# Strengthening the Alcohol and Other Drug (AOD) service system for improved client experiences

Stakeholder Consultation
Summary Report

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# Background

AOD agencies in the EMR working together to identify and implement strategies that strengthen the AOD system.

Key Issues :

- coordination of care across the service system
- management of the transitions between services
- duty of care

**Aim of project**

The "Strengthening the AOD service system for improved client experiences" project aims to work with AOD agencies in the EMR to identify and implement strategies that strengthen the AOD system. The project is being implemented by the Outer East Primary Care Partnership (OEPCP) with funding from the Department of Health and Human Services (DHHS).

The purpose of this project is to identify and implement system changes to address issues identified in the review commissioned by DHHS of a critical incident in 2017. The review raised issues regarding the coordination of care across the service system, the management of transitions between services and duty of care issues.

Feedback from consumers of the AOD system also highlighted areas that consumers felt could be improved. Key areas included:

- Enhanced coordination of services and reduced waiting times
- Increased ease of access to services
- Provision of greater support to promote client and carer engagement
- Increased support following discharge from a program/service.

The project will involve two phases. Phase one, stakeholder consultations, will inform phase two. Phase two will involve bringing agencies together to consider the findings of stage one and identify priority areas for improvement. Agencies will be offered support to implement system improvements using a quality improvement process.

# Background

This report outlines the findings of stakeholder consultations and identifies key areas agencies could work on together to improve AOD services in the EMR.

**Phase One: Stakeholder consultations**

The purpose of the stakeholder consultations was to gain a greater understanding of the current system challenges and identify opportunities for improvement.

The review involved state funded community based AOD services in the EMR. This included agencies in the two consortiums in the region, the Eastern Consortium of Alcohol and Drug Services (ECADS) and Substance Use Recovery (SURe). Residential rehabilitation services, forensic services (ACSO) and youth services (YSAS), operating in the region, were also invited to participate in the consultations.

Agencies involved in the consultations included:

- EACH (including Residential Rehabilitation at MARP )
- Australian Community Support Organisation (ACSO)
- Eastern Health/Turning Point
- Access Health and Community
- Inspiro
- Anglicare
- The Salvation Army (Salvocare Eastern) (including The Bridge Residential Rehabilitation)
- Self Help Addiction Resource Centre (SHARC)
- Link Health and Community

# Methodology

Eighteen interviews across ten agencies were conducted.

A range of roles were represented in the consultations including managers, team leaders and clinicians.

**Target Audience**

A range of managers, team leaders and clinicians from each agency were invited to participate in the interviews. Eighteen interviews across ten agencies were conducted, with an even distribution of managers, team leaders and clinicians.

**Interview Questions**

The interview questions were developed through a review of the critical incident report and feedback from workshops held with AOD executives and managers in November 2017.

Key areas of focus for the interviews included:

- Level of confidence that clients can locate and access an appropriate service
- Waiting times for services
- Sharing of client and service information across agencies within the catchment
- Views on why some treatment streams are oversubscribed/undersubscribed
- Integration of care with other service providers
- Barriers to engagement and strategies for maximising engagement
- Key challenges in day to day work.

# Data collection and analysis

A content and thematic analysis of the summarised interview data was conducted to elicit key themes.

In-depth semi-structured interviews with service providers were conducted by an independent consultant.

Interviews were face to face or telephone interviews of approximately one hour duration, using the predetermined interview questions.

The same interviewer was used for all interviews. All interviews were taped, reviewed and each interview summarised. A content and thematic analysis of the summarised interview data was conducted to elicit key themes.

Key themes that emerged from the interviews were arranged under the following headings:

1. Promotion and awareness of services in the region to first time users
2. Consortium intake and referral processes
3. Withdrawal services and residential rehabilitation services
4. Information sharing
5. Forensic clients
6. Care and recovery coordination
7. Workforce and resourcing
8. The consortiums

# 1. Promotion and awareness of services in the region

Most interviewees acknowledged that their agency websites and consortium websites could be more user friendly and less agency focused.

There is scope to take a more systematic and coordinated approach to raising awareness of services across the region.

Direct Line was seen as an important gateway and referral process for people seeking support with AOD issues. There was a strong sentiment in the feedback that there should be more promotion of Direct Line at a state wide level (similar to Gamblers Help).

Active promotion of services to General Practitioners (GPs) and to the general community is limited. How best to promote services is complex, in particular for those services that are not funded for intake, as these agencies are required to redirect clients to central intake.

There was a mixed response as to whether or not agencies and/or the consortiums should be trying harder to promote their service to first time users. Some felt this was important. Others felt that most services were set up to deal with complex clients and given this group were usually frequent service users, already had the knowledge and experience required to access services.

It is unclear if GPs are fully aware of the range of AOD services available including the referral pathways. Interviewees indicated that most GP referrals tend to be for residential withdrawal units or for Turning Point via the Eastern Health website. AOD services for the EMR are not on HealthPathways - a localised referral pathway program developed for GPs.

Most interviewees acknowledged that their agency website and consortium websites could also be more user friendly and less agency focused.

# 2. ECADS and SURe intake and referral

New central intake processes are working well but opportunities to improve efficiency for agencies exist.

Waitlist times have improved but this is seen as precarious as waitlist times increase very quickly when agencies lose staff.

The new central intake processes for the two consortiums were seen as having both improved since the previous arrangement and continuing to improve as intake services and agencies "bed down" processes. Some agencies still have concerns about the equity of distribution of referrals across agencies.

Agencies expressed concerns that redirecting clients to central intake can be confusing for clients, especially if a client is referred directly to a service. Most agencies indicated that they do have a flexible approach to intake and try to respond immediately to people who present at their service. However some limitations exist. These include undertaking the intake screen when not funded to do so and a concern that they may be seen as taking on the role of another agency and/or a bypassing partnership agreements.

Both intake services indicated confidence that they were usually able to refer clients to an appropriate service within the region, in a timely manner, and that referrals are based on client need and preference. Although it was acknowledged that waitlist time can increase significantly if agencies lose staff.

There was a common view that the weekly allocation meetings held by the two consortiums supported a more equitable distribution of clients across the services and a more collegial approach. Some interviewees indicated further improvements could be made to minimise duplication for agencies and ensure that clients are directed to the agency that can best service their needs.

A central intake for the metro area was suggested by some. Benefits of a central intake might increase ease of client access and reduce the amount of time they spend attending allocation meetings.

# 3. Withdrawal services and residential rehabilitation services

Accessing residential rehabilitation services is a concern for all agencies.

Tensions exist for AOD workers and rehabilitation services in prioritising a limited resource and identifying appropriate clients for the service.

**Withdrawal services**

Most agencies felt that they were able to provide withdrawal support to their clients in the community and access residential units when needed.

**Residential rehabilitation services**

Accessing residential rehabilitation services was a concern expressed by most interviewees. Concerns related to:

- unresponsive intake processes and/or difficulty identifying intake contact points
- extended wait times
- inconsistencies and lack of transparency with admission criteria and processes
- frustrations with the assessment processes/information and time required to get clients into a service
- difficulty accessing services for clients with mental or physical health problems

The need to have a central waitlist for rehabilitation services and bed vacancy register was expressed by a number of interviewees.

Residential rehabilitation services also expressed a number of concerns:

- frustration that they receive referrals for clients that do not meet their entry criteria or are not mentally/physically well enough to participate in their program
- feeling pressure from clinciians to admit clients when they are not well enough to participate in their rehabilitation program.
- not being provided with all relevant information particularly in relation to mental health issues
- the challenge of aligning withdrawal and admission to rehabilitation

# 4. Information sharing

There is a high level of confidence in the systems and processes for information sharing on referral across the consortium partners but some concerns with information sharing at key care transition points.

Capacity to work collaboratively to plan care is variable depending on what other agencies are involved in the person's care.

There was a general consensus that there is a good working relationship between clinicians across services and consortiums. Existing shared agreements around what information is required for referral work well.

There was a high level of confidence that all appropriate information is shared across services when making referrals. Agencies indicated that there is still room for improvement in relation to reducing duplication and improving timely access to assessment data.

Clinicians also indicated that they work collaboratively and undertake joint care planning with other agencies, particularly mental health services. They reported that this works really well if the client is accessing mental health services from within their agency or from an agency that they have a strong relationship with. However it can be more challenging with private and acute services.

Concerns were raised about the varying and inconsistent levels of communication with clinicians when clients are discharged from some residential withdrawal units. Clinicians are often not provided with a notification of early discharge or discharge summary. This was seen as particularly concerning given that this period is a time of high risk for client overdose.

# 5. Forensic clients

Agencies face a number of challenges in engaging with and responding to the needs of forensic clients within the limitations of current resources.

There were a number of issues raised by services in relation to forensic clients and these were consistent across all services. Issues included:

- Limited resource for a large number of referrals
- High rate of Fail to Attends (FTAs) and difficulties contacting clients
- Frustration over having to prioritise these clients over other clients
- Lack of staff trained to work with forensic clients
- Difficulty meeting targets - for some agencies and across the consortium
- Lack of bridging support offered by ACSO
- Providing mandated treatment if the client is not ready for change
- Expense to train staff to be competent to work with forensic clients
- Extra resourcing required to try and engage these clients

Feedback from ACSO mirrored many of the concerns raised by services and highlighted the difficulties that ACSO has in responding to many of these issues. Issues identified by ACSO included:

- Wait time for forensic clients is highly variable across agencies and difficult for ACSO to monitor
- Long wait times for services result in a higher number of (FTAs)
- Engagement strategies are required to maximise opportunities such as sequencing treatment work with parole offices and/or contacting clients to introduce themselves before they attend their service.
- Clinicians without experience in working with forensic clients are not able to maximise opportunities
- Provision of bridging support for clients waiting to get into a service – there is some debate over who should provide this service - ACSO or AOD agencies
- Assessments for rehabilitation in jail - most rehabilitation services require a recent assessment making timing of assessment difficult as discharge dates can be unpredictable

# 6. Care and recovery coordination

Agencies are still working through the best model of care to integrate care and recovery coordination into their processes.

Most agencies indicated that they struggle to meet their care and recovery coordination (CRC) targets. There were a number of issues identified that made it difficult for agencies to meet these targets:

- Lack of clarity around the CRC role
- High number of contact hours required to meet targets
- Overlap between the counselling role and the CRC role– if counsellors are providing CRC it can be hard to separate this work from counselling work and accurately record each episode of care
- Difficulty in providing clear guidelines around eligibility for CRC as client need changes frequently between complex and standard care
- Tracking CRC hours is difficult

A number of different approaches to CRC were described. Approaches fell into two categories; either separating out the role, where clients have a CRC clinician and a counsellor, or embedding the CRC work into counselling. Agencies indicated that both these approaches have been difficult to embed. Most agencies are still trying to find the best model of care to integrate CRC into their processes so that it can be accurately reported on.

# 7. Workforce and resourcing

Resourcing and workforce issues were seen as important for all stakeholders.

There were three consistent themes when interviewees were asked if there were any other issues they wanted to highlight or provide feedback on. These related to workforce, resourcing and the consortiums.

**Workforce**

"The Reform" was reported by most as being highly disruptive, resulting in a mass exodus of AOD workers, difficulties in recruiting to positions and fatigue for those still in the system.

New integrated models in community health have resulted in AOD staff being supervised by people not skilled in the area of AOD.

The workforce is transitory due to the complexity of the work and poor remuneration. Consequently inexperienced clinicians are working with very complex clients.

**Resourcing**

The sector is seen as very under resourced with agencies indicating that standard counselling sessions do not meet the needs of most clients.

The fact that funding is based on population rather than demand was a concern for many agencies. There is a perception that the Inner East gets more money than the Outer East despite the demand being greater in the Outer East. Agencies did not have evidence to support this.

# 8. Consortiums

Stakeholders are confident in the consortium's processes, collaboration and coordination but question the efficiency of having two consortiums across both regions.

**The Consortiums**

Agencies reported that overall working relationships within and across the consortiums are good. Processes exist that improve transparency and support collaboration and coordination. Agencies indicated that establishing processes and developing a positive working relationship has taken a lot of time and effort. Some tension still remains as the focus is on each agency meeting their targets rather than a collective responsibility for targets.

Team Leaders and managers were positive about the governance and decision making processes that were in place with both consortiums although many commented that input into the distribution of funding was limited.

Most clinicians were unclear of what their consortium relationships and funding arrangements were. They indicated they felt out of the loop in terms of having knowledge and an understanding of the consortium arrangements and activities. The fact that the two consortiums have different processes was seen as particularly problematic for those clinicians that interact with both.

There was a consistent theme that having both consortiums operate across both catchments was not a good idea and that it would be far better to have one in each.

# Opportunities to work together

The findings from the consultation have highlighted areas that agencies could work together on to improve the service system.

The findings from the consultation highlight a number of areas that agencies could work collectively on to develop solutions for improvement. These include:

**Promotion and awareness of services in the region**

Consortium member agencies review how services are promoted/advertised and if this can be more streamlined for clients and other referrers (including greater clarity around who the target audience is e.g.., first time users and/or “frequent flyers”).

**Residential rehabilitation**

Consortium members working with rehabilitation services on the issues identified in this report to develop mutually agreed processes and test solutions that work locally to address the issues raised.

**Forensic clients**

Consortium members working with ACSO on the issues identified in this report to develop mutually agreed processes and test solutions that work locally to address the issues raised.

**Care and recovery coordination**

Consortium members agencies developing a common understanding of Care and Recovery, sharing experiences and testing new models.

**Information sharing**

All AOD agencies in the EMR working together to improve communication and sharing of information at key care transition points.

# Next steps

Next steps

•Include the consumer voice

•Agree on priorities

•Use a quality improvement methodology to identify and implement improvements.

**The OEPCP plans to:**

- Circulate this report to stakeholders
- Convene a workshop with stakeholders to consider the findings of the report and determine/prioritise areas that agencies would like to work together to implement improvements
- Facilitate and coordinate a quality improvement process for working on the agreed areas for change.

**Other areas for consideration**

- Consortium relationships

A number of issues raised in the interviews relate to the operational issues of the two consortiums. These may be issues that the two consortiums could work on internally or use a larger forum involving member agencies across both consortiums to look at developing consistencies across both consortiums.

- Consumer voice

Consulting consumers of AOD services in the EMR to collaborate the findings of the stakeholder consultations is recommended. Consumer input would provide a more robust review of current care delivery issues and ensure decisions/priorities on how the AOD system can be improved, align with the consumer experience.