# **Care and Complexity:** Towards a re-designed Victorian AOD Service System

Report prepared by:

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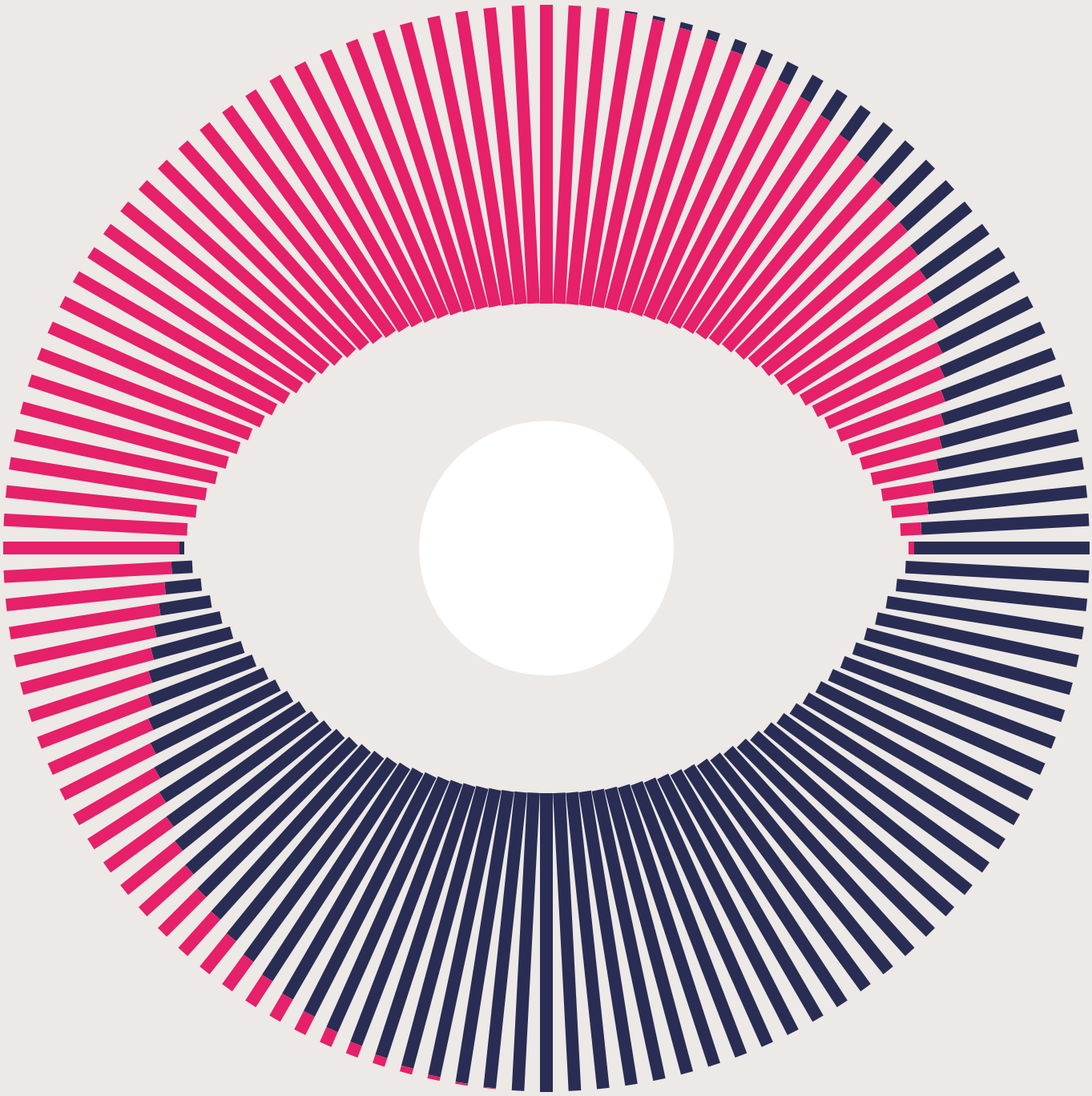

VAADA acknowledges Professor Alison Ritter, Meg Grealy and Keelin O'Reilly from the Drug Policy Modelling Program, Social Policy Research Centre, UNSW for undertaking this research and authoring the final report. We are also grateful to the participants whose voices, input and observations underpin the findings and recommendations. Thank you also to Sam Biondo, VAADA's former CEO, who initiated the project and whose vision for an improved AOD service system for some of the most marginalised Victorians never waned.

We acknowledge the Traditional Owners of the lands on which much of this research took place, the Bedegal people, and the Wurundjeri people, where the fieldwork was undertaken.

VAADA also acknowledges and celebrates people and their families and supporters who have a lived and living experience of alcohol, medication and other drug use. We value your courage, wisdom and experience, and recognise the important contribution that you make to the AOD sector in Victoria.

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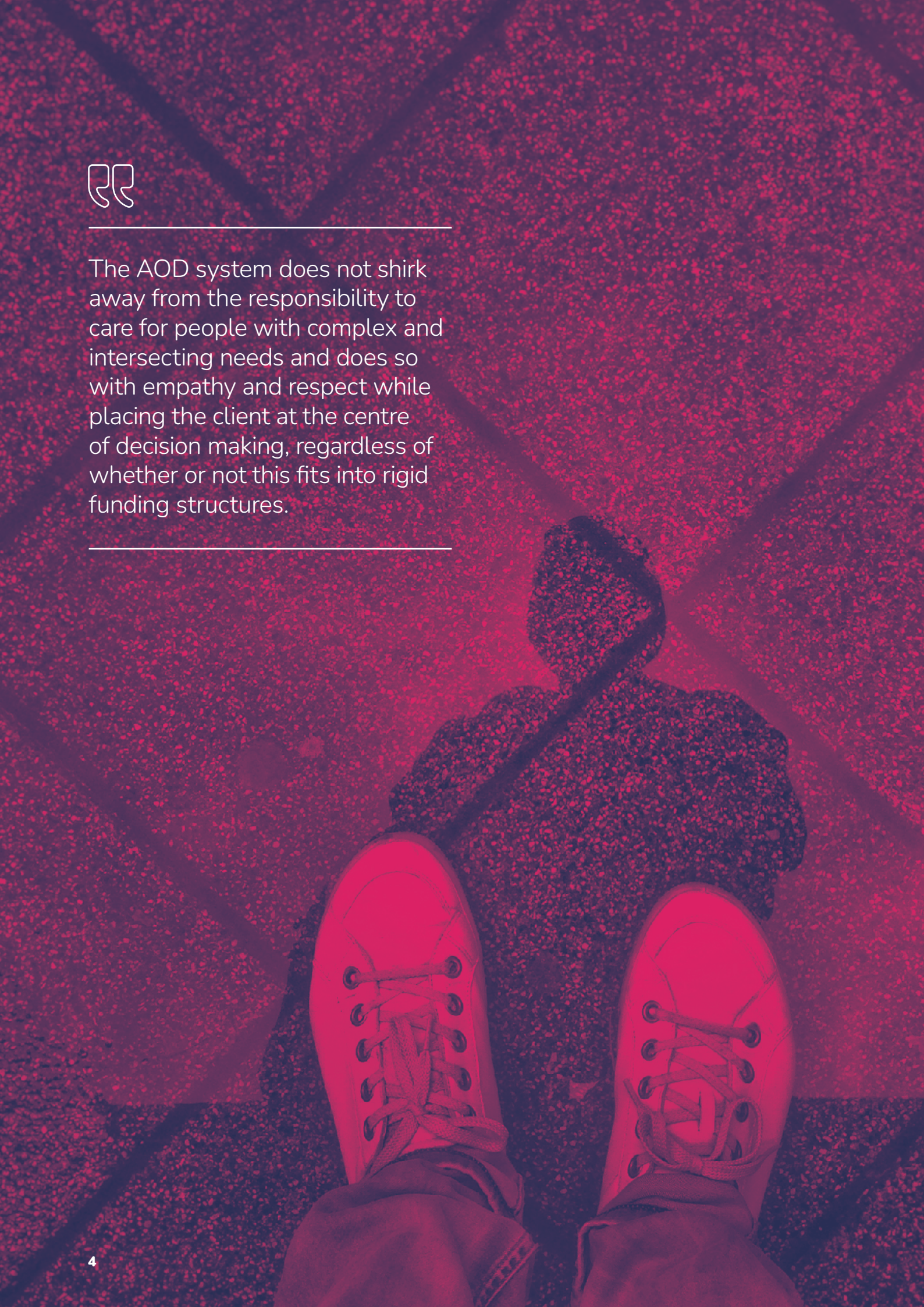

The AOD system does not shirk away from the responsibility to care for people with complex and intersecting needs and does so with empathy and respect while placing the client at the centre of decision making, regardless of whether or not this fits into rigid funding structures.

# 1. Background

## In 2023, the Victorian Alcohol and Drug Association (VAADA), engaged the Drug Policy Modelling Program, University of New South Wales (UNSW), to review the current state of the Victorian Alcohol & Other Drug (AOD) treatment system.

The goal was to generate a comprehensive picture of the strengths and weaknesses and specific challenges for the Victorian AOD sector and consider potential service system design solutions. This is a summary of the final report: Victorian Service System Design Project (Ritter, Grealy, O'Reilly, 2023.)

The Service System Design Project engaged multiple stakeholders from the AOD system and from intersecting systems of care via focus groups (91 participants), a one-day workshop (55 participants), and a small number of interviews (n= 10). These consultations were complemented by a historical overview and document analysis of program guidelines and policy documents from the Victorian Department of Health; previous reviews and inquiries of the Victorian AOD system or related systems; submissions to inquiries; and relevant literature and reports.

Aspects of the AOD system that were out of scope for this project included:

- Private hospitals and private AOD counselling services
- Self-help (AA, NA)
- Harm reduction services, except where provided in the context of NGO treatment services
- Opioid agonist treatment
- Drug law reform (decriminalisation, legalisation)

VAADA and the DPMP team are grateful to the large number of participants who gave freely of their time to contribute to this project by participating in focus groups, providing written materials, or attending the all-day workshop. We acknowledge your passion and commitment to improving the Victorian AOD service system.

**91**

**Focus group participants**

**55**

**One-day workshop participants**

**10**

**Interviewed participants**

# 2. Executive Summary

The Victorian AOD treatment system, like those in other states and territories in Australia, cannot meet the community's current need for AOD treatment. Chronic underfunding sees demand for AOD treatment far exceeding capacity, with significant wait times. Past reforms, designed to improve demand pressures and make the AOD system more efficient and effective have not remediated demand and have contributed to other problems.

One legacy of multiple reforms is a rigid and siloed set of commissioning systems which bear little resemblance to AOD treatment on the ground. This rigid set of commissioning systems and associated features such as defined service streams and performance targets have disempowered the workforce, stifled innovation, and reduced clinical flexibility. At the same time, gaps in other service systems, such as the mental health system, have increased workloads as staff work outside the bureaucratic boundaries (and beyond funding envelopes) to meet client need. This has also raised questions about how the Victorian AOD sector defines itself.

In response to demands from other systems of care, the Victorian AOD treatment system has evolved to fill treatment gaps. However, filling gaps in other systems of care has led the AOD system to be described as "all things to everybody" and has been at the expense of consolidating a specialised function. This tension (being specialised versus holistic) is evident where other systems of care such as the mental health system bump up against the AOD system and challenge the AOD system to work outside its more specialised function.

Articulating an agreed shared vision for the AOD treatment system which would include clearer specification of the problem(s) that the AOD system is trying to address is recommended.

Irrespective, and as noted in the Mental Health Royal Commission, clients do not care for clinical boundary issues and simply want service providers to manage these tensions and provide quality care. This is where the AOD sector excels. Service providers and staff model an exceptional level of commitment to clients and their welfare, whatever their needs. The AOD system does not shirk away from the responsibility to care for people with complex and intersecting needs and does so with empathy and respect while placing the client at the centre of decision making, regardless of whether or not this fits into rigid funding structures. Nonetheless, a review of the AOD funding model (the Drug Treatment Activity Unit – DTAU) is required to account for the actual work being undertaken by staff. Further, consideration of building more multi-disciplinary teams within services to meet multiple and overlapping client needs is worthy of consideration. Collaborating with other intersecting systems of care will also improve overall responses to AOD.

Past reforms have also failed to effectively fix some of the AOD sector's other big challenges including difficulties clients face navigating and accessing the AOD treatment system and moving between service systems. There was broad agreement by participants who informed the report that the catchment-based intake system was not working well and not achieving what was intended. The entry points are not transparent to the public, nor to other care systems (e.g. GPs, MH services) and there is not adequate support for clients navigating the start of their treatment journey. Notably for rural and regional services, the catchment-based intake is generally limited to telephone. This disadvantages many potential clients and does not allow for rapport building. The intake system needs to be improved.

Another long-standing issue relates to data. The challenges agencies face accessing accurate and timely data from the government's Victorian Alcohol and Drug Collection (VADC) system have been well documented.[1] Despite this, there has been little improvement. In the absence of government action, VAADA has initiated a data collaboration pilot project (VAADABase) with the AOD sector to empower agencies to take greater control over their data and generate more insights. Additional government support is required to fix the problems with data.

People who are seeking help from the AOD system are stigmatised, highly vulnerable and engage in behaviour that has the potential to have detrimental effects on their lives and at times the people around them. The Victorian AOD sector should remain vigilant in its own use of language and terminology to continue to role model practice that reduces stigma and supports therapeutic outcomes for clients.

Many of the issues outlined above are long-standing and complex. Within the AOD sector there are differences of opinion about the exact nature of the problems and their solutions. To work through these divergent perspectives and towards solutions requires creating space for dialogue among the AOD sector. These dialogic spaces need to ensure that there is representation from multiple stakeholders and that there is room for difference.

There was a broad agreement by interviewed participants that the catchment-based intake system was not working well and not achieving what was intended.

1 See for example the Victorian Auditor General Office's report into Victoria's Alcohol and Other Drug Treatment Data, October 2022 (https://www.audit.vic.gov.au/report/victorias-alcohol-and-other-drug-treatment-data?section=34251--1-audit-context)

## **Eight recommendations** for reforming the Victorian AOD treatment system were made by the authors:

1. **Articulate an agreed, shared vision for the AOD treatment system:** Create a clear narrative and vision for the AOD system which would include clearer specification of the problem(s) that the AOD system is trying to address, and the ways in which it does this.

2. **Improve the intake system:** Redesign entry pathways, enhancing visibility and focusing on relational engagement rather than impartial intake assessment.

3. **Empower the workforce and increase clinical flexibility:** Address workforce disempowerment and lack of clinical flexibility by advocating for supportive management practices, clinical supervision, and autonomy for practitioners.

4. **Establish and fund multi-disciplinary teams:** To provide holistic care, form multi-disciplinary teams including various healthcare professionals and integrate AOD treatment with mental health treatment to provide holistic care.

5. **Establish a new funding model and data collection system:** Revise the current AOD funding model (DTAU) and improve data collection systems to enable effective advocacy and service provision.

6. **Monitor terminology to role model the reduction of stigma:** Use person-centered language across the AOD sector to role model the reduction of stigma and discrimination, acknowledging the importance of inclusive terminology.

7. **Leverage reform in other systems of care:** Collaborate with other intersecting systems of care to improve overall responses to AOD.

8. **Create space for dialogue:** Foster spaces for dialogue among stakeholders to develop a shared understanding and solutions for the AOD system's challenges.

## Next steps

The recommendations on the previous page require strong collaboration between the AOD sector, the peak body and the Victorian government. The recommendations also require a vehicle or mechanism through which they can be realised.

In 2024, the Victorian Government announced its commitment to develop a Victorian AOD Strategy. Including the findings and recommendations from the Service System Design project into the development of a Victorian AOD strategy will help ensure the strategy is fit for purpose, reflects the needs of the Victorian AOD sector and most importantly, the needs of those who seek our help. The findings and recommendations of this report can be included alongside other inputs into the strategy to ensure coherence.

A Victorian AOD Strategy should include broad consultation with AOD sector stakeholders (and stakeholders in other intersecting systems of care), be resourced appropriately, and continue to be monitored and evaluated. VAADA will continue to work with government and our departmental colleagues toward the development of a Victorian AOD Strategy. Irrespective, the findings and recommendations in this report will underpin VAADA's continued work towards reducing AOD-related harms, promoting wellbeing and supporting people to reach their potential.

# 3. Findings

## 3.1 A Product of its Past

The AOD service system is young compared to the other established systems of care such as health and mental health. Prior to the late 1990s, AOD was largely integrated into the mental health system but was separated in the context of a broad governmental shift away from state-run services. Unlike other states and territories, Victoria's AOD services are now largely provided by NGOs, necessitating a complex system of commissioning.

Multiple reviews have highlighted longstanding challenges regarding service delivery and client experience in Victoria, including difficulty accessing and navigating the system, a lack of continuity of care, and poor links to other systems (MH, health, family violence, housing). An additional longstanding challenge identified is the AOD data collection system (the Victorian Alcohol and Drug Collection – VADC), which has been described as complex, lacking quality, and imposing significant resource cost or agencies for little benefit.

Unlike other states and territories, Victoria's AOD services are now laregely provided by NGOs, necessitating a complex system of commissioning.

In 2014, a major recommissioning of both AOD and MH sectors saw the introduction of a new centralised intake system, a shift from unit-cost funding to activity-based funding (the Drug Treatment Activity Unit – DTAU), and redefined service types. While system reform was justified, the reforms were piecemeal and incomplete, resulting in a service system both centralised and fragmented, highly rigid and bureaucratic (e.g. with internal structures and frameworks that do not reflect service delivery "on the ground"); with agencies caught between competing demands to be both holistic and specialised, and with rigid funding "streams" that impede their ability to provide wraparound care.

In addition, reform of related systems – most notably Domestic and Family Violence and Mental Health – have significantly impacted the AOD service system, increasing workload and skill requirements with only limited additional resources or support. This has provoked thinking about where to place the boundaries around an AOD system that requires overlap and co-ordination with intersecting systems of care.

Despite these difficulties the AOD workforce exhibits an exceptional level of commitment to clients and their welfare. The commitment to high quality care, meeting clients' needs, adapting to circumstances, and remaining positive were key features in the consultations. Further, the data highlighted a system that is respectful, empathetic, and understanding of the clients it seeks to serve. AOD services have an open-door policy, and do not turn people away.

## 3.2 Intersecting systems of care

There is a complex set of intersecting systems of care required to meet the needs of people with AOD problems. This includes the MH system; the criminal justice system; primary healthcare, hospital and emergency care; the social welfare system; families and carers; and other systems of support such as family and domestic violence services.

### Key conclusions from examining intersecting systems of care are:

- AOD does not operate in a 'vacuum' and each of these service systems need the others to operate effectively.

- The intersecting systems of care are under-resourced as is collaboration between these systems and the AOD sector.

- These systems represent the various complexities and components that enable holistic responses to a person, however, they are structured and operate as disparate systems. This is compounded and reinforced by different funding models, data systems and practice disciplines.

- Different philosophies underpin other systems of care which can cause tension and friction when they interact with the AOD treatment system.

## 3.3 Barriers, Challenges and Issues from within the AOD system

Within the Victorian AOD treatment system, there are a range of barriers, challenges, and issues. These include chronic underfunding; the impact of multiple past reforms; workforce challenges; a complex client base and different treatment approaches, and stigma and discrimination.

AOD treatment is underfunded with the demand for AOD treatment far exceeding the supply of treatment places. There are not enough treatment places and people have to wait to gain access to treatment. A severely constrained funding environment also creates competition between service providers for scarce resources.

Despite undergoing multiple reforms over the years, and unlike related systems, the AOD system has not had a royal commission. A sense of being responsive to changes in other systems, whilst not being able to drive change remains a source of tension.[2]

While workforce was out of scope for this project, there were many instances where workforce challenges were raised. These included issues such as a lack of a workforce development plan, no time/resources for professional development, no shared understanding of the minimum skills/competencies required for the AOD workforce, and the lack of promotion of AOD pathways in undergraduate degrees (e.g. medicine, nursing, mental health). Attracting and retaining workers was also highlighted.

The AOD sector has a complex and diverse client base. This necessitates multiple and varied treatment approaches and interventions. AOD treatment is provided across differing settings, ranging from acute hospital settings to outpatient community services. Each treatment service has its own philosophy and treatment approach, and models of care differ. There is great strength in such diversity, but it also comes with challenges, including speaking with one voice, and the extent to which the AOD sector regards itself as 'specialised' versus 'holistic'. Client complexity also requires the AOD system to form and maintain connections with other service systems presenting challenges to care coordination.

There is pervasive stigma and discrimination against both individuals with substance use issues and the workforce assisting them. Public attitudes are largely negative, especially towards illicit drug use, which is further compounded by criminalisation.

Addressing these issues requires addressing funding shortages, promoting workforce development, streamlining treatment approaches, enhancing connections with other service systems, combating stigma and discrimination and promoting policy reform.

Despite undergoing multiple reforms over the years, and unlike related systems, the AOD system has not had a royal commission.

2 It is also noteworthy that the 2014 reform of the AOD system was not completed and that there has been limited change in the 10 years since.

## 3.4 Findings Summary

# Four key themes arose from the data collected:

**Access to treatment and system navigation:** System navigation is difficult. The intake system is not fit-for-purpose and the centralised catchment-based intake system does not work well.

**"Holistic" and "specialised":** There is an inherent tension between being "holistic" and being "specialised". Holistic suggests a generalist approach – providing whatever care and support a client might need at that point in time, whereas specialised suggests a focus on one particular condition – in this case AOD-related harm. There is a need to clearly distinguish AOD from other systems of care and support, yet what this looks like in practice will require working through.

**System rigidity:** funding "streams" and funding mechanisms impeded the ability of services to provide wraparound care, flexibly deploying specialist AOD interventions as needed.

**Accountability, monitoring and data collection:** The VADC does not appear to collect data seen as important by the services, and services do not feel in control of their data.[3] Further, important activity that the system needs to have documented such as the amount/extent of mental health treatment being provided, or the amount of family engagement, is not recorded.

3 In response to this issue, VAADA has initiated a data collaboration project (VAADAbase). This project involves participatingVictorian AOD services sharing VADC data with a third-party data custodian to gain new insights and improved use of data.

# 4. Designing a new Victorian AOD treatment system

We have identified **eight recommendations** to improve the Victorian AOD service system. It also identifies the problem or problems each recommendation is attempting to solve and suggested approaches.

| Recommendation | Problem being solved: | Approaches may include: |
|---|---|---|
| 1<br>Articulate an agreed, shared vision for the AOD treatment system | **Lack of shared vision for the purpose of an 'AOD treatment system' sees the AOD sector being described as being "all things to everybody" and was noted as a key stumbling block for the sector.** | Articulate a clear narrative and vision for the AOD system, such as a shared vision statement, which would include clear specification of the problem that the AOD system is trying to address, and the ways in which it does this.<br><br>It could identify the core functions, roles, and responsibilities of the AOD treatment service system, and provide the opportunity to identify the common values and strengths of the AOD system. |
| 2<br>Improve the intake system | **The current intake system is not working effectively. Lack of clear pathways into AOD treatment and entry points which are not transparent makes access complex, and service navigation difficult.**<br><br>**Telephone-based intake does not allow for rapport building.** | Refocus towards relational engagement between service and client.<br><br>Engage with lived and living experience and families to support redesign.<br><br>Provide more support for clients navigating the start of their treatment journey. |

| Recommendation | Problem being solved: | Approaches may include: |
|---|---|---|
| 3<br>Empower the workforce and increase clinical flexibility | **Bureaucratic structures (such as funding streams and funding activity units) have resulted in a lack of clinical flexibility and impede the deployment of a variety of AOD interventions as needed.** | Engage in dialogue with the Department of Health to identify how flexibility and practitioner choice can be increased.<br><br>Appoint senior clinical leaders as champions for the sector.<br><br>Develop a shared strengths-based vision (Recommendation # 1) to build practitioner identity.<br><br>Build and support networks of practice to contribute to a sense of empowerment. |
| 4<br>Establish and fund multi-disciplinary teams | **To improve holistic, comprehensive AOD clinical care, multi-disciplinary teams are required. This would include psychological, social, medical, nursing, lived/living experience practitioners and harm reduction workers within all AOD treatment services.** | Examine existing multi-disciplinary models of care in the AOD sector, and their funding arrangements, to increase a more multi-disciplinary team approach.<br><br>Embedding family-inclusive practice across all AOD services.<br><br>Engage with the MH reforms with a co-design approach and create strong collaborative clinical care pathways between mental health services, AOD services and primary healthcare to allow for better integration of responses. |

| Recommendation | Problem being solved: | Approaches may include: |
|---|---|---|
| 5<br>Establish a new funding model and data collection system | **A significant amount of activity undertaken by AOD services is not covered by the DTAU.**<br><br>**The quality and accessibility of data are limited and there are substantial problems with the VADC.** | Develop clear documentation of the elements included within DTAU and identify clinical activities currently excluded to be matched with an appropriately agreed price.<br><br>Consider a shift to block funding for AOD services, either ceasing the DTAU or supplementing it with block funding. Hospital activity based funding, on which DTAU is modelled, includes a block funding component.<br><br>Implement recommendations from VAGO report; demonstrate efficacy of the VAADABase pilot; prioritise improving the quality and utility of AOD treatment data as part of a Victorian AOD Strategy |
| 6<br>Monitor terminology to reduce stigma | **Certain phrases such as 'forensic clients' merges the identity of the person with the system within which they are entangled.**<br><br>**The phrase "families and carers" is not inclusive of friends and other types of social support that may be important to an individual.** | Create a space for people with lived and living experience to share their preferences regarding potentially problematic language, phrases and terms.<br><br>Identify and change stigmatising terms and words used to describe people, functions and activities alongside Harm Reduction Victoria and SHARC.<br><br>Develop anti-stigma content for managers and leaders training. |

| Recommendation | Problem being solved: | Approaches may include: |
|---|---|---|
| 7<br>Leverage reform in other systems of care | **The AOD system is reliant on other intersecting systems of care, which themselves have their own challenges and issues and over which AOD has limited authority.** | Reform the specialised AOD system simultaneously with reform of the various allied systems of care.<br><br>Work closely with the intersecting systems of care and identify opportunities for change within those systems that do not rely on an external authority such as a Royal Commission. This may involve incentivising systems of care with benefits for more collaborative engagement. |
| 8<br>Create space for dialogue | **Opportunities for in-depth intra sector dialogue on the challenges facing the sector, and their solutions, are limited.**<br><br>**Insufficient dialogue with other intersecting systems of care.** | Invest in creating safe spaces for dialogue to discuss intra and inter sector challenges as part of the process of developing a Victorian AOD Strategy.<br><br>Give carriage to the peak body to lead in this work. |

# References

Ritter, A. Grealy, M. & O'Reilly, K. (2023) Victorian Service System Design Project. Drug Policy Modelling Program, SPRC, UNSW.

## About VAADA

The Victorian Alcohol & Drug Association (VAADA) is a member-based peak body representing organisations that support people who have alcohol and other drug (AOD) needs in Victoria. We work to prevent and reduce AOD-related harms in the Victorian community by ensuring the people experiencing those harms, and the organisations that support them, are well represented in policy design, program development and public discussion.

We do this by:

- Engaging in policy development
- Advocating for systemic change
- Speaking on issues identified by our members
- Providing system leadership
- Creating space for professional collaboration in the AOD sector
- Maximising opportunities to build professional capacity and capability
- Keeping our members and stakeholders informed about issues relevant to AOD
- Supporting evidence-based practice that reduces AOD-related harms and maintains the dignity of those who use AOD (and related) services.

## About DPMP

The Drug Policy Modelling Program (DPMP) at the Social Policy Research Centre, UNSW aims to improve alcohol and other drug policy. The goal of the DPMP is to create valuable new drug policy insights, ideas and interventions that will allow governments to respond with alacrity and success to drug-related problems. We do this through generating new research evidence which is timely and relevant to current drug policy issues; translating research findings into meaningful information to assist policy decision-makers, and studying policy processes. We are at the cutting edge of national and international work in alcohol and drug policy and conduct commissioned research for governments and non-government organisations across Australia.

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