuring the performance of AOD service providers. There is a department determined unit price per EOC for each service type and the department purchases target numbers of EOCs from service providers for defined service activities such as counselling or drug withdrawal support.

EOC activity targets set for providers create 'perverse' incentives for them to prematurely close EOCs either by opting for shorter, fragmented or partial responses to client needs; or by recording multiple continuous EOCs for the same client in the same service type, in order to meet targets and retain funding levels.

In this way, the EOC service model promotes episodic and fragmented service responses to clients. This is inconsistent with the underlying objectives of the AOD program which focus on continuity of care.

2.5.2 Unit prices

There is no longer a clear link between the unit prices paid to service providers and the costs of service delivery.

While indexed annually since 2003, unit prices have not been otherwise adjusted. Changes over time to models of service delivery, workforce composition, staff qualifications, service standards, accreditation requirements and growing client complexity, have driven up the cost of service provision. Concerns raised by the sector include the extent to which unit prices adequately recognise growing client complexity, which requires more intensive and time-consuming service responses. The assumptions used to determine the unit prices for each service type have not been reviewed since the late 1990s.

In 2010 the department released a unit price for five new counselling, consultancy and continuing care (CCCC) teams in growth corridors. The prices are significantly above the unit price for other funded CCCC services. The department explained this as reflecting the requirement for the new teams to provide a more therapeutic treatment approach. It is not clear why this is only required in growth areas. When compared to the existing unit price for CCCC services, the new unit price has a higher component for program overheads, which are unrelated to direct service delivery.

The Victorian Alcohol and Drug Association, the peak body for AOD service providers, has repeatedly questioned the adequacy of unit prices and recently reviewed the unit price for CCCC services. It identified a shortfall of up to 18 per cent in the department's unit price for this treatment type. The methodology used to arrive at this result was sound.

The department has committed to two projects in relation to AOD funding:

- a unit price review committed to in May 2010, but not commenced
- a funding models project, commenced in early 2009, to assess the funding models for delivery of mental health and AOD services. The project is on hold and the department advised it will be revisited in early 2011.

2.5.3 Managing demand growth

The relatively stable AOD funding over the last seven years has resulted in minimal direct expansion of the service system, despite a growing population and demand for services. The department and service providers have responded with a range of measures to manage growing demand within available funding.

At a systemic level, in 2007 the department reassigned all residential services as 'statewide', meaning that clients are able to access bed-based services anywhere in the state regardless of where they live. Previously, residential beds had been allocated on a regional basis meaning that, for example, clients in the Gippsland Region needed to travel to an adjoining region to access residential withdrawal.

The department's analysis of projected population growth in Melbourne's growth corridors predicts a 39 per cent increase in the number of people seeking to access AOD services in those areas over the next 10 years. This issue was responded to in the 2010–11 Budget which included new funding of $14.1 million over four years to provide five new AOD CCCC teams in Melbourne's growth corridors.

At a service provider level, agencies have a range of ways to manage the demand for services on a day-to-day basis including:

- an increasing trend to co-locate staff in other agencies or services to meet demand in specific locations. For example, locating AOD counselling staff at a community health service one day a week. While encouraged by the department, this approach does not attract additional funding despite involving additional vehicle and travel time costs for service providers.
- running group sessions for clients. Participants in service user forums undertaken for the audit discussed the benefits and value they perceive from their involvement in group work with peers.

Discussions with service providers revealed a level of confusion about whether the department allows group work. The department advised that it is allowable so long as it is accompanied by some one-on-one counselling with individual clients.

2.6 The specialist AOD treatment workforce

The majority of AOD treatment funding goes towards salary for the AOD treatment workforce. There are around 1 000 state-funded AOD treatment positions. The quality and effectiveness of AOD treatment services largely depends on the staff who counsel, treat, rehabilitate and support clients.

The AOD treatment workforce needs an appropriate mix of skills, qualifications and experience, ranging from trained AOD peer support workers to psychologists and addiction medicine specialists, to meet the increasingly complex needs of AOD clients.

2.6.1 Retaining a quality AOD treatment workforce

The department has successfully encouraged an increased proportion of the workforce to acquire minimum AOD qualifications but still falls short of its goal of the entire treatment workforce holding such qualifications.

In 2004 the department issued a minimum qualification strategy (MQS) for the AOD sector, which came into effect on 1 July 2006. The aim of this strategy was to develop a consistently competent and professional AOD workforce. The MQS applied to all AOD treatment workers funded by the department. It required them to have a qualification equivalent to, or above, the Australian Qualifications Framework Certificate IV in Alcohol and Other Drugs Work.

The department does not have complete data on the proportion of AOD workers with AOD specific qualifications.

A 2009 AOD workforce census attracted responses from around 70 per cent of the workforce. It showed that 67 per cent of respondents held qualifications specialising in AOD or addiction studies, and 30 per cent held qualifications in another specialisation. Overall, only 3 per cent of respondents had no formal qualifications.

Pay differences with other sectors and across jurisdictions mean that the AOD sector has difficulty competing for, attracting, and retaining staff. This is particularly true for more qualified workers.

At the entry level, AOD workers with a TAFE qualification or a three-year degree course, are paid more than equivalently qualified workers in the mental health workforce, demonstrating that there is no financial disincentive for graduates to enter the sector. However, remuneration for mental health workers is higher for a four-year degree or more, and for longer service. This disparity can encourage AOD workers to leave the sector for a higher paid position in another sector, after gaining a few years experience.

The AOD workforce census found that about a quarter of the workforce had two or less years experience in the sector. Unless addressed, the pay disparity across sectors has the potential to undo the progress made in encouraging a greater number of more highly qualified AOD workers.

The department is participating in National AOD workforce development planning.

The department's new AOD workforce development strategy needs to build on past achievements by addressing key findings and issues arising from recent reviews of the AOD workforce, in particular professional registration systems and career pathways. An established career path in the AOD sector would encourage AOD workers and clinicians to stay in the sector, gradually increasing the skill levels and professionalism of the workforce as a whole.

Recommendation

1. The Department of Health should:
   - implement a whole-of-government alcohol and other drug prevention strategy
   - deliver on the commitment to review unit prices
   - prioritise work on:
     - the capacity of the alcohol and other drug sector to attract and retain a specialist alcohol and other drug workforce
     - promoting careers in the alcohol and other drug sector in relevant higher education settings
   - revise its reporting requirements to address weaknesses in the use of the episode of care.

3 The treatment service system

At a glance

Background

More than 27 000 people access alcohol and other drug (AOD) treatment services each year. The service system is complex, as are the problems it seeks to address. Accordingly, for services to assist clients achieve positive outcomes they need to be accessible, integrated and consistent.

Conclusions

The treatment service system has changed little since its introduction in 1997 and has not kept pace with changing community needs. In addition, the complexity of the service system hampers accessibility for clients.

Findings

- The static service mix limits service system responsiveness and flexibility.
- The distribution of AOD resources across the state is not routinely examined for equity and available evidence suggests a lack of equity in the current distribution.
- Lack of information about services is one of a number of barriers to service access for those in need of treatment, including culturally and linguistically diverse groups.
- Longstanding fragmentation and inconsistency in the system have not been addressed.

Recommendation

The Department of Health should:

- revise the treatment service mix so that services funded align with need
- address the inequity of the current distribution of AOD resources
- address the longstanding fragmentation and inconsistency of service provision across the 105 service providers that make up the treatment service system.

3.1 Introduction

The costs to individuals and the community from the misuse of alcohol and other drugs (AOD) are significant. The 2010–11 investment in AOD services of $135.7 million is small when compared with the estimated cost to the community of $14 billion a year.

The AOD service system is complex, involving 105 service providers across the state delivering a broad range of services. The problems it seeks to address are also complex with AOD misuse and addiction recognised as a chronic relapsing condition.

This part focuses on the performance of the AOD service system including the extent to which services are accessible, integrated and consistent across the state.

3.2 Conclusions

The treatment service system introduced in 1997 was innovative in design. However, 13 years later it has not achieved its objectives of effective case management, continuity of care for clients and, where possible, tailoring services to a client's specific needs. The service mix has remained largely unchanged since 1997 and has not responded adequately to changing community needs.

Pathways into, through, and beyond treatment are not clear or seamless. Accessing the system is difficult, with a lack of information about AOD services as one barrier which is compounded by a system made up of many treatment types and providers, who deal inconsistently with clients.

The AOD treatment system is fragmented because services are not well integrated or connected to each other or to the other welfare, health and employment systems needed to support clients with complex needs.

The emphasis on episodic intervention rather than continuity of care runs counter to the underlying objectives of the system and the principles for effective treatment of the problems it seeks to address.

3.3 Service access

The 2005 version of the *Growing Victoria Together* policy statement noted the importance of achieving better access to alcohol and drug services, particularly in rural and regional communities.

To assess whether the department has reasonable assurance that services are accessible to those who need them, when they need them, the audit looked at the equity and timeliness of access, barriers to access and access by smaller cohorts of the population. The audit identified that:

- AOD resources are not equitably distributed across the state
- a lack of information about AOD services is cited by service users as one of the greatest barriers to access
- service use by culturally and linguistically diverse (CALD) groups is disproportionately low
- longstanding issues and risks around maintaining sustainable access to pharmacotherapy treatment remain to be addressed.

3.3.1 Equity of access

Available evidence indicates that AOD resources are not equitably distributed across the state, but the issue of service spread is not routinely examined by the department.

In 1997–98 when the service system was developed, each region received a share of state AOD funding based on evidence about their population, social and demographic features and other equity considerations. However, since then the department has not maintained the population-based approach to the distribution of funding for AOD treatment services. It does not regularly analyse funding distribution by service type and region in terms of population and evidence of service demand or changes in the patterns of substance use by clients.

Analysis of the current distribution of AOD services by region, undertaken as part of a recent review of the service system, showed that the rate of funding per 1 000 population ranged from 4.57 treatment ‘episodes’ in the Eastern Metropolitan Region to 11.67 in the Loddon Mallee Region. The disparity arises because funding is still based on historical patterns of service distribution which included weightings for rural and regional and socio-demographic factors. The department advised that additional funding since 1997 has targeted high needs areas and most recently focused on population growth corridors.

A report commissioned by the department and finalised in April 2010 identified that access to residential withdrawal, residential rehabilitation and pharmacotherapy services is difficult for people in rural and regional areas. For example, there are no residential withdrawal beds located in the Gippsland Region, meaning clients are required to travel to Melbourne for treatment.

For clients located in outer metropolitan Melbourne there can also be access issues as all AOD residential withdrawal services are located within 15 kilometres of the city. In 2009, the department prepared an unsuccessful business case for the development of an AOD extended stay treatment centre in Melbourne’s northern growth corridor.

3.3.2 Timely access

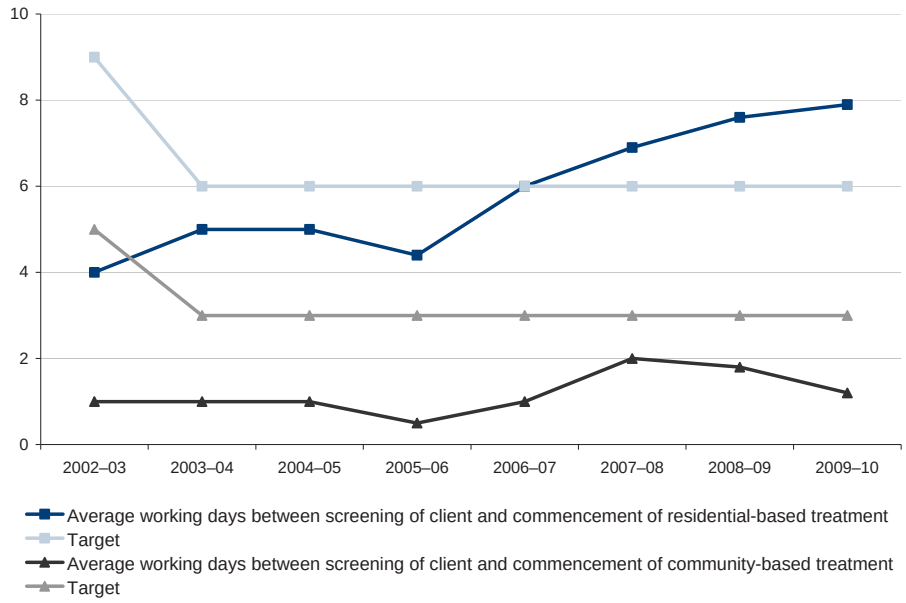
The timeliness of client access to services is monitored by using waiting times. The department defines waiting time as the average number of working days between the screening assessment of a client by a service provider and the commencement of the relevant treatment. The screening assessment typically takes place some time after a client first makes contact with a service provider seeking treatment.

Service providers indicated that the department's method of measuring waiting time is not a fair indicator of demand and waiting times. One of the issues raised by service providers in submissions to the department in response to its discussion paper for the *Amphetamine-type stimulant and related drugs strategy 2009–2012* was that clients may wait up to three months to be screened by a service.

The departmental waiting time target for access to residential-based treatment is an average of six working days and the target for access to community-based treatment is an average of three working days. Figure 3A shows the waiting times for these AOD treatments publicly reported by the department for the last eight years, against the related targets. Since 2005–06, waiting times for residential-based treatment have nearly doubled and those for community-based treatment have also increased.

Clients can wait up to three months, particularly for residential services, between first contact with a service and commencing appropriate treatment. The department expects clients to receive some service and support while waiting, such as counselling or engagement with support groups.

Figure 3A
Publicly reported waiting times for residential and community AOD treatment



Source: Victorian Auditor-General's Office based on data reported in *Budget Paper 3.*

The current system allows clients to approach a number of residential services at one time which can inflate waiting lists. *A new blueprint for alcohol and other drug treatment services 2009–2013* (the Blueprint) identified the need for a centralised residential treatment access model to be developed to streamline and ensure fair and equitable access. The department developed a proposal to address this issue in 2009–10 and will pursue this as part of broader reform of the program.

The audit found no evidence of regular or systematic collection and analysis of waiting time data by service type and service provider on a per region basis.

Waiting extended periods can impact adversely on outcomes for people seeking access to AOD services and their families—they may be in crisis. Figure 3B includes comments made by service users on wait times and related issues in focus groups conducted as part of the audit.

Figure 3B
Comments from service user forums

'You call in crisis and then wait a couple of weeks to see someone and then wait again after that. I did detox in January and had to wait 6–7 weeks to get into rehab, which meant I ended up having to do another detox before that, which is crazy.' Metropolitan service user.

'Although the wait list varies, you almost have to ring up every day and hassle them to get in.' Rural service user.

'People help in the time that you see them, but there is no help while you are waiting.' Metropolitan service user.

'On average it'll be 1.5 month wait, but once you're ready for withdrawal, you're ready and you don't want to have to wait. If you hear there will be that long a wait it puts you off.' Rural service user.

Source: Victorian Auditor-General's Office.

3.3.3 Barriers to access identified by service users

Clients of AOD services can be among the most disadvantaged in the community, with unstable living environments, and multiple complex physical and mental health conditions. Often, they have had contact with the criminal justice system in addition to experiencing substance use. Navigating entry into the AOD service system should be easy but in reality this is not the case.

Service users consulted as part of the audit identified a lack of information about AOD services as one of the greatest barriers to access. A number spoke about their experience of only finding out about the existence of services through peers and family members, a process which in some cases could take years and is reliant on a degree of luck. Service users also reported a lack of knowledge among general practitioners (GP) of what AOD services are available.

3.3.4 Access by under-represented groups

Service use by CALD groups is disproportionately low. Almost a quarter, 23.8 per cent, of Victoria's population was born overseas and almost half, 43.7 per cent, have a parent who was born overseas. Data gathered from AOD service providers indicates that less than 20 per cent of clients accessing services identify themselves as from a CALD background in terms of their place of birth. Trend analysis on this data shows little change over time.

Services visited as part of the audit reported difficulties establishing and maintaining links with CALD groups. Successful engagement was generally achieved by gaining the trust of relevant community leaders.

Overcoming barriers to AOD service access by CALD groups has been a goal of the department since 1997. Over the past 10 years the department has implemented a range of programs and initiatives, and research and training activities for the sector aimed at improving service access for Indigenous and CALD communities.

However, the Blueprint document raised CALD access as an issue still requiring attention. The Blueprint committed the department to developing a multicultural strategy for alcohol and other drug treatment services by the end of 2010 to assist in improving access for CALD people to information, support and treatment services. A draft CALD strategy has been developed by the department.

3.3.5 Barriers to accessing pharmacotherapy treatment

Longstanding issues and risks around maintaining sustainable access to pharmacotherapy treatment remain to be addressed.

Pharmacotherapy treatment is provided to people dependent on opioids, that is, opiates such as heroin. It is also referred to as opioid replacement therapy (ORT) and involves the medically supervised replacement of an addictive opiate with a longer acting but less euphoric opiate such as methadone. The evidence base to support the efficacy of pharmacotherapies for treating opioid dependence is well established and widely accepted.

The audit identified a number of widely known barriers to accessing pharmacotherapy services, relating to the way they are managed and delivered in the current system. Findings and recommendations from three reviews—1999, 2003, 2010—commissioned by the department, demonstrate these are long standing concerns that have not been adequately resolved. The barriers consistently relate to a lack of GPs willing to prescribe and pharmacists to dispense, plus cost and access for rural clients.

Input provided by participants in metropolitan and rural service user forums supported many of the findings from reviews undertaken by the department, in particular, long waiting times to access prescribing GPs, particularly in rural areas.

The review of ORT commissioned by the department in 2010 found that over the past four years the percentage of ORT clients in Victoria increased by approximately 15 per cent to more than 13 000, while over the same period the number of GP prescribers declined by the same percentage, from an already low base, to approximately 400 active prescribers. The review found that less than 10 per cent of GPs are involved in ORT provision in Victoria in any given year. The department is considering the findings and recommendations arising from this review.

In 2009, the department commissioned localised 'rapid situational assessments' in two rural areas experiencing particular problems with the delivery of the pharmacotherapy services. The reports on these assessments are yet to be finalised.

3.4 Service integration, consistency and continuity

Clients of AOD services can face multiple disadvantages and challenges that make it difficult for them to find and access services. The Blueprint indicated that the pathways into, through and beyond treatment should be clear and seamless for clients and their families. However, the AOD service system is complex and made up of many components both in terms of treatment types and providers.

The department has not addressed longstanding fragmentation and inconsistency in the service system and this adversely affects performance. The department-commissioned reviews of the AOD service system in 2003 and 2004 found a fragmented system with variable connections to other welfare, health and employment systems required to support clients with complex needs. The reviews also highlighted concerns that service arrangements did not facilitate smooth transition of clients between AOD treatment types, potentially inhibiting continuity of care.

Subsequent reviews in 2009 and 2010 found that fragmentation of service provision in the system remains. Findings from these reviews, which are consistent with matters raised by audited service providers include:

- an emphasis in treatment plans on discrete episodes of care, directly connected to service provider funding, rather than managing the client through a care pathway
- a legacy culture of competition between service providers
- not well established referral and information sharing protocols
- a lack of integration with health and other social service sectors.

The department continues to work on fragmentation and inconsistency in the service system and there are examples of effective service integration at the regional level.

3.4.1 Service integration

Service users consulted in the audit stated that once they gained access to the service system there was a tendency for service providers to rely on personal contacts when making referrals. This meant that if the client saw a less experienced worker they were not assured of getting appropriate referrals to other services and supports.

The department has initiated and supported a range of activities intended to develop and maintain effective linkages between service providers and across program areas and sectors. These included the dual diagnosis program aimed at building shared capacity in the AOD and mental health sectors to manage clients with both AOD and mental health issues. The department has also developed service coordination tools aimed at streamlining referrals to a range of health, welfare and support services. These are accessible from the department's data collection and reporting system for AOD services. A service coordination approach has also been piloted in one region and the results were shared with the sector in 2010.

The audit identified examples of AOD staff in regional offices working with associates in other program areas in the region—such as public housing—which may share common clients with the AOD system, to raise awareness about AOD issues.

The department has also conducted surveys in the sector on the nature and extent of partnering activity and is seeking to develop further strategies to improve the engagement of AOD agencies in primary care partnerships (PCP) in their regions. PCPs are local voluntary networks of primary care providers which seek to improve the health and wellbeing of the population in their catchment by better coordinating planning and service delivery.

Local area drug plans

In 2007, a one-off allocation of $1 million was provided for developing local area AOD action plans in each of the department's five rural regions. The plans were intended to improve service quality and coordination by developing better linkages with existing PCPs.

The department has not assessed or analysed the plans to identify common themes and issues, aligned them with departmental strategies, or drawn conclusions about their effectiveness for guiding future investment.

3.4.2 Service consistency

Discussion in the service user forums held for this audit showed that clients using more than one AOD service found the approaches of service providers were inconsistent. This related mainly to approaches to initial assessments, referrals, and follow-up after treatment, particularly after a residential stay.

The department recognises the diversity of service provider models and philosophies for alcohol and other drug treatment as both a strength and a weakness of the service system. The strengths lie in the potential for innovation and flexibility among diverse service providers. However, this diversity challenges the department's capacity to be confident that the organisations it funds are offering consistent, evidence-based treatment services across the state.

The initial intake and assessment of clients is particularly important in gaining an understanding of client needs and risk factors which may warrant accelerated access to treatment or other support. The department mandates the use of two tools for client assessment, but acknowledges that the sector uses many others.

A review of existing models of treatment intake in the AOD sector commissioned by the department in 2009 found four models of intake operating. The review found there is scope for a greater standardisation and consolidation of tools, including screening, assessment and data capture. The review found that action on this would improve consistency across the sector and increase the capacity for agencies to share assessment information if required.

The department plans to review AOD assessment tools during the reform activities planned for 2011.

3.4.3 Service continuity

The department's policy and strategy documents point out that alcohol and other drug misuse and addiction is a chronic and relapsing condition, and include commitments to a system focused on clients and their continuity of care.

When a client begins treatment, the service provider records the commencement of a new 'course of treatment' and identifies the treatment goal such as reduced substance use by the client. If, at the end of a course of treatment, the client has achieved one or more of the defined significant treatment goals then the course of treatment is regarded as successful and can be recorded as a completed episode of care (EOC).

The EOC service model which links funding and service performance to the achievement of EOC targets effectively promotes fragmented service responses to clients. The EOC model does not encourage service providers to keep clients engaged and to provide them with long-term support through effective case management and continuity of care.

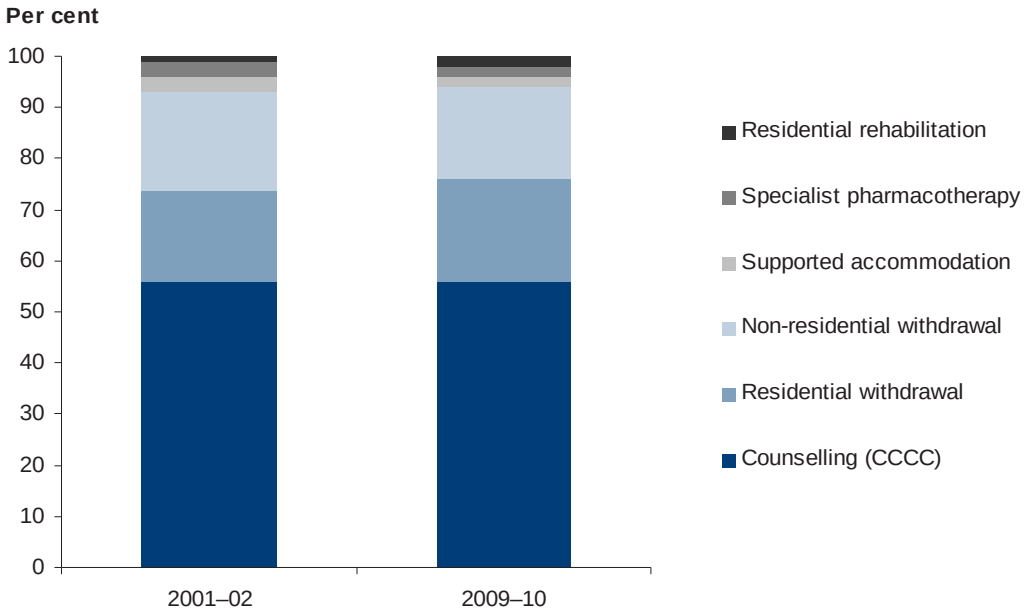
3.5 Service mix

Eighty-one per cent of the AOD budget for 2010–11, or $110.2 million, is allocated to treatment services. There are 19 different service types in the treatment system. The main service types include residential and non-residential withdrawal, residential rehabilitation, supported accommodation, pharmacotherapy, and counselling, consultancy and continuing care (CCCC). A detailed description of these and the evidence base supporting them can be found in Appendices B and C.

The current treatment system reflects what was put in place in 1997–98. The capacity of the AOD service system to respond effectively to changing community needs, as evidenced by changes in the characteristics of clients entering services, is compromised by a service mix which has remained the same despite expert advice to alter it.

Figure 3C compares the allocation of service activity targets across the six main service types in 2001–02 and 2009–10.

Figure 3C
Service mix comparison between 2001–02 and 2009–10



Note: 'Non-residential withdrawal' includes the three service types; home-based withdrawal, rural withdrawal and outpatient withdrawal.
Source: Victorian Auditor-General's Office based on Department of Health 2009–10 Alcohol and Drugs Information System data and Turning Point analysis from 2003.

Figure 3C shows that there was little change in the overall mix of services available in the treatment system between 2001–02 and 2009–10. The department did not act on recommendations received in 2003 to change the service mix by:

- disbanding the counselling, consultancy and continuing care service type and reallocating this activity to new and reconfigured service types, including locally-based central intake units, to provide the initial entry pathway and assessment of clients
- reducing the targets for withdrawal services, supported accommodation and residential rehabilitation
- increasing targets for pharmacotherapy.

An April 2010 report, commissioned by the department, recommended changes to the service mix for AOD services which were consistent with the changes recommended in 2003. These recommendations are under consideration by the department.

While the overall service mix has remained stable over a long period, the service specifications and activity targets for particular service types are also largely unchanged. For example, the 'average length of stay' implicit in existing targets for withdrawal services were devised in the mid-1990s. These targets do not align with the current evidence base, as described in AOD withdrawal practice guidelines commissioned by the department in 2009. The guidelines indicate longer withdrawal stays are warranted for certain drug types and client characteristics.

After determining the overall service mix for the system, the department allocates activity targets to service providers for each service type. Departmental data shows that some service types, including out-patient withdrawal and home-based withdrawal, consistently under-perform against their targets across state. The audit identified that where this occurs service providers use the funding provided for those under-used services to supplement funding for services in higher demand.

Central and regional office staff permit this practice as it provides some flexibility to service providers. However this undermines established accountability mechanisms. It can also prevent the department and the sector from gaining a clear picture of the treatments actually provided and reduces the department's ability to plan effectively. The department has acknowledged this issue and is investigating it further.

Recommendation

2. The Department of Health should:
   - revise the treatment service mix so that services funded align with need
   - address the inequity of the current distribution of alcohol and other drug resources
   - address the longstanding fragmentation and inconsistency of service provision across the 105 service providers that make up the treatment service system.

4 Service provider monitoring

At a glance

Background

Alcohol and other drug (AOD) treatment services are delivered by service providers across the state. The effectiveness and quality of services delivered should be monitored and managed to assure the best outcomes for clients.

Conclusion

Weaknesses in monitoring practices mean that there is not reasonable assurance that AOD services are delivering the intended outcomes.

Findings

- The commitment to actively monitor compliance with service quality standards has not been fulfilled.
- The integrity of data submitted by treatment service providers and which is used for decision-making is not assured.
- There are inherent data reliability problems with the legacy AOD data collection system.
- Steps taken in 2010 to improve the rigour of data collection and performance monitoring promise to address these weaknesses.

Recommendation

The Department of Health should:

- prioritise replacement of its data collection system
- implement data integrity assurance processes for information submitted by service providers
- clarify responsibility for monitoring service provider compliance with service quality standards.

4.1 Introduction

The delivery of alcohol and other drug (AOD) treatment services is contracted out by the Department of Health (the department) to 105 service providers located around the state.

It is important that the department effectively monitors performance, both in terms of the number of services provided against targets, and the quality of services, to assure the best outcomes for clients. Performance monitoring focuses on measuring and counting activity and outputs, while quality monitoring assesses performance against established standards.

The audit examined whether the department has robust arrangements to monitor service providers. It sought evidence on whether those arrangements include systems and processes capable of producing relevant and reliable data, and assurance about the performance and quality of AOD services.

4.2 Conclusions

The department does not gain reasonable assurance that providers are delivering the number of services they are funded for at an acceptable service quality. This is due to weaknesses in its data collection systems and monitoring practices.

During 2010, the department took steps to adopt a more rigorous, systematic and strategic approach to the monitoring of service provider performance, and the use of data generated from monitoring. It is too early to tell if this action has addressed previous weaknesses in these areas. Prior to this:

- monitoring the performance of service providers against service agreement targets occurred, but it was informal and inconsistent across regions, and few records were kept
- a systematic communication and reporting process between the department's central and regional offices on the monitoring of service performance could not be demonstrated.

4.3 Monitoring service provider activity

Details of expected service delivery activity are set out in a service agreement between the department and each service provider. Service providers are accountable for funding received and performance against treatment activity targets and must comply with quality standards.

4.3.1 Quality of data collected

Service providers submit quarterly performance data to the department. The department collates and reports quarterly on the performance of individual service providers against their service targets, and on regional and statewide trends in client numbers, episodes of care (EOC), service activity, client demographics and primary substance of use.

A new blueprint for alcohol and other drug treatment services 2009–2013 (the Blueprint), released in 2008, acknowledged poor data quality, and problems with the systems and methods used to monitor the performance of providers in the AOD service system.

Data collection systems

Current data collection systems and processes do not support the gathering of accurate, complete and timely information on the performance of AOD services.

Service providers record and report AOD treatment data through one of three systems:

- **Alcohol and Drugs Information System (ADIS)**—the dedicated AOD database used by most stand-alone AOD service providers, which is now a legacy system
- **Health*SMART* TRAK**—in use at most health services
- **SWITCH**—now a legacy system but still used by some service providers.

Users of Health*SMART* and SWITCH and other new systems are able to report AOD treatment data through an AOD module based on ADIS data definitions.

There have been ongoing issues with the reliability of data reported by the department's ADIS because of errors arising from service provider data entry practices, and problems with the processes used to extract data from service providers into ADIS.

Service providers included in the audit raised the following issues regarding ADIS:

- data reported by ADIS on their performance is often inaccurate
- it provides little information to them in return for the time they invest in data entry
- they cannot obtain their own information from the system for further analysis
- they consider the data is not sufficient on its own for adequate service planning
- the data does not fully reflect the work undertaken by service providers, limiting the department's ability to measure the performance of the service system.

One service provider responded to these issues by creating its own variant of ADIS that is more useful for its service management purposes while still delivering on its compliance obligations to the department. Other service providers use their own systems in parallel. The department advised that service providers have access to the same level of information that the department collects through their generated quarterly extracts. In addition, service providers can extract information for analysis at any time through the ADIS data export function and can request detailed analysis of agency data from the department.

The department accepts that there are problems with data accuracy but indicated that it does not believe they are systemic, but rather a result of some agency misinterpretation owing to:

- the department mainly reporting activity to departmental-funded EOCs only
- agencies inadvertently miscoding activity and then expecting a different outcome to what is reported.

ADIS is more than 10 years old and is now a legacy system. The department is considering options for its replacement. It has also taken steps to improve the processes used to compile service provider data into ADIS and to provide better and timelier feedback to service providers and regional offices on data errors.

Service providers gave positive feedback on the responsiveness and quality of advice and assistance provided by the department's ADIS help desk. However, service providers using Health*SMART* TRAK and SWITCH reported little support.

Data entry practices

Problematic data entry practices by service providers and the department's data extraction processes mean there are errors in reports on individual provider performance. These errors were known about and seemingly tolerated for some time. The introduction of a new data importer tool in October 2010 to identify errors for correction was a positive development. However, prior to this it was not clear to service providers or regional departmental staff whose responsibility it was to correct data errors.

The audit found:

- service providers use a variety of practices, processes and guidance material for gathering, recording and validating their service data.
- apathy among clinicians in the sector towards ADIS data entry. They see it as a compliance exercise, providing little value to agencies. They question ADIS data accuracy.
- a clear trend for agencies to close courses of treatment in the last week of each quarter and particularly at the end of each financial year. This pattern is linked to the process requiring service providers to submit data to the department on a quarterly basis. There is no clinical reason why courses of treatment would conclude in this pattern throughout the year.
- inaccurate application of the department's counting rules for recording funding sources for service activities—a persistent issue.
- practices, such as batching data entry at the end of a week, month or quarter, lead to a higher risk of data entry errors.
- training in the use of ADIS is offered by the department in response to service provider requests. However, some service providers, especially in rural areas, reported difficulty accessing this training on a timely basis for new staff. The department does not currently track attendance by agencies at ADIS training. Consequently, service providers tend to train their own staff in the use of ADIS which can result in the transfer of flawed data entry practices to new staff.

Data collation and validation processes

The Mental Health, Drugs and Regions division validates the data extracts from service providers and imports them into a central reporting database repository known as Full-ADIS. However, until recently 'valid' only meant that the data was in the right format, for example that numeric fields did not contain text. This provided no assurance that the data complied with business and counting rules or was accurate and complete.

A new 'data importer' tool deployed by the department in October 2010 not only validates the format of the data but also validates key data elements against business rules. For example, it checks whether year of birth is not less than 1900, key date fields are within a set range, and whether data entered for service type, source of funding, and other variables match allowable codes.

The new data importer tool can provide error reports on data extracts that detail the source of errors. This better enables service providers to correct errors. The department expects that this will reduce the incidence of data entry errors over time. While this is an improvement, the new data importing tool will not provide assurance about the underlying accuracy and completeness of the data submitted by service providers.

Assurance processes

The department does not obtain independent assurance that the data it collects and reports on AOD service provision is accurate and complete. It does not require service providers to certify the completeness and accuracy of the performance data they submit.

This problem was identified by the department's internal audit branch in 2010. The internal audit recommended that a formal framework for systematically verifying the integrity of data entered by agencies be established. The Mental Health Drugs and Regions division did not agree to this but indicated it would further educate service providers on the importance of data integrity.

4.3.2 Adequacy of service provider monitoring

The department, in past years, lacked a rigorous approach to monitoring service provider performance against service activity targets but strengthened its performance management systems in October 2010.

Prior to the department establishing a new performance management framework in 2010:

- monitoring of individual service provider performance against targets occurred inconsistently across regions with little evidence retained of this activity.
- evidence of regular, systematic communication and reporting between the department's central and regional offices on the performance monitoring of service providers was lacking. Meetings and contact occurred on these matters but were not documented or followed up.
- the department did not have a regular program of targeted or random audits to provide assurance about the integrity of individual service provider data, nor did it routinely analyse data to identify and follow up outliers to determine whether data was accurate or whether performance issues existed.

Department staff in regional offices—called program and service advisors (PASA)—are responsible for monitoring the performance of individual service providers against the measures and targets in their service agreement.

There is evidence that PASAs have positive and constructive relationships with the service providers they monitor and a good understanding of their operations, level of activity and barriers to service delivery and performance. The services included in the audit predominantly reported a good working relationship with their regional office.

However, departmental data shows some treatment types consistently underperform against target across the state, including outpatient and home-based withdrawal services. The department does not routinely recall funding from service providers who do not achieve EOC targets. However, a policy on AOD funding accountability approved in March 2010 indicates that the department will now consider recalling funding from service providers where they underperform against EOC targets by more than 5 per cent in any quarter or contravene the service agreement.

Based on data examined for 2009–10, around 70 per cent of service providers could have been subject to funding recall as they underperformed by more than 5 per cent on at least one service type. However, the strict application of the department's policy might have invited further 'gaming' of the system by service providers.

4.3.3 Action to improve service provider performance monitoring

In April 2010, the department initiated a new performance management framework for the AOD program. As part of this new approach twice-yearly meetings between senior staff from the central and regional offices are held to monitor and examine service provider performance in each region. These meetings commenced in mid 2010.

During 2009–10, there has been a greater focus on analysis and follow-up of ADIS performance data with individual service providers. Service providers reported improved feedback on data during 2009–10.

4.4 Monitoring service quality

Service quality is central to delivering the best outcomes for clients. To assure this, the department needs to set and communicate clear AOD service quality standards and then monitor that the service providers meet them.

The department does not gain reasonable assurance that service providers meet quality standards for AOD services.

Setting quality standards for AOD treatment services

The department was slow to establish quality standards for AOD treatment services. It was not until April 2008, that the department released a quality framework for the AOD sector setting out quality standards and requirements. Appendix E lists these standards and requirements.

This was despite:

- The 1997 framework for alcohol and drug treatment services noting inconsistent service standards and quality of care in the system and committing the department to develop and monitor standards for AOD services. The department developed a quality plan for AOD services in 1997.
- In 2000, the Drug Policy Expert Committee recommended the development of quality standards for AOD treatment services as part of a quality assurance strategy.
- The department's 2002 overarching service quality framework included principles for funded services in all program areas including AOD services.

The department consulted the AOD sector and its regional staff when drafting the quality framework. Consultation with the sector included an organisation funded by the department to represent the views of AOD service clients.

Communicating standards to providers and clients

Contracted service providers need to know about the service quality standards and requirements they must meet.

The department adequately informed the sector about the release of the quality framework in April 2008. However, more regular communication and follow-up was required so that service providers could fully understand the quality standards and keep their knowledge current as staff changed.

Service providers included in the audit were largely unfamiliar with the framework and the standards. These providers confirmed that departmental staff do not focus on compliance with the quality framework when interacting with them.

The department has not informed AOD clients about what they should expect in terms of service quality. It did not tell them about the quality framework when it was released in April 2008. A charter of service quality commitments to clients was approved for release by the then Minister for Mental Health in March 2008, but has not been issued. The 40 000 copies of this charter printed in April 2008 remain undistributed.

The status of the client charter remains unclear. It was available on the department's website, although difficult to find. The department advised it is currently reviewing the document and plans to arrange distribution to consumers in early 2011.

Accreditation against the service quality standards

The department's quality framework requires service providers to achieve accreditation against an appropriate independently administered quality accreditation program. The framework identifies Quality Improvement and Community Services Accreditation (QICSA), and Evaluation and Quality Improvement Program (EQuIP) as the appropriate accreditation programs.

A year after releasing the quality framework the department mapped its AOD quality standards to the QICSA standards and found them to be consistent. It did not perform the same analysis against the EQuIP standards.

In situations where the department is depending on an external third party to check service quality, it needs to obtain ongoing assurance about the robustness of the accreditation programs it relies on. The department advised that it obtains assurance through its representation on the state advisory committee for EQUIP and through regular meetings with QICSA.

The audit identified inaccuracies in the departmental records on the accreditation status of AOD agencies. The department needs to keep track of the accreditation status of its funded agencies. Accreditation status may change if accreditation conditions or service provider practices change after initial accreditation, or if serious quality problems with the service are detected. The department's central and regional offices need to clarify whose job it is to do this.

Monitoring compliance with service quality standards

Part of the role of PASAs is to monitor service provider adherence to service agreements, including the quality standards. However, the department has not told PASAs how it expects them to monitor compliance with the standards.

The audit included four of the department's eight regional offices and found that PASAs were not aware that they are expected to monitor service providers against the quality standards, and do not do so.

PASAs do conduct annual desktop reviews of service providers to assess compliance with service agreements, including service standards and guidelines. However, the desktop review does not include an assessment of agency adherence to quality standards or its accreditation status.

PASAs also regularly contact service providers and monitor incident reports, fire safety certificates, and may sight service provider accreditation credentials. However, such activities do not take the place of a structured assessment of service quality.

Consistent, systematic documentation of the monitoring activity that does occur is also lacking.

Monitoring critical incidents

The department's incident reporting protocol seeks to support high-quality services for clients through detailed and accurate reporting and analysis of adverse events. Incidents can be a chance to learn and improve services.

AOD agencies must report incidents or adverse events involving clients and staff to the department. Incidents are categorised by the department according to their seriousness. Category one incidents are the most serious and include client deaths through natural and other causes including drug overdose and suicide, non-fatal overdoses, sexual assaults, violence, self-harm by clients, and misconduct by service staff.

The department's reporting protocol classifies any incident or event with the potential to involve the Minister for Mental Health or the department through media exposure, or subject the department or funded agency to a high level of legal scrutiny or public interest as category one.

In the four regions included in the audit PASAs monitored and kept documents on critical incidents reported by AOD services. PASAs were well informed about service provider handling and reporting of critical incidents. A number of service providers commented on the positive response and support they received from PASAs after critical incidents. Some PASAs participate in agency reviews of significant incidents such as the death of a client.

The department records category one incidents to supplement data in its records management system. Figure 4A shows the number of category one incidents reported by AOD service providers to the department by calendar year since 2007.

Figure 4A
Number of category one incidents reported by alcohol and other drug service providers

Calendar year	Total number of category one incidents
2007	31
2008	55
2009	37
2010 (to end October)	36

Source: Victorian Auditor-General's Office based on Department of Health data.

The number of incidents is low considering more than 27 000 people use AOD services each year. It is important to note that many of these incidents did not occur on service sites.

Critical incident reports are a valuable source of information. The department should regularly analyse trends in critical incidents to inform its planning, support continuous quality improvement, and report significant trends to service providers. One region was undertaking such analysis at the time of the audit.

Analysis of incident reports could focus on trends such as incidents with clients waiting to enter withdrawal or other services, clients exiting services, or clients moving from the youth to the adult service system. Sustained trends in any of these areas should prompt the review and refining of service responses.

Recommendation

3. The Department of Health should:
   - prioritise replacement of its data collection system
   - implement data integrity assurance processes for information submitted by service providers
   - clarify responsibility for monitoring service provider compliance with service quality standards.

5 Performance reporting and review

At a glance

Background

Public reporting on the performance of the alcohol and other drugs (AOD) service system should be accurate, relevant and appropriate.

The effort expended on monitoring and reviewing service system performance should be leveraged to deliver improvements.

Conclusion

Public reporting on the performance of the AOD service system is not sufficiently robust and comprehensive.

Recurring themes in multiple reviews undertaken over the past decade indicate that chronic problems with the AOD service system have not been adequately addressed.

Findings

- Key elements of the publicly reported information on the performance of the AOD service system are not relevant, accurate or appropriate.
- Steps taken during 2010 to adopt a more rigorous, systematic and strategic approach to the monitoring of overall system performance promise to address previous weaknesses in these areas.
- The primary indicator of performance used to fund and monitor the AOD system, the episode of care, does not adequately capture the performance of services and creates an incentive for service providers to manipulate or 'game' the performance reporting system.
- Constant review of the AOD treatment system over the past decade has not been leveraged to deliver system improvements.

Recommendation

The Department of Health should:

- improve the performance measures used for reporting publicly on the AOD program
- take definitive action on the wealth of review recommendations.

5.1 Introduction

It is important that the Department of Health (the department) effectively monitors the performance of the alcohol and other drugs (AOD) service system to assure the best outcomes for clients and allow accurate public reporting of performance information.

The targets for the service system appear in the state's *Budget Paper 3* annually. The department publicly reports on the performance and quality of AOD services in its annual report and annual State Budget papers.

The department has undertaken a wide range of reviews of the service system and its elements over the past decade.

5.2 Conclusions

Key elements of the publicly reported information on the performance of the AOD service system lack relevance, accuracy and appropriateness.

During 2010, the department took steps to adopt a more rigorous, systematic and strategic approach to the monitoring of system performance and the use of data generated from monitoring. It is too early to tell if this action has addressed previous weaknesses in these areas.

There are weaknesses in the primary indicator of performance used by the department to fund and monitor the AOD system, the episode of care (EOC). These affect the department's capacity to adequately capture the performance of services and create an incentive for service providers to manipulate or 'game' the performance reporting system. This led to around 40 per cent of service providers recording multiple continuous EOCs for the same client in the same treatment type during 2009–10.

The department has commissioned or conducted reviews of the AOD treatment system constantly over the past decade. The recurrence of themes arising from this review activity indicates that the department has not adequately addressed chronic problems within the system.

The department has embarked on a major reform program for the AOD service system but governance arrangements for this need refinement to be fully effective.

5.3 Public performance reporting

The department publicly reports on the AOD program against a range of performance measures and targets, in its annual report and *Budget Paper 3*. This is the primary means by which the department discharges its accountability responsibilities for the management of the AOD program.

Figure 5A sets out the publicly reported performance of the AOD program including the drug prevention and control output, and the drug treatment and rehabilitation output for 2009–10. The audit identified the following issues with the relevance, accuracy and appropriateness of elements of this publicly reported information:

- The measures for drug prevention and control are not sufficiently relevant as they relate to the effectiveness of treatment and reducing the harms associated with advanced drug use only.
- The reported percentage of AOD treatment agencies that have external accreditation was incorrect in 2008–09 and 2009–10 due to a lack of rigour in gathering, recording and reporting this data. The department reported that 100 per cent of treatment agencies were accredited in each of these years, but the actual percentages were 94 and 98 per cent respectively.
- Much of the information reported, including courses of treatment and waiting times, is obtained from service providers through the department's dedicated AOD data collection and reporting system, the Alcohol and Drugs Information System (ADIS). The integrity and reliability of this data is not assured.
- Reported timeliness measures for access to drug treatment understate client waiting times because they do not capture the period clients wait before they are screened by services.
- Activity levels for commenced and successful courses of treatment for community-based and residential drug treatment include activity funded by the Commonwealth. The annual report and Budget papers are not transparent about the extent of this Commonwealth-funded activity. Data held by the department indicates that it represents around 20 per cent of reported treatment activity.

Figure 5A
AOD program reported performance for the drug treatment and rehabilitation output in 2009–10

Performance measures	Unit of measure	2009–10 Target	2009–10 Actual
Drug prevention and control			
Quantity			
Contacts through Family Drug Help	number	5 000	5 150
GPs trained to prescribe pharmacotherapy	number	70	24
Licences and permits for supply or use of drugs and poisons	number	1 275	1 293
Needles and syringes provided through the Needle and Syringe Program	number ('000)	7 200	7 724
Participants in peer education programs for injecting drug users	number	250	220
Quality			
Pharmacotherapy permits processed within designated time frame	per cent	100	100
Total output cost	**$ million**	**24.1**	**27.3**
Drug treatment and rehabilitation			
Quantity			
Clients on the pharmacotherapy program	number	11 800	13 054
Commenced courses of treatment: community-based drug treatment services	number	33 420	43 994
Commenced courses of treatment: residential-based drug treatment services	number	6 062	5 725
Quality			
Drug treatment services accredited	per cent	100	100
Evaluation, research and development projects satisfactorily completed	per cent	100	100
Successful courses of treatment (episodes of care): community-based drug treatment services	number	31 085	43 153
Successful courses of treatment (episodes of care): residential-based drug treatment services	number	5 636	5 646
Alcohol and drug workers accredited	per cent	85	67
Timeliness			
Average working days between screening of client and commencement of community-based drug treatment	days	3	1.1
Average working days between screening of client and commencement of residential-based drug treatment	days	6	7.9
Total output cost	**$ million**	**103.4**	**104.3**

Source: Department of Health *Annual Report 2009–10*.

5.4 Internal performance reporting and monitoring

The department monitors a range of other measures for its internal management purposes in addition to those it publicly reports. These other measures include:

- the ratio of new to repeat clients accessing the system
- the percentage of EOCs which result in reduced substance use by the client
- the percentage of EOCs which result in improved relationships for the client.

The audit examined departmental data on service performance at various levels. This showed that in 2009–10:

- department-funded services achieved 73 per cent of EOC targets
- there was variation across regions against EOC targets achieved, ranging from 55 to 80 per cent
- the treatment types with the highest performance against EOC targets were specialist pharmacotherapy, residential rehabilitation and rural withdrawal
- the treatment types with the lowest performance against EOC targets were outpatient withdrawal and home-based withdrawal
- around 68 per cent of clients accessing the service system were repeat clients
- around 92 per cent of courses of treatment resulted in the achievement of at least one significant treatment goal attainment (STGA), with an average of three STGAs achieved for each EOC
- the percentage of EOCs recorded as resulting in reduced substance use by the client was around 49 per cent
- the percentage of EOCs recorded as resulting in improved relationships for the client was around 16 per cent
- there was a pattern of Aboriginal community controlled service provider organisations failing to provide service performance data to the department.

The department has lacked a rigorous approach to using this performance data to inform AOD system monitoring, management and reporting.

Department staff in regional offices monitor individual service providers against the performance measures and targets in their service agreement with the department. AOD program managers in the department's central office are responsible for using the results of this monitoring to examine whole-of-program performance, inform service development and discharge accountability obligations.

Prior to the department establishing a new framework in 2010, there was a lack of strategic overview and use of service performance data apart from a quarterly report to the department's senior executive group which focused on a small number of performance measures. Specifically:

- there was no formal reporting on performance data between the department's central and regional offices
- quarterly reports on service data were produced but evidence that senior AOD program management actively monitored and used information and commentary on program performance, trends and compliance issues at the statewide, regional or service provider levels was not retained by the department
- regional and statewide performance against targets at the service activity level was not monitored. A report showing this was developed during the audit.

5.4.1 Action to improve system performance monitoring

Under the department's new performance management framework for the AOD program, initiated In April 2010, it commenced regular meetings of senior program staff to review service and program performance, trends and compliance issues. Under the new framework, a performance advisory group was tasked with:

- improving data compliance, integrity and quality
- making strategic use of all data sources across the program
- providing a quarterly report to the program executive, covering actual performance against target across the system, and identifying systemic and local issues impacting on agency performance.

The advisory group met twice in 2010 but evidence provided on its activities to date indicate that it is not yet fully discharging the role set for it under the new framework.

5.5 Issues with the episode of care measure

The department's approach to measuring the activity and performance of the AOD service system was established in the mid 1990s and is based on EOC delivered for clients.

There are weaknesses in the primary indicator of performance used by the department to fund, monitor and report on the AOD system, the EOC. These affect the department's capacity to adequately capture the performance of services and create an incentive for service providers to manipulate or 'game' the system. The department has known of these weaknesses for a considerable time. It has not addressed them, nor has it addressed the potential that services are providing treatments other than those for which they are funded.

At the time of its introduction the EOC was a positive attempt to move the measurement of agency performance beyond indicators of inputs and client throughput, towards the measurement of outcomes attained.

However, problems with the EOC measure have been highlighted in various reviews and documents since 2000 including in the:

- Report of the Drugs Policy Expert Committee (DPEC) in 2000
- Episode of Care review of 2003 commissioned by the department
- *A new blueprint for alcohol and other drug treatment services 2009–2013* (the Blueprint)
- Systems and performance analysis of the AOD service system commissioned by the department in 2010.

Specific issues identified with the EOC measure and re-confirmed by the audit include:

- the EOC measure does not indicate the intensity of work involved in delivering treatment to a client—for example it does not distinguish between treatment episodes involving say, three or 30 client contacts
- varied interpretations and applications of the EOC concept within and across service providers
- the perception that EOC targets limit flexibility, innovation and capacity to provide more intensive service responses for the growing numbers of clients with multiple and complex needs
- that EOC performance targets can create incentives for agencies to prematurely close EOCs by opting for shorter, fragmented or partial responses to client needs, or by recording multiple continuous EOCs for the same client in the same service type in order to meet targets and retain funding levels.

Audit analysis of reported EOC data

The 2003 EOC review and the Blueprint acknowledge the potential for 'gaming' in reporting EOCs. The audit analysed underlying data to understand whether the use of the EOC to measure service performance was leading to misreporting. The data sought during the audit is not routinely examined or analysed by the department.

Data was examined from 2009–10 to determine the extent of 're-episoding' of clients. This practice involves closing a course of treatment for a client, recording an EOC, and then opening a new course of treatment for that client for the same service type the next day or within a few days.

Our analysis indicates that around 40 per cent of treatment agencies regularly engaged in 're-episoding' for at least one service treatment type. There may be clinical considerations for closing and reopening an EOC due to the chronic and relapsing nature of addiction, however, these considerations can be compromised by the imperative for agencies to meet their EOC targets. Concerns about whether EOC unit prices are adequate also drive this behaviour.

The analysis showed that re-episoding clients occurs most often for the supported accommodation treatment type. This is consistent with other information gathered in the audit about the difficulties agencies face in achieving target EOC numbers for this treatment type. A lack of alternative long-term housing options for clients makes it difficult to move existing clients out of supported accommodation to make way for new clients.

There was also evidence of re-episoding by some agencies for the counselling, consultancy and continuing care service type. This is the most commonly offered treatment type in the service system.

The data also showed a pattern of agencies closing courses of treatment at the end of each quarter and particularly at the end of the financial year. This pattern correlates strongly with the requirement for service providers to submit data to the department quarterly. There is no clinical reason why courses of treatment would conclude in this pattern over the year.

Further data requested as part of the audit showed that during 2009–10, clients had around 1.8 EOCs on average across the service system. Data examined on what are known as 'frequent flyers', that is, clients who are frequent repeat consumers of services show a small cohort of clients, around 3 per cent of total clients, with more than 10 EOCs over the last five years. Eight of these clients had 50 EOCs or more, with one client recorded as having 110 EOCs between 2005–06 and the end of 2009–10. A pattern of service use of this nature warrants follow-up to determine whether some additional or alternative support needs to be offered to the client.

The department has acknowledged issues with the EOC measure but has not addressed them effectively. For example:

- Its 2003 review, in response to the 2000 DPEC findings, identified the need to establish a more complete performance measurement system, rather than simply revising or refining the EOC. The department has not done this.
- The Blueprint committed the department to deliver a service system with EOC targets that provide accountability for expenditure of public moneys and incorporate flexibility to account for multiple client needs and innovative service responses. The department is scheduled to implement this reform by the end of 2011.
- The department commenced a further review of the EOC in May 2010 but has not completed it. The department explained that this project is 'on hold' as the project scope will be influenced by a range of other system review projects underway. This explanation is at odds with the project brief for this review which saw it as being complementary to the other reviews and able to provide input to them.

The EOC measure is the main element for data collection in existing data collection systems and any changes to the measure of service delivery will require major system and reporting changes.

5.6 System reviews and reform

The department has commissioned or conducted reviews of the AOD treatment system constantly over the past decade. The audit found that the department has acted on only a few of the findings and recommendations from these reviews.

The recurrence of themes over the period indicates that there are chronic problems within the system that the department has not adequately addressed. Areas to which recurring themes relate include:

- service integration
- workforce qualifications/training and career pathways
- unit prices
- design of the pharmacotherapy program.

The department could not demonstrate timely analysis of findings or evidence of formal consideration of recommendations arising from many of these past reviews including the major reviews of the service system in 2003 and 2004. Notwithstanding this, it has acted on some of the findings and recommendations from these reviews.

The department has conducted or commissioned many reviews of the AOD service system or system elements since the system was established in 1997, with 31 reviews undertaken since 1999. Figure 5B lists these reviews. A number of other reviews are currently in progress on matters such as the use of the EOC measure in the system and the funding model for AOD services.

Figure 5B
Service system and service element reviews 1999–2010

Year	Review
1999	Evaluation of Specialist Methadone Treatment Services
2000	Evaluation of Community Drug Withdrawal Services
	Youth Alcohol and Drug Outreach Services
2001	Counselling, Consultancy and Continuing Care Service Evaluation
	Peer Support Program Evaluation
2002	Parent Support Program Review
2003	Review of the Victorian drug treatment service system
	Episode of Care Review
	Alcohol and Drug Youth Consultant Program Evaluation
	Pilot Youth AOD Day Program Evaluation
2004	Review of the Youth Drug Treatment Service System
	Review of the Drug Treatment Service System in Regional and Rural Victoria
	Evaluation of Victorian Methadone Regional Outreach Worker Programs
	Evaluation of the Mobile Overdose Response Service
	Statewide Dual Diagnosis Initiative Evaluation
2005	Parent Support Program Review

Figure 5B
Service system and service element reviews 1999–2010 – *continued*

Year	Review
2006	Adult Community Residential Drug Withdrawal Services Review
	Alcohol and Other Drug Supported Accommodation Programs Review
	Post Withdrawal Linkage Workers and Post Residential Rehabilitation Support Workers: An Investigation of their Existing and Potential Role
2008	Youth Community Residential Drug Withdrawal Services Review
	Acquired Brain Injury AOD Clinical Consultant Evaluation
2009	Forensic Drug Treatment System Review
	Rapid Situational Assessments of Pharmacotherapy in two regions
	Treatment and access in the Victorian AOD sector
2010	Defining AOD Treatment and Workforce project
	Victorian Pharmacotherapy Review
	Systems and Performance Analysis of the AOD Treatment System
	Evaluation of the Victorian Dual Diagnosis Initiative
	Evaluation of Victoria's Needle and Syringe Program
	Evaluation of the Victorian AOD Workforce Development Strategy
	AOD Treatment Needs and Service System Responses for People Aged Over 65 years

Source: Victorian Auditor-General's Office.

Current reform strategies

Three key government strategies set out a suite of current reform activities in the alcohol and drug sector and in part seek to address some of the above issues:

- *Restoring the balance: Victoria's Alcohol Action Plan 2008–2013* (VAAP) is a whole-of-government approach to address risky drinking focusing on the consequences for individuals, families and the community.
- *The Victorian Amphetamine-type stimulant and related drugs strategy 2009–2012* seeks to build AOD sector capacity to respond to amphetamine-type stimulant and related drugs more effectively.
- *A new blueprint for alcohol and other drug treatment services, 2009–2013* (the Blueprint) is a five-year guide for reform priorities and investment decisions for the AOD service system.

The VAAP, released in 2008, includes a range of funded initiatives across government focusing on health, community education, alcohol advertising and enhanced enforcement. One of the VAAP actions is the implementation of the Blueprint.

The Blueprint is the main strategy behind the current reforms. It represents the department's response to the findings and recommendations of major reviews of the service system that the department finalised in 2003 and 2004. Work started on the Blueprint in 2005–06 but it was not released until December 2008.

The Blueprint set new directions, they are to be achieved largely within existing resources, apart from the $14 million VAAP funding that was committed to Blueprint actions.

Governance and coordination of current reforms

The department established a steering committee on alcohol and drugs (SCAD) to oversight and coordinate the progress of the 140 Blueprint and other strategy actions or initiatives. The committee comprises senior department officers. The department also set up an advisory group of representatives from the sector, its peak body and research bodies to provide advice on introducing key strategies and reforms.

The audit identified that:

- The advisory group has no consumer or worker representation—which is a significant omission, given the scope and nature of reforms and the potential impacts on consumers, their significant others and the AOD sector workforce.
- The first SCAD meeting in May 2009 noted the need for a communications strategy and plan for the reform development and implementation. The department has no approved communications plan for the reform process. This is a shortcoming given that the extent and scope of planned reform activity warrants a comprehensive communications strategy to facilitate the involvement of the sector and other key stakeholders in the change process.
- The department completed 72 per cent of the Blueprint actions due for implementation by December 2010 and has finished some actions ahead of schedule.
- While the department has not met it's commitment to formally brief the Minister for Mental Health quarterly on Blueprint actions it did provide the Minister with a range of information on progress during 2009–10.
- The department has not met a commitment to consult with consumers to develop detailed processes and strategies for each Blueprint action.
- While SCAD has clearly helped coordinate reform, it has been less successful in regularly monitoring and pushing to meet deadlines. It met only three times in 2009. It met more often in 2010 but did not get regular consolidated progress reports. Minutes show it did not focus on meeting reform deadlines.
- There is no clearly documented register of risks to the successful and timely delivery of the reform process—a significant gap given the complexity and importance of the reform process and its status as one of the department's six strategic directions.
- The department is still working on an evaluation framework for measuring the reforms' effects.

These findings indicate that the governance arrangements around the reform require refinement to be effective.

The next 12 to 18 months will be crucial if current reform goals are to be realised. Equally crucial to the success of the department's reform agenda will be whether the sector takes ownership of the proposed changes. Appendix D outlines the department's planned process for reform of the AOD system.

The department needs to identify and effectively manage the risks associated with the reforms including the effects of the government's funding decisions.

Recommendation

4. The Department of Health should:
   - improve the performance measures used for reporting publicly on the alcohol and other drug program
   - take definitive action on the wealth of review recommendations.

Appendix A.
Prevention initiatives

Prevention in health settings, including those responding to alcohol and drugs, is commonly the promotion of healthy behaviours and environments across life course, at different levels of the health and illness continuum.

- Primary prevention seeks to prevent and/or delay the uptake of alcohol and dug use.
- Secondary prevention aims to reduce the harms and intervene early in alcohol and drug use.
- Tertiary prevention or harm minimisation seeks to minimise or reduce the negative impact of dependent use.

Areas of focus for the prevention of alcohol and drug related harm can be grouped into two key approaches:

- **Population-based approaches**—such as legislative changes, cultural changes, maintenance and creation of healthy environments, and data collection and research. Responses at this level can include social marketing such as media campaigns, drug education, parenting support, and activities designed to enhance community awareness and connectedness.
- **Treatment and support approaches**—such as services for the whole population and workforce development; and services for groups at risk. Responses at this level can include general practitioner advice or internet and telephone helpline services.

Figure A1 lists the programs and projects which the Department of Health funds as prevention initiatives. The initiatives in this list include programs designed to prevent the uptake of drug or dangerous alcohol use and early intervention programs intended to prevent further harm among established drug users.

Figure A1
The Department of Health's prevention initiatives

Activity	Initiative
Information campaigns and provision	*Will you handle your alcohol, or will alcohol handle you?* January – March 2009 Campaign aimed to increase awareness of the behavioural consequences of excessive alcohol consumption, especially violent and aggressive behaviour. Television, press, radio, outdoor and the internet.
	Is your high getting you low? June 2009 – November 2009 Campaign aimed at increasing awareness of the links between cannabis use and mental health problems. Short films, fact sheets and an online self-assessment.
	Ice. It's a dirty drug November 2007 and March 2008 Campaign aimed to prevent the use of ice through increasing awareness of the mental and physical health risks associated with use of the drug. Television, posters and billboards.
	GHB campaign Posters and messages distributed through dance party operators and venues.
	DrugInfo Clearinghouse A website of information about alcohol and other drugs.
Supporting parents	*Family Drug Helpline* A 24-hour telephone counselling and support line for families needing help with alcohol and drug use of family members.
Supporting community connection	*Municipal Drug Strategies* Funding to help five local government areas prevent drug use and tackle local drug issues through Municipal Drug Strategies.
	The Good Sports Program Encourages sporting clubs to develop income streams other than from alcohol.
Early intervention	*Dance Wize/Rave Safe* Drug prevention, education and information resources promoting harm minimisation and encouraging safe practices among partygoers—about 12 events a year.
	Schoolies week Prevention and safety arrangements at Schoolies Week celebrations (through 2008–11). Initiatives include information provision to students and their parents.

Figure A1
The Department of Health's prevention initiatives – *continued*

Activity	Initiative
Harm reduction for existing drug users	*Drug Overdose Peer Education Program (DOPE)*
	Overdose prevention workshops for high-risk injecting drug users.
	Needle and Syringe program
	Provides sterile injecting equipment and health information and advice to injecting drug users.
Legislative changes	Stop the sale of cocaine kits (2006) and ice-pipes (2004) used to smoke methamphetamines.
	Free drinking water in licensed venues from 1 November 2010.
	Code of practice for running safer dance parties for promoters, venue owners and operators.

Source: Victorian Auditor-General's Office.

Appendix B.
Treatment and service types

Background

The redevelopment of the alcohol and other drug (AOD) treatment system during the mid-1990s established the broad treatment types which make up the fundamental approaches to AOD treatment. The four treatment types were:

- behavioural therapies and support aimed at changing behaviour to reduce or cease alcohol and drug use
- withdrawal, a supervised process of physical withdrawal from dependency
- residential rehabilitation
- pharmacotherapy or substituting opiates with other drugs.

The current service system is made up of discrete service types which are based around the four treatment types. The Department of Health (the department) now funds 19 service types in the AOD system. Residential rehabilitation and pharmacotherapy have only one or two related service types, whereas the behavioural therapies treatment type has attracted many service types. This is reflective of the range of possible interventions and activities which can be provided within that treatment type.

Figure B1 sets out the 19 funded service types as they relate to the broad treatment types.

Figure B1
Treatment types and funded service types

Treatment type	Funded service type
Behavioural therapies and support	Counselling, consulting and continuing care (CCCC) (Y) • Post residential support • Acquired Brian Injury Clinical Consultant
	Koori community AOD workers
	Koori community AOD resource services
	AOD supported accommodation (Y)
	Family counselling
	Ante and post natal support
	Mobile overdose response
	Peer support
	AOD youth consultant
	Alcohol rehabilitation
	Youth outreach
	Youth Outdoor therapy
Withdrawal	Residential withdrawal (Y)
	Outpatient withdrawal (Y)
	Rural withdrawal
	Home-based withdrawal (Y)
Residential rehabilitation	Residential rehabilitation (Y)
Pharmacotherapy	Regional pharmacotherapy outreach
	Specialist pharmacotherapy

Note: (Y) indicates there is a youth specific service
Source: Victorian Auditor-General's Office, based on information from the Department of Health.

The rest of this appendix provides a detailed description of 19 of the service types by treatment type. Descriptions of service types have been drawn primarily from the department's 1997 *AOD Framework for Service Delivery* and the department's website.

Behavioural therapies and support

Behavioural therapies are clinical interventions aimed at behaviour change in relation to AOD use. They can include one-to-one sessions with a trained counsellor, group sessions or family counselling. These interventions are intended to increase motivation for AOD treatment, offer harm reduction and relapse prevention strategies, and build communication, parenting and relationship skills.

Counselling, consulting and continuing care

Services provided may include assessment, treatment and consultancy, outreach, referral and ongoing case management. Within this umbrella service type there are a number of sub-activities including post-residential workers and Acquired Brain Injury clinical consultants.

Post residential workers

Post residential workers aim to provide continuity of care service to all people who have undergone a withdrawal program and link them to post-withdrawal counselling support in their local area.

Acquired Brain Injury clinical consultant

AOD Acquired Brain Injury clinical consultants provide assessment and treatment of clients with acquired brain injury and cognitive impairment and facilitate cross-agency and cross-sector links, planning and coordination. Key activities include the development of local networks; training and consultation, and modelling of good practice through direct clinical intervention, and shared care arrangements.

Koori community alcohol and other drug workers

The Koori community alcohol and drug worker undertakes a number of program development activities based on a harm minimisation approach, including health promotion, information provision, education activities, development and maintenance of community linkages, referrals, counselling interventions, the provision of advice to generalist services, liaising with relevant programs and fulfilling an advocacy role on behalf of the service user.

Koori community alcohol and other drug resource services

Koori community AOD resource services provide an alternative to incarceration for Koori persons who are found to be alcohol and drug affected in public. They provide short-term accommodation for an average of 48 hours in a safe, non-threatening environment.

AOD supported accommodation

Supported accommodation is aimed at clients who have undergone withdrawal and are able to live independently. It offers the combination of stable housing and low-level AOD support from an AOD support worker in a community-based, 'share house' setting designed to maintain positive behaviour changes and assist their reintegration into community living.

Family counselling

These are short-term therapeutic group programs for families of drug users, facilitated by AOD clinicians. The aim of the program is to increase the capacity of the family to respond to a family member's drug use. It does this by developing parents' confidence to cope with challenging behaviours associated with drug use and their understanding of drugs and drug treatment.

Ante and post natal support

The Royal Women's Hospital provides counselling, information, education, referral and follow-up as well as specialist inpatient and outpatient treatment and advice for pregnant women and babies with drug problems.

Mobile overdose response

As part of the Mobile Overdose Response Service, workers assist ambulance officers and emergency department staff who encounter people who have overdosed. They offer overdose survivors support, information and assistance with accessing rehabilitation services. Referrals to the service also come from users, families and friends, support and user groups, needle and syringe programs, and health services.

Peer support

Peer support provides mutual support and information from individuals with personal experience of alcohol and drug use to individuals who may be having, or who have had, difficulties in the past associated with their alcohol and drug use. Peer support groups or activities are usually established by current or past alcohol and drug users, and may operate out of, and be supported by, community organisations, alcohol and drug agencies or community health centres.

Alcohol rehabilitation

This is a medium-intensity community-based rehabilitation service providing support for people with alcohol problems exiting hospital or withdrawal services. It incorporates intensive group work and counselling, centred on behaviour changing therapeutic interventions, as well as after hours support to prevent relapse.

Youth outdoor therapy

Outdoor therapy involves adventure activities as therapy for young people experiencing alcohol and drug problems.

AOD youth consultant

AOD youth consultants provide specialist drug and alcohol assessment, treatment and monitoring of child protection clients in out of home care, residential facilities and Adolescent Community Placement.

Youth outreach

Youth outreach provides assessment, support and ongoing case coordination to young people with alcohol and drug problems, in their own environment. It also supports generalist agencies that work with young people, through information, education and training.

Withdrawal

The goal of withdrawal is to assist people to manage the physical and mental side effects of reducing or stopping taking a substance of dependence. Depending on the substance and level of dependence, these side effects can last for a few days or several weeks or months. In some instances, such as with heavy alcohol use, complete recovery may never be possible.

Withdrawal services include residential and non-residential settings and can include the use of medications to help manage the side effects of withdrawal. A residential setting is common for alcohol or opioid withdrawal or if a client experiences severe withdrawal side effects or has complex behaviours. A non-residential setting, such as home-based or outpatient withdrawal, typically involves clients experiencing less severe withdrawal side-effects and who have a level of stability in their lives, including supportive friends or family and stable housing.

Withdrawal includes the following funded service types:

- residential withdrawal
- outpatient withdrawal
- home-based withdrawal
- rural withdrawal.

Residential withdrawal

Residential withdrawal services provide alcohol and drug withdrawal to young people and adults through a dedicated community-based residential facility or through hospital-based treatment. Community residential drug withdrawal is provided to clients in a suburban setting located close to a public hospital with psychiatric facilities.

Outpatient withdrawal

Outpatient withdrawal services are provided to clients who are experiencing mild withdrawal symptoms which can be appropriately managed without admission to a residential withdrawal service. The service provides a series of intensive individual outpatient consultations over a short period, followed by ongoing counselling and support to complete the withdrawal.

Home-based withdrawal

Home-based withdrawal services are provided in cases where the withdrawal syndrome is of mild to moderate severity and the client is able to be supported by a family member or friend at home. This service may be provided as part of the rural withdrawal support service following a short hospital admission, or as the complete treatment if no hospital admission is required. The service is provided by an experienced nurse in conjunction with a medical practitioner, preferably the client's general practitioner.

Rural withdrawal

Rural withdrawal services combine a short hospital stay (where required) with a period of home-based withdrawal for clients located in rural Victoria.

Residential rehabilitation

Residential rehabilitation services are offered to AOD clients who have undergone a drug withdrawal or other AOD programs and have not been successful in reducing or overcoming their drug use problem, and are not suited to attend an outpatient program.

Residential rehabilitation provides an environment removed from the wider community to enable residents to address issues underlying their drug use. It aims to ensure lasting change and to assist reintegration into community living through a range of interventions, such as individual and group counselling with an emphasis on mutual self-help and peer community. At least three months stay is required for effective outcomes.

Pharmacotherapy

Pharmacotherapy in Victoria is provided through a 'community based' model. This means that clients access services in the community rather than through an institution. Nearly all pharmacotherapy clients (92 per cent) see a prescribing general practitioner and community pharmacy which dispenses the pharmacotherapy medications. The aim of community based pharmacotherapy is to 'normalise' and 'de-stigmatise' the treatment and to improve client access to this form of treatment.

Regional pharmacotherapy outreach

Regional pharmacotherapy outreach is intended to strengthen the role of trained general practitioners in encouraging, recruiting and retaining opiate dependent persons in treatment and ultimately assisting in an effective withdrawal.

Specialist pharmacotherapy

While the pharmacotherapy program is generally administered through general medical practitioners, the need for specialist pharmacotherapy services occurs where there are associated complex medical, psychiatric or psychological problems. Specialist pharmacotherapy services operate in association with a general hospital.

Appendix C.
Evidence base

Background

The following discussion of the evidence base for the service system is based on the core treatment types, described in appendix B, rather than each funded service type.

Figure C1 provides an overview of the current evidence base for the core treatment types by common substances.

Figure C1
Overview of the evidence base

Treatment type	Substance					Dual diagnosis
	Alcohol	Opiates	Cannabis	Amphetamines	Benzodiazepines	
Behavioural therapies	+++	+++ if used with pharmacotherapy	++	++	+ if used with pharmacotherapy	+++ non-substance/ setting specific
Withdrawal *	+++	+++ if used with pharmacotherapy	+	++	++ dependent on setting	
Residential rehabilitation	+	++ if used with pharmacotherapy	+	++	–	
Pharmacotherapies	+++	+++	–	–	–	

Note: –, +, ++, +++ denotes the strength of evidence, from no evidence to widely accepted evidence of efficacy; treatment types that do not have +++ require further evidence.
* Refers to the treatment of physical and mental side effects of withdrawal from a substance of dependence, not long-term behaviour change.
Source: Victorian Auditor-General's Office based on Turning Point research and Cochrane Reviews.

The information presented here is based on research commissioned by the Department of Health (the department) and carried out by the Turning Point Alcohol and Drug Centre in 2003 and 2010, and Cochrane Reviews, systematic reviews of primary research in human health care and health policy.

The evidence base supporting the effectiveness of behavioural therapies, withdrawal and pharmacotherapies for alcohol and opioid dependence is well established. It is less well established for other substances.

Available research evidence supports the effectiveness of residential rehabilitation, but studies to date have not compared its effectiveness with other treatment responses. Residential rehabilitation is the most expensive treatment, at $12 387 per person per episode of treatment, compared to $818.58 for counselling. It would be valuable to have evidence of its success compared with other options.

Research evidence shows that when a person has both mental health and AOD issues, called a dual-diagnosis, it is most effective to treat both at the same time.

Evidence base for treatment types

Behavioural therapies

Current research evidence shows that counselling, which focuses on cognitive behavioural therapy (CBT), is effective for motivating or maintaining behaviour change relating to the problematic use of alcohol, cannabis and amphetamine-type stimulants (ATS). CBT aims to assist clients to anticipate and cope with lapses and relapses, help them change their lives to reduce exposure to high-risk situations, and strengthen and implement more effective coping strategies.

For treating cannabis use, there is some evidence to support including families or significant others in treatment to improve outcomes. Counselling in isolation is not adequate for treating opiate abuse. Further research is required to demonstrate the effectiveness of some other psychosocial interventions for ATS.

Most behavioural therapy in the current AOD service system is delivered through the Counselling, Consulting and Continuing Care (CCCC) service type. Research commissioned by the department in 2003 and 2010 recommended that CCCC service type be withdrawn and a new service type ‘outpatient’ or ‘behavioural therapy’ be developed. The new service type would encompass a range of evidence based therapeutic interventions, including individual and group counselling, relapse prevention, motivational interviewing and day programs.

In 2009–10 five new ‘therapeutic CCCCs’ teams were funded in five metropolitan growth-corridors. The ‘therapeutic CCCCs’ model includes a provision for group work and family therapy, which is consistent with a 2003 recommendation from the AOD Service System Review. If found to be effective, the department intends expanding this model.

Withdrawal

A person can withdraw from a substance of dependence in a residential or outpatient setting. Depending on the substance or the severity of their withdrawal side effects, they can use medication to manage the side effects or go without.

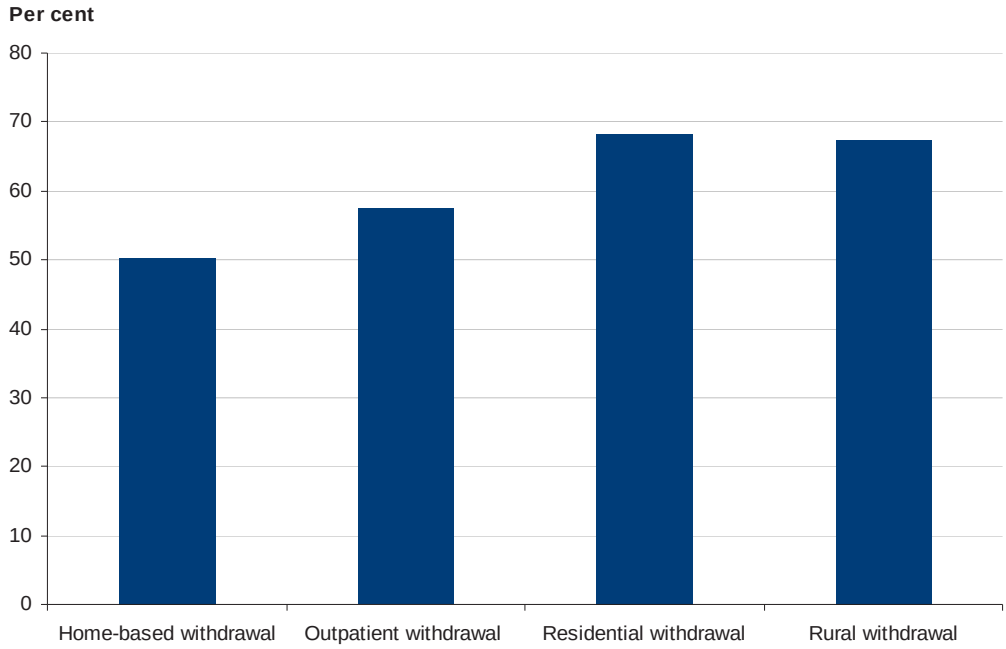
The research evidence supports the effectiveness of the use of medications, such as methadone and buprenorphine, for opiate dependence, and benzodiazepine, acamprosate and naltrexone, for alcohol dependence.

There is no evidence that shows residential treatment is better than non-residential treatment for people dependent on alcohol. There may be an exception for some people who require medically supervised detoxification, respite care, or those who are itinerant, for whom residential settings may be more effective.

Data from the department shows that residential withdrawal and rural withdrawal far outperform the other withdrawal service types in achieving the goal of 'reduced substance use'. Figure C2 compares the withdrawal service types that resulted in substance use reduction in the final quarter of 2009–10:

- **residential withdrawal**—68.2 per cent
- **rural withdrawal**—67.4 per cent
- **home-based withdrawal**—50.2 per cent
- **outpatient withdrawal**—57.7 per cent

Figure C2
Percentage of withdrawal service types resulting in reduced substance use



Source: Victorian Auditor-General's Office based on Department of Health Alcohol and Drugs Information System data Q4 2009–10.

Residential rehabilitation

There is some research evidence which shows that residential rehabilitation can be effective for reducing and maintaining reduced opiate and amphetamine use for between three and 18 months after treatment. There is a lack of research evidence to support residential rehabilitation treatment for people with alcohol problems.

Current evidence does not enable a comparison between the effectiveness of residential rehabilitation and other treatment responses.

Pharmacotherapy

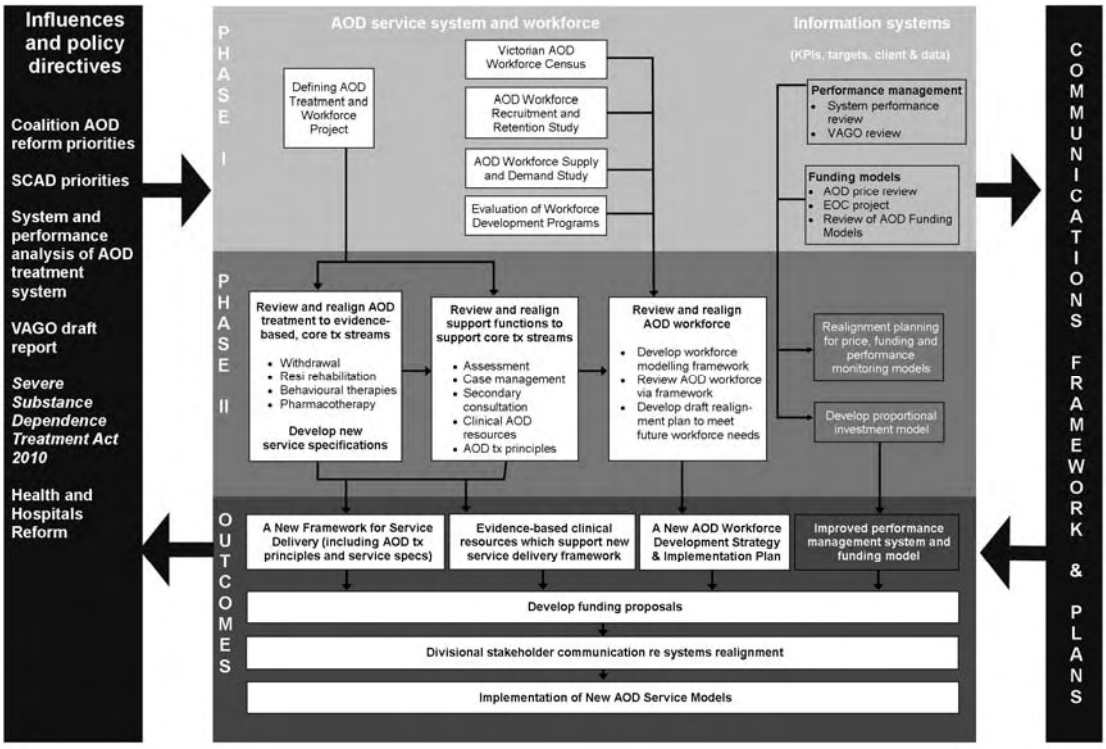
The evidence base for buprenorphine and methadone pharmacotherapies in reducing heroin use, reducing crime, reducing deaths due to overdose, improving psycho-social functioning and reducing HIV transmission is well established.

There is good evidence for the use of anti-craving medications for the treatment of alcohol dependence. However, there are currently no guidelines for the use of pharmacotherapies for amphetamine dependence.

Appendix D.
Current reform implementation

The current reforms comprise a range of projects intended to enable the introduction of new alcohol and other drug (AOD) service models. Figure D1 illustrates the connection between the planned reform projects and the phased implementation over the next two years.

Figure D1
Current alcohol and other drug treatment reform



Source: Department of Health.

Appendix E.
Service quality standards

In April 2008 the Department of Health released *Shaping the Future: The Victorian Alcohol and Other Drug Quality Framework*, which set out quality standards for alcohol and other drug services. The quality framework comprised six standards with 13 specific service standard requirements. The standards and requirements are listed in Figure E1.

Figure E1
AOD Quality Framework Service Standards

Core standard	Specific service standard
Consumer focus	That funded AOD services: • recognise and respond to consumer rights and responsibilities, actively encourage consumer participation, and use consumer feedback in the planning, development and delivery of services, programs and interventions • are developed and delivered in a respectful and sensitive manner with regard for different cultural backgrounds, diverse ages and stages in life and different family circumstances.
Evidence-based practice	That funded AOD services: • ensure that programs and interventions work within, and contribute to, developing the evidence base for AOD treatment • have continuity of care as a central feature encompassing greater connectedness, communication and coordination • have comprehensive program policies, procedures and practices that are evidence-based and canvass all aspects of the treatment pathway from first contact to exit.
Continuous quality improvement	That funded AOD services: • imbed a comprehensive system of continuous quality improvement, promoting best practice and regular review of structures, systems, processes and practice, to improve services and consumer outcomes • are accredited or work towards accreditation through an appropriate quality accreditation program such as the Quality Improvement and Community Services Accreditation (QICSA) or the Evaluation and Quality Improvement Program (EQuIP) • have comprehensive, accessible, relevant, and accurate policies and procedures to guide decision-making that are regularly reviewed and updated.
Corporate and clinical governance	That funded AOD services: • are governed and managed to maximise efficiency, transparency and effectiveness and to ensure accountability • have sound incident response, management, reporting and review policies and procedures, and processes that comply with legislative and departmental requirements.
Workforce development strategy	That funded services are adequately and appropriately staffed and have workforce policies to develop individuals and their knowledge base to support maximum service effectiveness.
Partnerships	That funded services work towards sustainable partnerships that support the development and delivery of programs that result in improved outcomes for consumers.

Source: Victorian Auditor-General's Office from *The Victorian Alcohol and Other Drug Quality Framework*, 2008, Department of Human Services.

Appendix F.

Audit Act 1994 section 16—submissions and comments

Introduction

In accordance with section 16(3) of the *Audit Act 1994* a copy of this report was provided to the Department of Health with a request for submissions or comments.

The submissions and comments provided are not subject to audit nor the evidentiary standards required to reach an audit conclusion. Responsibility for the accuracy, fairness and balance of those comments rests solely with the agency head.

Submissions and comments received

RESPONSE provided by the Secretary, Department of Health

Department of Health

Secretary

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e2190389

Mr D D R Pearson
Auditor-General
Victorian Auditor-General's Office
Level 24, 35 Collins Street
MELBOURNE VIC 3000

Dear Mr Pearson

Thank you for your letter dated 3 February 2011, enclosing the proposed report on the *Managing drug and alcohol prevention and treatment services*.

Consistent with section 16(3)(b) of the *Audit Act 1994*, please find attached the Department of Health response for inclusion in the report.

The Department essentially accepts the recommendations in the report and will use the findings to improve the quality of the drug and alcohol prevention and treatment services provided across Victoria. However, the Department holds a different view from the Auditor-General on the following:

- Since 1997 the treatment system has been refined and changed more than the report acknowledges. Notwithstanding this, the Department agrees that change has not occurred at a system level.
- Contrary to what is stated in the report, the Department is of the view that it gains assurance that service providers meet quality standards for AOD services through monitoring accreditation status and regional office performance monitoring. However, active monitoring of service compliance with quality standards requires strengthening.

Should you require any additional information, please contact [redacted] Mental Health, Drugs & Regions Division, on [redacted].

Yours sincerely

Executive Director

pp **FRAN THORN**
Secretary

encl

State Government Victoria

RESPONSE provided by the Secretary, Department of Health – continued

Response provided by Secretary, Department of Health

Audit Recommendation	Department of Health's response
1. The Department of health should:	
• Implement a whole of government AOD prevention strategy	The Department accepts the need for clear communication of its approach to alcohol and drug prevention. The Department accepts the need to seek support for a whole of government AOD prevention strategy and will consult further with other Departments and agencies accordingly.
• Deliver on commitment to review unit prices	The Department accepts the need for further analysis of the price and funding models for alcohol and drug treatment services.
• Prioritise work on o The capacity of the AOD sector to attract and retain a specialist AOD workforce o Promoting careers in the AOD sector in relevant higher education settings	The Department accepts the recommendation.
• Revise its reporting requirements to address weaknesses in the use of the EOC.	The Department accepts the recommendation.
2. The Department of Health should:	
• Revise treatment service mix so services funded align with need	The Department notes the recommendations and is considering them along with recent review findings and the development of a reform strategy to achieve better and lasting outcomes for clients.
• Address the inequity of the current distribution of AOD resources	
• Address the longstanding fragmentation and inconsistency of service provision across the 105 service providers that make up the treatment service system	
3. The Department of Health should:	
• Prioritise replacement of its data collection system	The Department accepts the recommendation and work in this area has already commenced.
• Implement data integrity assurance processes for information submitted by service providers	
• Clarify responsibility for monitoring service provider compliance with service quality standards	
4. The Department of Health should:	
• Improve performance measures used for reporting publicly on the AOD program	The Department accepts the recommendation and work in this area has already commenced.
• Take definitive action on the wealth of review recommendations.	The Department accepts the recommendation. Outcomes of the key recent reviews will inform AOD service system reform. Work in this area has already commenced.

Auditor-General's reports

Reports tabled during 2010–11

Report title	Date tabled
Portfolio Departments: Interim Results of the 2009–10 Audits (2010–11:1)	July 2010
Taking Action on Problem Gambling (2010–11:2)	July 2010
Local Government: Interim Results of the 2009–10 Audits (2010–11:3)	August 2010
Water Entities: Interim Results of the 2009–10 Audits (2010–11:4)	August 2010
Public Hospitals: Interim Results of the 2009–10 Audits (2010–11:5)	September 2010
Business Continuity Management in Local Government (2010–11:6)	September 2010
Sustainable Farm Families Program (2010–11:7)	September 2010
Delivery of NURSE-ON-CALL (2010–11:8)	September 2010
Management of Prison Accommodation Using Public Private Partnerships (2010–11:9)	September 2010
Soil Health Management (2010–11:10)	October 2010
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The Department of Human Services' Role in Emergency Recovery (2010–11:12)	October 2010
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Security of Infrastructure Control Systems for Water and Transport (2010–11:15)	October 2010
Auditor-General's Report on the Annual Financial Report of the State of Victoria, 2009–10 (2010–11:16)	October 2010
Restricting Environmental Flows during Water Shortages (2010–11:17)	October 2010
Victorian Registration and Qualifications Authority (2010–11:18)	October 2010
Acquittal Report: Results of the 2009–10 Audits (2010–11:19)	February 2011
Effectiveness of Victims of Crime Programs (2010–11:20)	February 2011
Motorcycle and Scooter Safety Programs (2010–11:21)	February 2011

Report title	Date tabled
Construction of Police Stations and Courthouses (2010–11:22)	February 2011
Environmental Management of Marine Protected Areas (2010–11:23)	March 2011

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