

# Improving communication, coordination, and collaboration amongst alcohol and other drug treatment funders

Alison Ritter, Liz Barrett and Katinka van de Ven  
Drug Policy Modelling Program  
Social Policy Research Centre  
UNSW Sydney

June 2021

## Table of contents

Executive summary .....	3
Introduction .....	7
The benefits of improved CCC between government agencies .....	8
Approach and methods.....	9
AOD treatment funding – the context for CCC.....	11
The strategies.....	12
1. Building relationships.....	15
Finding common ground .....	15
Build trust and reciprocity .....	16
Grow informal networks .....	17
2. Information sharing .....	18
A central register of funded services .....	18
Publish funding data .....	19
Share strategic plans, procurement practices .....	19
3. Coordinating mechanisms .....	20
Committees, working groups and meetings .....	20
4. Working together.....	21
Coordinated or collaborative planning.....	21
Coordinated or collaborative funding processes.....	23
Coordinated or shared performance monitoring tools .....	23
5. Governance arrangements .....	24
Leadership commitment to CCC .....	24
Role delineation .....	24
Clear governance structures.....	25
Written agreements/MOUs .....	27
Accountability mechanisms .....	28
6. Resourcing CCC .....	29
References .....	31

## Executive summary

Implementation of the National Framework for Alcohol, Tobacco and other Drug Treatment (2019) (otherwise known as the National Treatment Framework or NTF) requires a significant change management program involving all the stakeholders. This project focussed on the multiple governments and organisations who plan, commission procure and fund alcohol and other drug treatment. The presence of multiple funders requires highly effective communication, coordination, and collaboration to give effect to the principles documented in the NTF and to ultimately support the realisation of the NTF aim:

“All Australians seeking alcohol and other drug treatment are able to access high quality treatment appropriate to their needs, when and where they need it”.

This project, commissioned by the Commonwealth Department of Health and undertaken by the Drug Policy Modelling Program, sought to document processes for improving communication, coordination, and collaboration (CCC) between and amongst alcohol and other drug (AOD) treatment funders. It involved data collection (interviews, literature), data analysis (discussions and forums with stakeholders) and preparing this report, which outlines the areas where CCC could be developed. Strategies, actions and discussion of barriers and enablers is also covered. This work should be seen as the start of a process for creating improved CCC amongst AOD treatment funders.

Effective CCC is identified by governments and public administration literature alike as critical to achieving efficient, effective, and accessible public services and better governance. CCC is a central tenet of good practice. In addition to improving efficiencies, CCC is increasingly seen as necessary to achieve greater impact and more durable solutions, and to meet rising expectations of citizens for services tailored to the needs of people and places.

Improved CCC across AOD treatment planners, funders, and commissioners can:

- Improve the accessibility and availability of AOD treatment
- Foster innovation
- Better identify and address service gaps and silos
- Build capacity, partnerships, and networks
- Generate efficiencies for funders and commissioners
- Reduce duplication of machinery of government, and
- Ultimately improve health outcomes for people seeking AOD treatment.

This project identified three core areas where CCC could be developed and actioned. These are:

1. Building Relationships
2. Information Sharing, and
3. Working Together.

These are supported by:

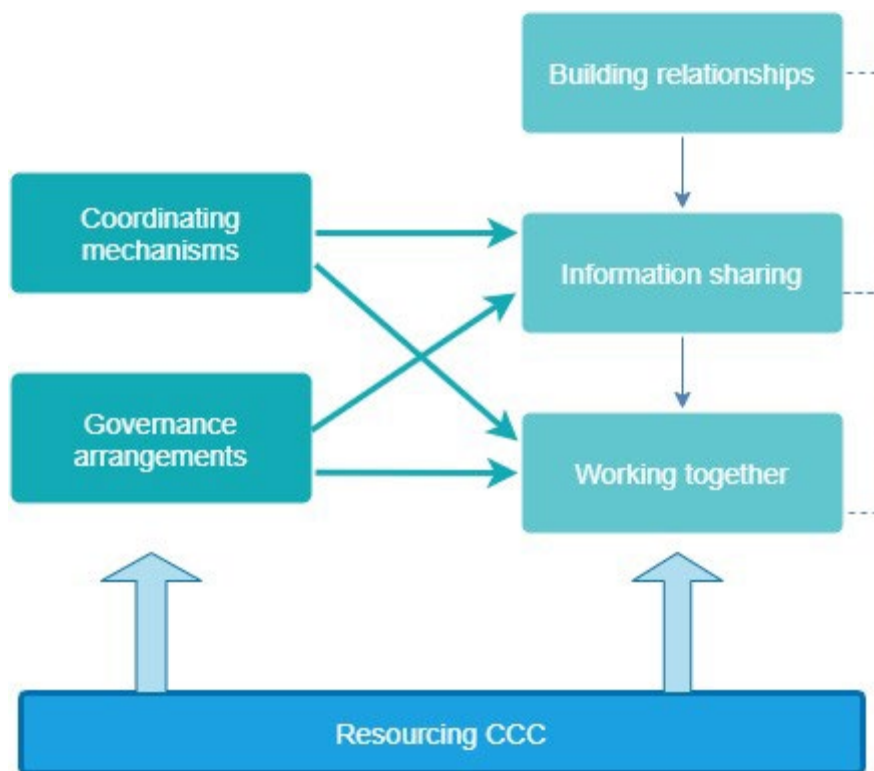
4. Coordinating Mechanisms, and
5. Governance Arrangements.

And underpinned by the notion that:

6. CCC needs to be resourced.

These 6 areas form the structure to the below report.

It is possible to think about each area to improve CCC as building on each other, integrated, and as progressively more advanced strategies:



The areas are all related to each other. For example, without good relationships, information sharing can be impeded. Governance arrangements support working together and working together can create trusting relationships.

Within each of these six areas, there are a number of potential strategies, as detailed in Table 1 below. There is a need for improved CCC at the inter-jurisdiction level (between Commonwealth and states/territories), at the intra-jurisdiction level (between different state departments, between Primary Health Networks (PHNs) and states or between Commonwealth Department of Health and NIAA), and at the intra-department level (between sections within a department of health). Some strategies have greater relevance for improving CCC at the inter-jurisdiction level, whereas others are best suited to the intra-jurisdiction level.

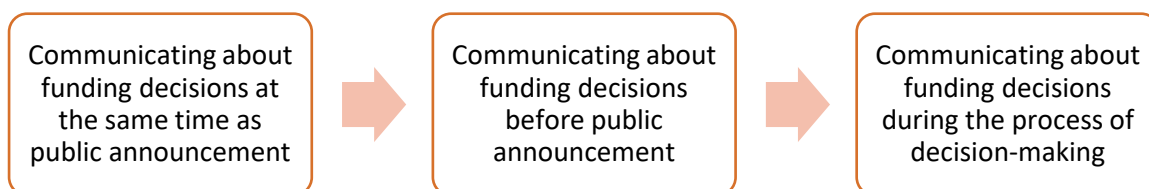
Table 1: Core areas of CCC and related strategies

Core area	Strategies
<b>Building relationships</b>	
	Find common ground/shared interests
	Build trust and reciprocity
	Grow informal networks
<b>Information sharing</b>	
	A central register of funded services
	Publish funding data
	Share strategic plans/intentions
	Share information about funding practices

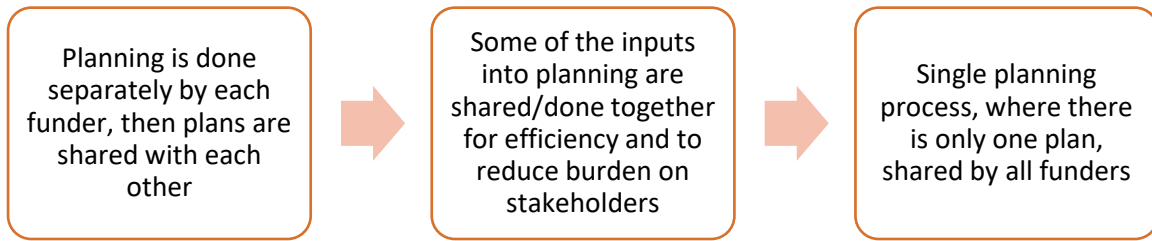
Core area	Strategies
	Verbal/informal information sharing
<b>Coordinating mechanisms</b>	
	Coordinating committees
	Inter and intra-jurisdiction committees/meetings/working groups
	One-off (ad hoc) meetings
	Leveraging existing meetings/committees
	Informal meetings/networking events
<b>Working together</b>	
	Coordinated or collaborative planning
	Coordinated or collaborative funding processes
	Coordinated or shared performance monitoring tools
<b>Governance arrangements</b>	
	Leadership commitment
	Role delineation
	Clear governance structures
	MOUs / written agreements
	Accountability mechanisms
<b>Resourcing CCC</b>	
	Time
	Resources
	Skills development
	Incentives
	Systems thinking

Some of the strategies offer simpler, less resource-intensive strategies (such as a one-off networking event), whereas others require more complex negotiation between different bodies. It is important to pair strategies with the level of coordination being sought and provide the resources to make it happen.

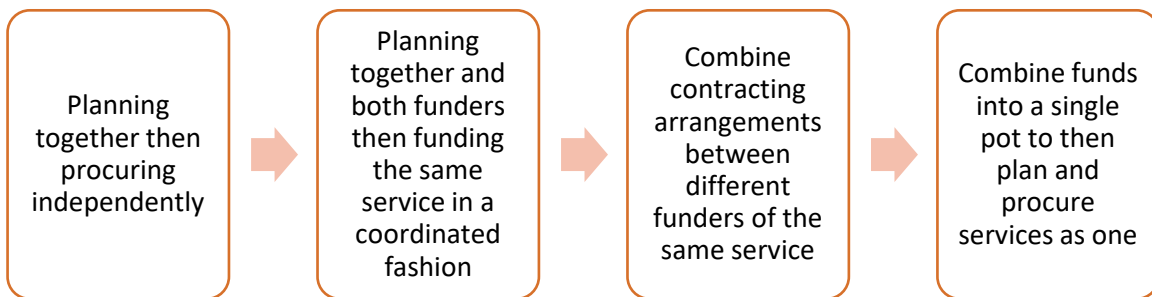
Hierarchies of action can be seen within each area, with simple, informal and/or ad hoc strategies at the beginning, moving towards more integrated, intentional and planned actions. For example, within Information Sharing a hierarchy of actions may look like this:



Working Together, with reference to planning processes for AOD treatment, a hierarchy of actions may look like this:



In the third example, commissioning in a coordinated and collaborative fashion may involve the following stepped approach:



The requirement to engage in effective CCC is now ubiquitous across national strategic frameworks and plans, and a core expectation of government work. This report is a resource for relevant AOD treatment funding bodies to use as they develop action plans toward greater CCC. The strategies identified in this work provide a range of actions funding bodies can undertake to immediately improve CCC, and supports longer-term actions that can be taken suited to agencies at different stages of readiness. There needs to be a body established to drive effective CCC at the national level or it is unlikely to evolve. In the absence of funding bodies taking action on CCC, the aspirations of the NTF will not be realised.

## Introduction

The National Framework for Alcohol, Tobacco and other Drug Treatment (2019), referred to as the National Treatment Framework (NTF) provides a framework for understanding the AOD treatment service system and covers:

- Principles for effective treatment (section 4)
- Principles for effective treatment planning, purchasing, and resourcing (section 5)
- Principles for effective monitoring, evaluation, and research (section 6); and
- Partnerships that are required for a successful AOD treatment service system (section 7).

Full implementation of the NTF requires a major change management program to achieve the outlined principles. In summary, this change management program would need to cover changes within clinical services (for example to align them with the treatment principles), changes to the ways in which treatment services are planned and commissioned (to align them with the planning, purchasing, and resourcing principles), and changes to the ways in which the system is monitored and evaluated. Changed behaviour is required from all the stakeholders – from the multiple governments and organisations who procure treatment to the service provider sector.

Improving communication, coordination, and collaboration (what we refer to herein as CCC) is fundamental to many of the principles articulated in the NTF, and getting CCC “right” was identified by the NTF Working Group as a necessary first step for other elements of the NTF to then be realised. While the NTF principles require improved CCC at all system levels, this project was focussed on CCC amongst AOD treatment funders. The principles in the NTF that explicitly articulate the need for greater CCC amongst treatment funders are outlined below:

**Planning principles (p.14):** “Alcohol and other drug treatment should be carefully planned to meet population needs and occur in a coordinated and joined up way between, within and across funders and between government and non-government sectors, be undertaken in a timely and efficient manner, and engage treatment consumers in planning processes”.

“This means that alcohol and other drug treatment planning should:

- Engage all funders of alcohol and other drug treatment at all levels of government, as well as funders and planners of other systems of care that impact on alcohol and other drug treatment.
- Be conducted in a coordinated and joined up fashion and be resourced to do this.
- Involve sharing data, resources, knowledge, and tools such that duplication of planning efforts are minimised”.

**Purchasing principles (p.14):** There are a variety of alcohol and other drug treatment purchasing approaches, policies and procedures across Australia. Treatment purchasing should be efficient, effective, transparent and be designed for continuity and treatment system capacity”.

“This means that treatment purchasing processes should:

- Be transparent and equitable.
- Aim to ensure value for public money and support safe, high quality and equitable services.
- Be timely, effective, and efficient for the funder, and for the treatment providers”.

Additional NTF principles that also support greater CCC between funders include:

**Holistic and coordinated (p. 13):** “Australian alcohol and other drug treatment funders and treatment providers should work together to ensure that there is a comprehensive treatment and support system, gaps are minimised, and attention is paid to ongoing communications between all stakeholders”.

**Accountability (p.17):** “Non-duplicative monitoring systems should be in place. This includes clarity about the respective roles and responsibilities of funding bodies and service providers for data collection and data management”.

**Partnership principles (p.18):** Notes that achieving the principles outlined in the NTF requires a strong partnership approach between many different levels of government and the broader sector. “Without partnerships across and between all these bodies, the principles documented in this Framework will not be able to be achieved”.

### The benefits of improved CCC between government agencies

Effective CCC is identified by governments and public administration literature alike as critical to achieving efficient, effective, and accessible public services and better governance (ANAO, 2010; O'Flynn & Wanna, 2008; Wilkins, Phillimore, & Gilchrist, 2015). CCC is a central tenet of good practice and often features as a key role and responsibility across many guiding documents of the Australian Public Service (Wilkins et al., 2015). There are many different types of, and names for, collaborative engagement which include: inter-agency relationships, ‘whole of government approach’ (Management Advisory Committee, 2004), integration or integrated governance (Fifth Mental Health Plan), and networking or network governance (O'Flynn & Wanna, 2008). What they all have in common is the central idea of different entities working together across organisational boundaries, for a common goal (Wilkins, Phillimore, & Gilchrist, 2016).

A range of cost benefits are expected to be realised across the system where increased CCC leads to a reduction in fragmented and duplicated commissioning processes. In addition to improving efficiencies, CCC is increasingly seen as necessary to achieve greater impact and more durable solutions, and to meet rising expectations of citizens for services tailored to the needs of people and places (Department of the Prime Minister and Cabinet, 2019; Productivity Commission, 2017). Increased CCC can build capacity, partnerships and networks inside and outside of organisations (Wanna, 2008) with those partnerships able to draw on different perspectives, fostering collaboration and innovation in service delivery (Department of the Prime Minister and Cabinet, 2019).

There is also an increasing focus on CCC across various strata of governance and systems - between government agencies, different levels of governments, other various stakeholder groups and third parties including public, private and not-for-profit organisations (Management Advisory Committee, 2004; Shergold, 2008). The need for CCC is particularly acute for intractable and complex issues where multiple parts of the system, governments and agencies are involved; and where all parts are needed to work together in an integrated way to ensure that people can access the help they need (Department of Health, 2017; Management Advisory Committee, 2004). As noted by a report on competition and collaboration in the National Disability Insurance Scheme:

“Collaboration and the establishment of networks are especially important in areas of health and social care such as disability services where providers and



professionals need to provide coordinated care for people with complex conditions irrespective of funding arrangements.” (Green et al., 2017)

AOD treatment is one such area confronted with system complexities: funding for treatment flows from a range of different bodies (including Commonwealth and state and territory government agencies, and philanthropic organisations), through a range of health services, including the Pharmaceutical Benefits Scheme (PBS), General Practitioners (GPs), hospitals and other allied health professionals. People needing or seeking AOD treatment services often have other socioeconomic needs straddling a range of sectors and government responsibilities including housing, homelessness, social security, employment, health and mental health, and domestic violence (Lubman, Manning, & Cheetham, 2017).

The requirement to engage in CCC is now ubiquitous across national strategic frameworks and plans. In Mental Health for instance, the Fifth National Mental Health plan notes that all parts of the system involved in mental health provision need to work collaboratively together in an integrated way in order to address system shortcomings (Department of Health, 2017). In another example, the recent final report into Victoria's Mental Health System listed “collaboration and communication...at all levels of government” as one of 7 guiding principles for the sector (Royal Commission into Victoria’s Mental Health System, 2021).

Collaboration between and across sectors, organisations, and administrative layers is now “the new normal” (Dickinson, 2014). It should be noted that despite this focus on CCC, there has been relatively little evaluation or systematic study of the successes or limitations of different approaches to collaboration (O’Flynn & Wanna, 2008; Wilkins et al., 2015).

During consultations, many real-life examples were provided of how improved CCC between treatment funders could provide greater efficiencies and effectiveness across the whole system. Particular examples given included identifying service gaps and silos, cutting down on duplicated planning processes, savings in time, energy and resources, reducing the administrative burden for services and in minimising community and service frustration and ‘consultation fatigue’. For instance, one person noted that when funding organisations collaborated on community consultations as part of a needs assessment process, it saved communities from having to talk about the same things to two or three different parties who would have likely each had their own processes.

At the opposite end of the scale, some spoke of PHNs with no central coordinating apparatus and each with its own systems and processes, a particular issue in states with multiple PHNs. One peak recalled being asked to provide input on AOD funding priorities independently into each PHN (clearly not a good use of time, resources and expertise, all of which would be put to better use in a well-coordinated, collaborative system between AOD treatment funders). A number of stakeholders noted the impact that limited coordination between funders had on service providers that received funding from different PHNs, with an increased administrative burden from different reporting requirements and cycles.

## Approach and methods

The Drug Policy Modelling Program was commissioned by the Commonwealth Department of Health to identify strategies, processes and actions to improve CCC between and amongst treatment funders in order to give effect to the planning and purchasing principles documented in the NTF. The

scope of the project focussed on AOD treatment funders, that is state and territory health departments, Commonwealth Health Department, the PHNs and other treatment funders (e.g. AG's/Justice/Corrections).

This final report represents the body of work undertaken. The approach to this project was to engage as many different funders of AOD treatment as possible, and work with them to understand the barriers and facilitators of CCC. Additionally, consultations aimed to determine practical strategies and actions that could be implemented in order to realise greater CCC across AOD treatment funders in Australia.

The project in itself created opportunities for communication: in some cases the consultation forums allowed funders to meet each other for the first time, and sharing experiences of CCC provided an example of 'working together'. In this sense then, this project provides an example of the ways in which treatment funders can communicate, coordinate, and collaborate.

The project combined in-depth interviews with funders, written feedback and reactions to the interview data, and two structured discussion forums. The interviews were conducted between 27<sup>th</sup> August 2020 and 26<sup>th</sup> November 2020. A total of 49 people were interviewed across levels of government and jurisdictions, all of whom were involved with funding of AOD treatment services. Participating agencies included all state health departments, representatives from the Australian Government Department of Health, PHNs, Commonwealth state offices, National Indigenous Australians Agency (NIAA), Justice/Corrections departments, and other state/territory government departments that provide some level of funding for AOD treatment services.

A detailed summary of the interview data was prepared and sent out to 37 people<sup>1</sup> from the interviewed list for comment. In addition, 9 working group members (who were not interviewees) received a summary of the interview data for feedback/comments as well as 8 NGO peak bodies. In total 54 people were provided an opportunity for input into the written summary. We received feedback from 10 people/groups (of which 5 were the peak bodies) with suggestions, comments, and corrections to the interview data.

We then held two online discussion forums<sup>2</sup> (15<sup>th</sup> and 29<sup>th</sup> April 2021). Outside of DPMP project staff, 13 people attended the first forum and 10 people the second. Representatives included all state and territory health bodies (bar Victoria), Commonwealth Department of Health, PHNs, the NIAA and NGO peak bodies.

All data collected was supplemented with literature on CCC, with a preference for Australian literature and those papers that evaluated effectiveness of different CCC mechanisms.

---

<sup>1</sup> Twelve people had changed roles in the interim.

<sup>2</sup> Originally it was envisioned that we would hold a one- or two-day forum with the working group and other key stakeholders to develop a list of priority actions for implementation. Due to Covid restrictions, these forums were reconfigured.

## AOD treatment funding – the context for CCC

There are many funders of AOD treatment services both at the Commonwealth and state/territory level creating different sites and hierarchies of CCC and bringing considerable complexity to the pathways for CCC.

The majority of government AOD funding comes from the following domains:

- Commonwealth funding: through the Department of Health and the National Indigenous Australians Agency (NIAA),
- State and territory health and/or mental health funding: which may occur centrally (i.e. through state Departments of Health) and de-centrally (e.g. through local health districts)
- Other state/territory agencies including Departments of Corrections, Justice, Housing, Disability, Community Services as well as special grants provided through Premier/Treasury or local MPs

Aside from government-type bodies (whether departments or organisations that distribute government funding), there is also:

- Philanthropy and auspice organisation contributions;
- Client fees and co-payments; and
- Private health insurance.

We found that on average, most state health departments are working with 3 or more other departments.

As well as multiple funders, there are also different types of AOD treatment funding:

- Core project funding;
- Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS);
- Special one-off grants or initiatives;
- Pilot funding (for new initiatives);
- Top-up funding for extra core services;
- Top-up funding for extra non-core services; and
- Infrastructure funding.

There is no role delineation for these different types of funding; that is, all the funders can provide all the above types of funding for AOD treatment.

Reflective of the different levels of funding and responsibility for AOD treatment, we identify three potential levels for CCC: inter-jurisdiction (between Commonwealth and state/territories), intra-jurisdiction (between government agencies all located at the same state level), and intra-department (between different sections of the same department). In the case of intra-department and intra-jurisdiction, these are both horizontal CCC – both parties are at the same level if you like. Vertical CCC refers to where one party sits at a different level of government than another.

While often the focus is on vertical CCC, for example the relationship between the Commonwealth and the state/territories, there are many sites for horizontal CCC including: between PHNs and state health, between state health and state corrections; between mental health and AOD and acute care; and between Commonwealth Department of Health and NIAA. Additionally, some horizontal CCC may occur between different states and territories where populations and services overlap.

These simplified vertical and horizontal, inter-and intra- sites of CCC belie a complex array of relationships with additional hierarchies at play between the Commonwealth and PHNs and State and local health districts. This means that even if the source funder expects CCC, some subsidiaries or channelers of the funds may not follow through on that expectation.

It is also worth noting that the challenges of CCC at intra-jurisdiction level are as significant as those occurring at an inter-jurisdiction level; that is, sharing a common leader (e.g. a Premier), does not mean that things work better or more smoothly. The same is true of intra-department CCC – just because a department may have the same Secretary does not necessarily mean that those disparate parts of the department naturally engage in CCC. Therefore, when thinking of possible solutions to improving CCC it is important to maintain an understanding of how both vertical and horizontal CCC plays out across each of these levels and not be overly fixated on vertical Commonwealth to state dynamics only<sup>3</sup>.

## The strategies

The strategies and examples of associated possible actions are given in the below table. The text details each strategy and all the possible actions.

Table 2: CCC strategies and possible actions

Strategies	Examples of possible actions
<b>Building relationships</b>	
Find common ground/shared interests	Design processes that create opportunities for agreeing to a shared vision amongst parties and levels of government engaged in AOD treatment planning and purchasing. Examples of activities that can lead to common ground and shared interests: <ul style="list-style-type: none"> <li>• Joint workshops to identify treatment system strengths and weaknesses</li> <li>• Joint reviews of good practice</li> <li>• Reference Groups for shared activities</li> <li>• Documentation of shared goals and vision.</li> </ul>
Build trust and reciprocity	Encourage mutual problem-solving. Understand the mutual dependence of AOD planners and purchasers and develop respectful working relationships.
Grow informal networks	Recognise the importance of connections, ties, and friendships, without relying on these as mechanisms for CCC. Share contact details between all those involved in AOD treatment planning and purchasing.

<sup>3</sup> An additional point for potential future consideration is that if a systems lens is applied to AOD, consideration may also need to be given to how different funders, agencies, and departments interact with other areas that do not directly fund AOD treatment but provide funding to other systems of care (i.e. other primary health services, mental health, housing, education, justice, unemployment etc) which support to people in AOD treatment,

Strategies	Examples of possible actions
<b>Information sharing</b>	
A central register of funded services	<p>Establish mechanisms to share lists of service providers and what services are being funded. This requires that each funder know what they fund and maintain internal records.</p> <p>Efficient and effective sharing of funding and service information amongst funders requires systems/structures/mechanisms (for example “a central repository”).</p>
Publish funding data	<p>While most government entities mandate the publication of funding information, this is not always the case. The Commonwealth could ensure that PHN’s publicly report on the funding allocations the PHNs make to services.</p>
Share strategic plans/intentions	<p>Engage in information-sharing about strategic plans, work programmes and future intentions.</p>
Share information about procurement practices	<p>Give drafts of procurement documents to other funders for potential input/feedback or at minimum for information sharing.</p>
Verbal/informal information sharing	<p>Where there is not written shared information (such as a central register of all AOD funded services, or public access to all funding outcomes), maximise times when funders meet to share information verbally (examples include an annual meeting set up by the Commonwealth under the NTF for all funders or by state and territory governments for all intra-jurisdiction funders).</p>
<b>Coordinating mechanisms</b>	
Coordinating committees	<p>Maximise the use of existing formal structures (for example the Health Chief Executives Forum) to provide authority for more effective, efficient planning and purchasing, and promote accountability for these processes.</p> <p>Establish new multi-jurisdictional or multi-portfolio coordinating committees for AOD treatment systems coordination.</p> <p>Establish formal ongoing AOD treatment planning committees that have representation from all funders and service providers.</p>
Inter and intra-jurisdiction committees/meetings/working groups	<p>Leverage existing committee/meeting structures for greater CCC.</p> <p>Establish inter and intra-jurisdiction committees/meetings for AOD treatment.</p> <p>Support an inter-agency strategy group for AOD planning and purchasing.</p> <p>Form Reference Groups with all stakeholders represented to oversee collaborative activities.</p> <p>Consider specific, time-limited working groups to achieve specific treatment system reforms, address pressing issues (for example COVID-19 working group) or for specific projects (for example service mapping/data gathering).</p>
One-off (ad hoc) meetings	<p>Create one-off meetings of all AOD treatment funders at critical decision points in the commissioning cycle.</p>

Strategies	Examples of possible actions
Leveraging existing meetings/committees	Tap into existing meeting structures of AOD treatment funders at state/territory level and consider expanding to include other treatment funders (other states, Commonwealth).
Informal meetings/networking events	Maintain the opportunity for informal meetings or networking events that present opportunities to meet counterparts and share information off the record.
<b>Working together</b>	
Coordinated or collaborative planning	<p>Develop a roadmap with all stakeholders.</p> <p>Create protocols for how agencies conduct joint needs analysis, gaps analysis, and priority setting.</p> <p>Support each other's planning processes, by sharing some of the inputs into planning (for cost-efficiency and to reduce burden on stakeholders e.g. joint community consultations).</p> <p>Undertake a single planning process (e.g. at state level), where there is only one plan, shared by all funders, with shared priority-setting. Develop and use standardised planning tools and/or standardised demand measurement e.g. DASPM.</p> <p>Leverage new funding to conduct a state-wide review of existing provision and gaps analysis.</p> <p>Engage relevant Ministers in planning process.</p>
Coordinated or collaborative funding processes	<p>Invite other funders to participate in funding and procurement processes (for example sitting on panels).</p> <p>Assess capacity to align commissioning cycles between funders.</p> <p>Develop a co-commissioning framework.</p> <p>Leverage new funding to jointly develop tender process for new services.</p> <p>Consider establishing 'lead funder' agreements with services.</p>
Coordinated or shared performance monitoring tools	<p>Develop standardised performance monitoring tools/templates and outcome tools and measures in consultation with all stakeholders to be shared by all funders.</p> <p>Develop a nationally agreed AOD performance measurement framework.</p>
<b>Governance arrangements</b>	
Leadership commitment to CCC	<p>Confirm high level commitment (e.g. Minister, Premier, etc.) to collaboration and coordination amongst AOD treatment funders.</p> <p>Ensure there is senior leadership buy-in.</p> <p>Integrate CCC outcomes into agency goals.</p>
Role delineation	<p>Encourage clear documentation of roles/responsibilities of different AOD treatment planners and funders.</p> <p>Accept and manage system complexity, and porous role delineation.</p>
Clear governance structures	<p>Document the existing national and state governance structures for AOD treatment planning and procurement.</p> <p>Consider a new inclusive national governance structure for AOD treatment policy.</p>

Strategies	Examples of possible actions
	Identify the national level body responsible for driving effective CCC.
MOUs / written agreements	Map existing written agreements between agencies. Develop an agreed set of best practice examples to develop templates for formal arrangements. Create new agreements (these could be between state and federal; between PHN and state; between two departments) and be bilateral or multilateral.
Accountability mechanisms	Create clear deliverables, timeframes, lines of responsibility and follow-up for CCC.
<b>Resourcing CCC</b>	
Time	Ensure there is adequate time available for CCC.
Resources	Provide resources specifically dedicated to CCC. This includes resources within jurisdictions, and resources for peaks and for other stakeholders (eg consumer representatives) to participate in CCC. Access new resources for CCC. Funders could work together to prepare a briefing note about the rationale for CCC between funders such that each can advocate within their own systems for this activity to be adequately resourced.
Skills development in CCC	Establish skills development and capacity building opportunities to train/teach funders in CCC.
Incentives for CCC	Encourage recognition of the benefits of CCC in reducing costs, administrative burden, and increases to efficiency in planning and funding. Consider putting in place incentives (financial, other) for funders to engage in CCC (e.g. for those seeking to create an MOU, providing funding for that work, or creation of central positions and resources that can assist organisations seeking greater CCC). Create national and local bodies to drive effective CCC.
Systems thinking	Encourage all parties to think at a systems-level: AOD treatment as a complex system of providers, funders, planners and organisations, encouraging recognition of the multiple funders and the impacts that the actions of any one funder may have on other funders' decision-making.

Each of these strategies and associated actions are discussed below, including examples, facilitators, and barriers.

## 1. Building relationships

### Finding common ground

The importance of identifying and recognising common interests, a shared vision, and shared outcomes was noted by the interviewees as foundational to supporting partnerships, aligning activities, and better enabling a person-centred sector and whole of systems approach. In the interviews, many noted that each funder has its own priorities, timeframes, funding cycles, systems, processes, and even goals and approaches which all act as barriers to greater CCC.

Identifying where the goals do not align was also noted in interviews as critical for successful communication and cooperation between funders which could then lead to a process to address this. Finding common ground, when it may not be at all apparent at the outset, is a crucial task according to interviewees, with the need for this work to be done at the start of any collaboration rather than trying to retrofit it. Some mentioned that this ‘groundwork’ of deciding common goals, language and outcomes was critical: “it’s the skeleton that you hang everything else on”. Agreeing on definitions was also raised as something that could improve CCC across agencies:

“It’s as if we’re talking from different universes sometimes, using different data, different understandings, it’s difficult to get a common understanding”.

A number of processes could be strategically employed to establish shared vision and common ground. Examples from elsewhere range from workshoping strengths and successes and joint reviews of good practice among funders, to broader processes involving the formation of reference groups to undertake further stakeholder consultation (see for instance the creation of a mental health plan in Ireland (Department of Health, 2020) or the creation of the APS Policy Capability Roadmap (Australian Public Service Commission, 2020). The creation of the *Vision 2030 for Mental Health and Suicide Prevention* involved holding town halls across Australia for people with lived experience of mental illness, their families, carers, community, and services to contribute to the vision as well as seeking feedback via an online survey (National Mental Health Commission, 2020).

The process of developing a written agreement (see below section) provides a vehicle to focus the commitment of different parties towards an agreed outcome. Putting shared goals and principles down on paper was felt to bring people together and identify a shared commitment.

#### Build trust and reciprocity

Many of the strong informal relationships that existed between people of different agencies have been forged over many years. While some noted that high staff turnover can impact negatively on building any kind of relationships with counterparts “when you get a good person at the [funder] you don’t want them to leave (and vice versa)”, others noted that the longevity of staff at different agencies meant they knew exactly who to go to for information, had created opportunities over the years for mutual work and had therefore strengthened relationships.

All stakeholders identified that good relationships results in more effective CCC. Some of the ‘good relationships’ that existed between funders involved close ties, friendships, or connections with counterparts in other agencies. The existence of these relationships allowed some types of information to be frequently and freely shared via informal catch-ups or spontaneous telephone calls. The kind of information shared informally generally related to funding plans and sharing information on service providers (both of which did also sometimes occur where relationships did not exist). Others mentioned fairly frequent informal catch-ups just to talk about “what’s on both our plates”. Some mentioned that having good relationships in other agencies helped with implementation of formal requirements, or that projects had originated from these informal conversations and relationships.

Other times these relationships/networks were more about collegiality than collaboration, for example sharing frustrations or brainstorming solutions together: “We could help each other out – one funder might have a problem, talk to the other funder, see what might be possible, problem solving”.



The COVID-19 pandemic was raised as an example of working together where these networks offered support. “Collaborating on practical things, so when a crisis occurs, can reach out, help, support each other”.

A theme raised in almost every interview was the low trust between different funding agencies. Examples were given at all levels (inter-jurisdiction, intra-jurisdiction and intra-department) where a lack of trust prevented a range of different CCC activities. This mistrust included suspicions between agencies as to the agenda of each body, for example “the states think that PHNs are a covert Commonwealth operation”. In some cases, mistrust was driven by competition for funds, for example competing for bids up to Treasury by different state actors and competition between states and territories for Commonwealth funding.

Others mentioned a range of related actions and behaviours as exacerbating or contributing to a lack of trust, including information blockages and lack of reciprocity in information sharing. The perception that funders held their “cards close to chest” was present in a number of interviews, and agencies being “somewhat cagey” led to an unwillingness to share data or be transparent about activities including procurement plans. Other factors driving perceived lack of trust included blurred roles and responsibilities within the sector with multiple funders funding the same service for the same thing creating tension; and power differentials between funders causing animosity where it was felt they were excluded or treated differently due to their relative ‘purchasing power’.

Overall, low trust and collegiality was seen by some to contribute to the notion of each funder fighting for their patch or turf as opposed to a starting premise of having one shared purpose or vision or shared outcomes. “Often there’s a turf war – that’s my patch not your patch - that operates at many levels but definitely at the funding level”. This can lead to hostilities “I’ve been accused of commissioning duplicate services in their area when that’s not the case”.

### Grow informal networks

It was clear that people valued their relationships with those in other agencies where they existed and took opportunities to build collegial networks with counterparts where they could, it was just that oftentimes the opportunity never presented itself. As mentioned, the forums convened for this project work provided the first time for many people to meet each other.

The ability to spend time together also produced CCC by accident – with funders finding out important information due to incidental conversations: “we get all kinds of information that we wouldn’t otherwise get”. These sites of informal information exchanges that were off the record were seen as valuable by some of the interviewees.

Relationships were also a site of value for many, adding a sense of fulfilment and satisfaction to their work. However, while a number of people mentioned that most CCC in the AOD space hinged on good relationships, stakeholders were in general agreement that informal relationships cannot be relied upon as a strategy and there was value in more formalised arrangements. It “cannot be up to individuals and personality”; and “what would happen if me and xxx leave? Would the next people work so well together?”. This highlights both the importance of individual level relationships in fostering CCC, and the need for CCC mechanisms to be binding at the organisation level and immune to personnel level changes.

## 2. Information sharing

Transparency was a theme raised in almost every interview: “we cannot proceed until we have transparency”. In addition to transparency related to information between funders there is also a sense of having transparency between funders and the general public in order to safeguard taxpayers’ money, create accountability and to help inform service planning and funding. Transparency also related to understanding how decisions are made and who is part of the decision-making. Some feedback on this topic suggested that “maybe if we improve transparency of investment, then the way decisions about future investment are made will be improved (because the outcome is more objectively measured against the existing investment)”.

Many of those interviewed shared frustrations with gaining access and/or timely access to information from other funders with a perceived reluctance to share information common between funders. Some noted a lack of reciprocity in information sharing and the need for it to work in both directions or else risk dissolving into ‘tit for tat’: “We don’t give them info as part of decision-making, and they expect/want that; but they don’t do it with us”. One said it was “disempowering” when other agencies fund projects “without telling us”.

There was a perceived need to “free up the information flow”. The kinds of information that appeared to be most difficult to share related to funding, including funding amounts, details on the types and provider of services funded, and the terms and conditions of funding. Some saw information sharing and the establishment of a ‘funding footprint’ as the first step for CCC in order to identify gaps in the system.

### A central register of funded services

The absence of shared data on treatment service funding was raised many times across the project. Back in 2004 the Commonwealth report ‘Connecting Government’ noted that:

“Information sharing plays a critical role in generating better decision making and program delivery. The information that agencies collect, analyse and store can be better connected through more structured information management and the development of clusters of shared information...[through] shared infrastructure, architecture and protocols to facilitate both whole of government and multiagency activities.”(Management Advisory Committee, 2004, p. 59)

While there was informal information sharing (e.g. phoning a counterpart when new funds were available to get a sense of existing provision and needs in an area), systematic and detailed information sharing appeared to be limited: “[there is] random access to information about what is being funded”.

Although there was evidence of verbal and written agreements between agency heads/executives to share data (including funding data), it was reported that they were sometimes ignored. “There is a data sharing agreement but it doesn’t work”. Permissions to release data were often not communicated down to the people responsible for managing this information, stalling its release. “When it came to the crunch of sharing indicators – who is being funded, by how much and for what, it all fell over”.

Some interviewees talked about needing systems in place to share data: “If we had a mechanism to share data that would be great ... Such a thing could facilitate conversations about joint planning”.

Proper, maintained databases were called for: “the idea of people sharing their excel or word docs is not going to work”. It was noted that any system/infrastructure would ultimately need to have resources dedicated to it to ensure data were current, and also a clear understanding of who had responsibility for maintenance.

There were many calls for a central repository of information that included lists of service providers and associated funding amounts by funder. Some of this information is already available (for example the Australian Charities and Not-for-profits Commission records) but it is frustratingly difficult to create and maintain a central register of the more than 500 service providers (as demonstrated by multiple attempts over the past 20 years) let alone funding information about each of these.

Others were wary of the focus on shared databases: “the challenge is that people tend to latch on to the databases thing as the panacea when in fact there are a range of options to increasing CCC”. This point is also reflected in other barriers raised in relation to information sharing including a lack of structures for funders to actually meet and talk with each other; shared infrastructure for activities such as planning and data collection/management; standardised or shared data collection tools; implementation/accountability when information sharing decisions have been made; resourcing; and a lack of incentives to release information.

#### Publish funding data

The notion that government bodies have a moral and fiduciary obligation to freely share details on funding was commonly shared in the forums. This does not currently occur, as evidenced by one peak who in the absence of this from governments(s) collates data on funding amounts and then shares that back to funders who would otherwise not have that information. As noted by one: “it would be great if this type of data was coordinated nationally and available at the jurisdictional level”.

One issue raised is that these data are potentially considered ‘commercial in confidence’ and both funders and service providers may not wish to share that level of information. There were strong feelings on this point with others noting that for publicly funded services (i.e. tax-payers money), there is a necessary accountability. Some states require that every contract or procurement is listed on a public website<sup>4</sup> and there were questions from some participants about why this was not a standardised requirement of all service funders, including PHNs.

#### Share strategic plans, procurement practices

Other documentation that stakeholders felt it was useful to share between funding agencies included strategic plans and priorities, procurement plans and practices, and work programs/implementation plans. There was evidence that this was happening between some agencies although in a fairly informal manner and more frequently after policies and plans had been completed. Sharing plans earlier, while they were still in draft phase, or even approaching other

---

<sup>4</sup> Note: we were advised that this is not a requirement of PHNs (they are only obliged to disclose to the C/W, and not obliged to publish publicly anywhere). This compares to most state governments who are obligated to disclose funding contracts.

agencies before planning processes have commenced was seen to be preferential to give other funders the opportunity for feedback or input.

### 3. Coordinating mechanisms

#### Committees, working groups and meetings

Coordinating committees with appropriate high-level staff were mentioned as a good driver of CCC with examples at the intra-jurisdiction level and also inter-jurisdiction level. Working groups formed by those involved in CCC activities such as data gathering, and representative of different agencies or portfolios were also mentioned as a good structure. There needs to be consideration of appropriate governance structures – which may include a genuine partnership with independent oversight, collective oversight, or endorsement of one body with ultimate authority.

In terms of coordinating structures, inter-agency committees were commonly mentioned. These usually had one agency that chaired meetings and were seen as responsible for driving CCC initiatives. In some situations, this created imbalances in the relationship and disincentives to participate (with people viewing the project as ‘theirs’ rather than a joint initiative). Having an external oversight body was seen as preferable in these circumstances. Others felt that the inter-agency committees and CCC initiatives were based more on genuine partnership.

Interviewees noted that it was important that the right people were at meetings, for example, and that the meeting had the right mix of people, which may include CEOs, Executives, and Directors, as well as managers and members of AOD teams who may be carrying out any joint activity work. The ability of committee, or meeting to achieve outcomes depended on have the right people participate. We heard examples where meetings were held and the people sent as proxies did not have authority to make decisions or have adequate knowledge of the issues.

Regular meetings between all AOD funders (Commonwealth, state and territories, PHNs, etc.) were a good way for people to share information and grow their relationships and networks with those from other agencies. Some meetings were purely networking events, and a means to create trust and develop relationships. Others were for the purpose of sharing information, one-off special purpose meetings or events, or more action based around advancing particular projects. While information exchange was valued, some preferred meetings with a focus on action and “not just a talk fest”. On the other hand, we heard examples of meetings that were deliberately “un-minuted” or “off the record” in order to create a more collegial, relationship-oriented meeting, rather than a highly structured, action-focussed meeting.

Some noted that they had no regular meetings regarding AOD funding or services, but had opportunities to meet counterparts at other meetings; e.g. monthly meetings between PHNs and state health departments or through their involvement on joint committees (e.g. a committee on GPs between PHNs and Health “has been a crucial vehicle through which we’ve formed good relationships with [Health]”).

Some had no meetings with other AOD funders at all. Those with no or few meetings did identify other meetings or working groups happening at different jurisdictional levels (e.g. between state/territory agencies, or between different health agencies) that they felt would be beneficial to join and a simple way to improve relationships between agencies. These are examples where one could leverage off existing meeting structures.

One comment suggested that establishing appropriate meeting structures was a good first step to achieving other elements of CCC, whilst also illustrating the complexities of pinpointing individual actions due to the inter-related nature of all of these points of CCC: “Structures to develop and maintain the relationships required for effective collaboration are the first step (i.e. meetings with obligations to attend and share information)”.

#### 4. Working together

Participation in small, discreet joint-agency projects in non-controversial areas were mentioned by multiple people as a mode through which they had developed relationships with other agencies.

Potential opportunities to leverage existing initiatives which have brought players together were raised by some, who believed that this could then segue into an ongoing (commitment) to information sharing/communication/coordination.

Participants noted that specific projects provide good opportunities for CCC. One-off funding or initiatives such as the National Ice Action Strategy provided opportunities for different groups to work together on reviewing existing provision and gaps and development of a tender process for a new service. The provision of dedicated extra funding, urgency, and a specific focus was beneficial. COVID working groups were an example raised by many as a working example that may have benefit for the AOD sector. We were also given examples of working together around procurement processes, for example being members on each other’s procurement panels. Some did note however that limited time-bound projects may lead to initial high levels of CCC but “then it dies down” once the project is over. This then raises the question of how to put systems, processes, and procedures in place to maintain ongoing CCC.

##### Coordinated or collaborative planning

CCC is central to effective planning process, and effective planning processes result in coordination and collaboration. Good experiences of planning were evident where appropriate timeframes were provided for planning, the right people were involved and there was accountability built into the process. In one interview a participant spoke about the importance of focussing on small achievable tasks in the first instance (e.g. those on the beginning of the engagement continuum) rather than jumping to large projects that require higher levels of trust, resources, and turf:

“Collaboration on commissioning often jumps straight to the design of procurement. It is much better to have collaboration in planning and needs assessment at the start of the cycle, and then monitoring mid-cycle. If you have those two things done right it would be a vast improvement, even if the actual procurement happens separately. This helps lay the groundwork for future joint procurement”.

A range of joint planning initiatives across the engagement continuum were raised as either examples of where good CCC was occurring or as having potential to increase CCC between agencies.

There are any number of variants to coordinated, collaborative planning<sup>5</sup>: it may be that a single existing plan is shared between all funders (guiding their funding decisions); or that there are shared planning processes, for example community consultations happen together, then each department takes the information they need and develops their own plan (reducing the burden on service providers/community). Another variant is separate planning processes with subsequent information-sharing: so each funder can use similar underlying data and facilitate greater understanding of each other's plans and strategies.

Planning processes have the potential to produce a shared "roadmap" that has engaged all stakeholders in its development. It also, according to interviewees, may provide the opportunity for each funder to then act autonomously but in line with the shared "roadmap".<sup>6</sup> There may be lessons from mental health here in relation to the National Mental Health Service Planning Framework, and how that has (or has not) facilitated greater collaboration amongst funders, as well as the National Mental Health and Suicide Prevention Plan. A range of structures, tools and resources created to support the planning framework (e.g. the creation of specific working groups, and documents that outline the joint responsibilities of local health districts and PHNs in joint regional planning) could potentially be adopted to support similar processes in joint AOD planning.

One such guide from mental health, the *Joint Regional Planning for Integrated Mental Health and Suicide Prevention Services* notes that an initial step towards joint regional planning is the creation of a foundational plan which focuses agencies on identifying service gaps and shared priorities (Integrated Regional Planning Working Group, 2018). During our consultations local needs assessments and planning were activities raised by many as discrete, relatively uncontroversial projects that had provided a good opportunity for agencies to work together, resulting in networks and good relationships. Mapping services and pathways was another step listed in the *Joint Regional Plan*. The Drug and Alcohol Services Planning Model (DASPM<sup>7</sup>) was raised in a few of the interviews as a good example of attempting to use a single planning tool to create greater coherence to AOD treatment system planning and provide the basis for the potential for greater collaboration amongst funders from different levels of government.

Feedback on the draft report suggested that irrespective of the type of planning used, strategies for engaging the relevant Ministers in the planning process are needed to ensure that they are aware of existing issues in treatment funding and to assist in consistent funding approaches. During interviews, examples were given of Ministers making independent funding decisions without broader sector consultation. Prior engagement may help to remedy this and also provide broader buy-in for a collaborative approach to planning in AOD treatment: "It can be hard to engage in meaningful planning when decisions are made with minimal consultation, and out of line with funding processes".

---

<sup>5</sup> Noting that planning for AOD treatment is in the context of finite resources and where different funders have differing capacities with reference to budget amounts, resources, and opportunities which may create an 'un-level playing field'.

<sup>6</sup> A key tension seems to be between maintaining autonomy whilst acting cooperatively with other funders.

<sup>7</sup> Previously DACCP.

## Coordinated or collaborative funding processes

“Co-commissioning” was a term used in various discussions across this project. There does not appear to be a shared definition of “co-commissioning”. Distinguishing between planning together then procuring independently; planning together and jointly funding a service; combining contracting arrangements between different funders of the same service; and combining funds into a single pot to then plan and procure services all entail different levels of coordination and collaboration.

Treatment funders working together in full collaboration, where two (or more) funders collaborate together to jointly fund a service appeared rare. In one example given, it occurred only because of the service provider themselves – forcing the funders to work together to solve a problem. In the second example, it occurred by accident (a fortuitous meeting where two funders were present and discovered they were both about to embark on a procurement for the same service type from the same pool of service providers). Interviewees agreed that formal arrangements to co-fund and/or co-commission services was a worthy goal, but rarely occurred in practice (and seemed accidental or coincidental, as demonstrated by the examples). Interviewees agreed that co-funding is a good strategy, noting that when both funders have “skin the game” there is a greater likelihood of effective collaboration. Lead funder arrangements are mentioned in the literature as offering a potential structure for agencies co-funding the same service (see Role delineation below for more detail).

We heard about co-commissioning frameworks between PHNs and state/territory government health departments that provide principles around planning and purchasing at all stages of the commissioning cycle, an articulation of when it makes sense to co-commission and establish mechanisms that need to be in place for co-commissioning to occur.

Collaborative procurement practices require appropriate timelines. Collaboration at this level represents valuable moments for sector innovation and advancement but tight timeframes work against CCC and reduce the ability to use and share information. “They tell us that we need to do proper co-design but then give us a month to do it”; “if there’s new funding or new plans it would be good to have everyone on the same page including the community and services.” This links to the above point about keeping Ministers advised on planning processes, and planning outcomes.

## Coordinated or shared performance monitoring tools

An area that has received considerable attention to date has been the lack of shared reporting templates, databases, performance measures and outcome tools and measures between AOD treatment funders. Almost everyone agrees that it would be very useful to have harmonised performance monitoring, templates and tools, databases and outcome measures. Indeed, this would be an excellent project to build collaboration. Harmonisation of data collection/reporting was identified in a number of interviews as an end goal of better coordination between funders. Interviewees noted that even at an intra-department level, this can be difficult. Multiple agencies operating at the same level (e.g. PHNs and local health districts) each have their own reporting, data collection and procurement templates and processes (and may also have contractual requirements for services to use particular client management systems).

The area of shared tools speaks to issues of autonomous funding bodies. In the interviews, many noted that each funder has their own priorities, timeframes, funding cycles, systems, processes and

even goals and approaches which all act as barriers to greater CCC. One example raised in interviews was the lengths of funding arrangements that differ between funders. So while there may be commitment to the principles of collaboration, in practice the funder is locked into their own cycle and cannot readily step out of the cycle that they are in, despite a desire for collaboration.

Despite this potential barrier, all stakeholders recognised the enormous value of such a project, notwithstanding the challenges (“While theoretically possible, in practice it’s a nightmare to implement... which databases, one tool or many, agreeable timelines, common templates etc....”). In feedback on the report it was noted that the NTF working group has the potential to drive such work in a sequential manner based on an agreed order of priority. There are existing projects at jurisdictional level to develop an agreed set of performance monitoring tools that could be the springboard for national agreement and coordination.

## 5. Governance arrangements

### Leadership commitment to CCC

The literature identifies leaders, including senior staff members, Secretaries and agency heads, as critical to shaping the success of CCC activities (Management Advisory Committee, 2004). CCC is enabled where leaders explicitly and consistently support CCC and model “better practice working models” both within their agencies and across services as a whole (Management Advisory Committee, 2004, p. 43). However, leaders must also be supported to do this through provision of appropriate resources, structures and systems that provide authorisation for appropriate decision making and incentives to undertake CCC (for example, through the presence of CCC outcomes in agency goals) and appropriate accountability mechanisms (Management Advisory Committee, 2004).

The clearest example of how organising culture influences CCC was in the differences in approach by two similar agencies. One agency respected the knowledge and professionalism of another agency they worked closely with, recalling that they would often seek out their advice on issues, and trusted their expertise in procuring AOD services. The other agency did not participate in CCC with other agencies and did not see the need to: “we have our own needs and priorities so [collaborating with others] is not very useful”.

### Role delineation

There were two distinct opinions on the need for role clarification and delineation in treatment funding. During consultations, the first opinion emerged where it was perceived that the existence of clear role definition and delineation of agencies (across all levels including intra-jurisdiction and intra-department) facilitated better planning and co-commissioning of services. It was felt that when a health department held sole responsibility for funding and commissioning AOD treatment (without other departments involved), there were fewer problems with coordination, and cooperation. As noted by one participant: “[with] role delineation and role clarity, then everything falls into place”. This was also present in departments that did not have primary responsibility for AOD treatment but “bought in” treatment services from health: “Health knows what they need in terms of treatment so we just let them do their thing”.

There were examples provided from other sectors too, for instance in mental health, where PHNs funded only discreet projects (GP support) that complemented the work of state-funded mental



health services and where it was felt funding accountabilities were better delineated. The hybrid model of AOD treatment, where both the Commonwealth and state governments are engaged, was perceived to be problematic in the absence of coordination and collaboration.<sup>8</sup> As asked by one person: “why is the Commonwealth doing residential rehabilitation? Just give this money to the states”.

Solutions in the literature to improving role clarity and delineation between different agencies range from the creation of lead funder arrangements (The Scottish Government Third Sector Division, PricewaterhouseCoopers LLP, & Forth Sector Development, 2014) through to better knowing people and processes in other agencies which can be a formalised or informal process (Gil-Garcia et al., 2019). For example, an ANAO report on inter-agency collaborative agreements found:

“Creating structured, workable arrangements, with sufficient authority and clarity of purpose for the lead agency to undertake its role without diluting the accountabilities of other agencies involved, is a challenging but important element of effectiveness” (ANAO, 2012, p. 14).

An opposing view to the need for boundary setting and clear role delineation of funders was raised at the forum and holds that the AOD funding system in Australia is messy. Accepting that attempts to establish role delineation have not been successful, the task becomes trying to find ways to work better together given the complexity. This was seen as preferential to “unpicking the giant knot”. Here, calls for role delineation were seen as somewhat of a distraction. Under this second view, the impetus to implement any large-scale review of roles and responsibilities is lacking.

#### Clear governance structures

From our interviews, the presence of clear governance structures and set protocols were seen as critical in aiding CCC among different agencies, particularly where there was a mandate or written agreement to collaborate. This finding is mirrored in the literature with governance arrangements consistently identified as pivotal for effective collaboration and constituting the majority of issues and barriers in relation to failed CCC attempts (Wilkins et al., 2015).

Even with the best of intentions and commitment statements, poor governance has the ability to derail CCC. In NSW for example, *Their Futures Matter* (TFM) was a ‘whole of government’ reform aimed at improving outcomes for vulnerable children, young people and families. Secretaries of all relevant departments formed a cross-agency board and pooled funding from existing programs to form an investment pool, with an aim to direct and prioritise resource allocation to evidence-based interventions across the departments of families, health, education and justice (Audit Office of New South Wales, 2020). Additional funding was allocated to the reform by the NSW government over four years.

Despite these efforts, a review of the TFM reform concluded that the governance and cross-agency partnerships used to deliver TFM were ineffective – largely because they did not provide sufficient independence, authority and ‘cross-agency clout’ to deliver the reforms, lacked mechanisms to secure cross-portfolio buy-in and lacked the necessary powers needed to drive reprioritisation (Audit

---

<sup>8</sup> Normally it would be states that are responsible for funding and delivering specialist AOD treatment services, with the Commonwealth confined to primary care role, through Medicare.

Office of New South Wales, 2020, p. 2). Particular issues stemmed from the creation of governance bodies within the Department of Families and Community Services (FACS) rather than creating a new stand-alone authority, which were subsequently unable to secure support from Ministers beyond the FACS portfolio (Audit Office of New South Wales, 2020). This documented example may provide some important lessons for AOD treatment funding governance structures.

The AOD area has had a plethora of committee governance structures over time, including the Ministerial Drug and Alcohol Forum and its sub-structures (and the previous Intergovernmental Committee on Drugs (IGCD) structures). There are also other governance structures that are related to AOD treatment funding and may have some clues as to how AOD funders could better communicate, collaborate and coordinate. These include the National Health Reform Agreement, the Health Chief Executives Forum (formerly the Australian Health Ministers' Advisory Council), at local council level the Local Government Grants Commission, the Victorian Government's Social Procurement Framework, the National Mental Health Commission, and various other mental health coordinating governance structures at state level.

There may be useful lessons from past coordinating and governance structures that can be applied.

During consultations, feedback and in the forum, there were some who felt there was a need to establish a new national body like the Ministerial Drug and Alcohol Forum: "The AOD sector NEEDS a national governance structure, because AOD sits across multiple sectors". Proponents of this idea suggested that a national body could improve coordination, provide a forum for sharing information and "line of sight", and also tackle issues of national importance and develop nationally consistent policy advice. There was not a consensus on what this national body would look like (whether a committee or a commission for example). Another idea was that all the jurisdictional funding bodies (states/territories and Commonwealth<sup>9</sup>) create their own AOD commissions and nominate one representative to sit on a national body. During discussion at the forums, participants felt that the success of such a group would be largely based on structure, membership, and remit.

Effective governance arrangements would deal with one of the barriers our respondents identified – a lack of buy-in. "[Agency] do not want to engage with us and there's no incentive for them to do so". Another impediment to effective CCC amongst funders, the notion of preserving funder autonomy, may also be redressed with effective governance arrangements. People spoke about how CCC can challenge the decision-making autonomy of a funding body: "no way to integrate feedback without losing autonomy". This meant that CCC was sometimes avoided: an interviewee noting that it was "unlikely and rare to actively seek input into the pre-stages [of tendering]". There is also a view that one agency needs to be in control; multi-party decisions said one person, "don't work in the real world". Stakeholders also recognised that departmental Ministers like to retain control of funding decisions in their portfolios: "Ministers like to be clear that they are the ones that make the decision". This may work against governance arrangements that are perceived to spread decision-making authority amongst relevant parties.

---

<sup>9</sup> In this view, the Commonwealth is one more jurisdiction operating in the same way as states/territories as a funder of AOD treatment rather than occupying a top-down power relationship with states/territories.

## Written agreements/MOUs

Written, formal agreements are frequently used to facilitate productive cross-agency relationships and formalise collaborative relationships (ANAO, 2010). It is a common governmental mechanism for coordination and shared understanding. AOD has a good track record with MOUs, for example those developed with police services around harm reduction activities; or the agreements in place between Health and Justice in relation to court programs. Indeed, in many interviews, the examples of written agreements pertained to service delivery aspects, not to funding arrangements between different levels of government (or the same level of government for that matter).

Many of the people we interviewed noted that they had written agreements in place with other agencies that laid out common principles, goals, and activities. Most frequently these were through MOUs but some co-commissioning frameworks were also in place. Many more had experience of MOUs and other types of formal written agreements in areas outside of AOD including bilateral agreements, protocols, and National Partnership Agreements.

There was one suggestion made that it may be useful to map current written agreements at the inter-jurisdiction and intra-jurisdiction level to identify and leverage existing provisions for greater CCC. An agreed set of best practice examples could then be used as templates to facilitate the establishment of more formal arrangements to enable greater CCC.

Four states/territories (WA, Vic, Tas and SA) spoke about having an MOU in place between the state health department and PHNs, and another state/territory mentioned a Protocol between a PHN and local health districts/departments. Most participants mentioned that the MOUs contained shared principles statements and appreciated intent statements to increase communication, coordination, and collaboration. We have sighted 2 of the MOUs. Based on the information in these documents and that relayed in consultations, MOUs appeared to detail a commitment to some or all of the following:

- Collaboration
- Information sharing
- Joint needs assessment
- Transparency
- Joint planning
- Improvements in connections to primary care and intersection with AOD
- Coordinated approach to market/collaborative procurement processes.

While there were mixed experiences of the MOUs, there was lots of good will evident. There was also general agreement that the process of forming and carrying out an MOU had provided opportunities to review work and see where problems exist and where systems align and had facilitated some CCC between agencies, even if not as much as originally hoped. One participant noted: “[MOUs] can arguably be toothless but that could be the case anyway”.

While there were many positives to MOUs, they were not all successful in achieving everything they set out to do, with barriers to information sharing (particularly on funding) and coordinated approaches to market and other activities not implemented. Signed MOUs may be able to “overcome officer-level reluctance to share information”, especially where they are signed off by executives or those in senior roles with appropriate power/authority. Others suggested having “buy-in” from, and accountability to appropriate senior-level staff and/or oversight and management from executives and CEOs (beyond merely signatures) was needed for activities under the MOU to

be realised, and that communication from that authority needed to filter down to people who were expected to undertake CCC activities. Others suggested that improvements to future MOUs would be to ensure that timeframes are realistic and take into account existing timeframes/responsibilities of agencies. As noted by one participant:

“Formal agreements need to state the purpose and outcomes of a group – what are you doing, why are you doing it, and then it needs to be endorsed at the senior level”.

Based on an audit of over 200 cross-agency agreements from 21 public sector agencies, the Australian National Audit Office (ANAO) in 2010 produced Better Practice Principles to assist agencies in improving the overall quality, usefulness and management of MOUs and similar cross-agency arrangements (ANAO, 2010). These Principles echo many of the suggestions of the participants including that agreements should clearly define agreed roles, the responsibilities and functions to be undertaken by each agency, and the establishment of governance mechanisms. The ANAO Principles also suggest that agreements should include details on performance requirements and other key administrative matters and document potential risks (ANAO, 2010). Without these mechanisms built into agreements, ANAO suggested that agreements will only provide a “perfunctory basis for building inter-agency collaboration” (ANAO 2010: 17).

#### Accountability mechanisms

Accountability related to ensuring there were appropriate structures set up for the different tiers of people involved in the work so that decisions could be made in a timely way, implementation was monitored by people with relevant authority to compel action and the authority to act was filtered down to the people doing the day-to-day work. Where such structures existed, it facilitated CCC.

One example provided was a funding body who was able to get and share information with others on funding because of the existence of a governance group that included relevant decision-makers. “They were able to make the call and then got a consultant in to do the work in a relatively short amount of time who had authority to compel people in the agencies to hand over the correct information”. An agreement to protect privacy through not sharing agency-specific details and keeping the information to the governance group only also assisted in overcoming some reluctance among people to share data.

Accountability mechanisms require a clear statement of what activity or behaviour is being held to account. It is not clear whether there is any formal requirement by the range of different AOD treatment planners and funders to engage in CCC. PHN funding agreements with the Commonwealth require PHNs to undertake ‘stakeholder engagement’ that includes establishing partnerships and integration/coordination with regional stakeholders including state and territory government agencies, drug and alcohol peak bodies, local health agencies and AOD services. There was reported to be some variability between what was required of ‘stakeholder engagement’ in the funding agreement, and what occurred in practice. Feedback received was that this engagement is difficult to monitor at the Commonwealth level, and enforcement levers are limited.

Of course, PHN funding only represents a small proportion of total AOD funding, and it is not clear what obligations are currently in place for other parties (i.e. Commonwealth and state and territory bodies) to engage in CCC with other AOD funders at the inter-jurisdiction level (between

Commonwealth, states and territories), intra-jurisdiction (e.g. health and corrections), or intra-department (e.g. mental health and AOD).

## 6. Resourcing CCC

All funders need to be adequately resourced to undertake CCC. This includes having the time available, having it as part of their responsibilities, and having the necessary skills. Even in the example of a central repository for all funding information (see elsewhere), this would need to be resourced to maintain the information as up to date.

CCC activities (such as shared planning, co-procurement and so on) can take time, even where this work may be laying the groundwork to greater CCC (e.g., growing networks, initial meetings): “finding the time to have the conversations is difficult”. Even where there is good intent, or indeed an obligation on funding agencies to engage in CCC, this can be curtailed if there are short timeframes that do not allow consultation with other funders or appropriate data analysis/collection to occur.

Ensuring that others are engaged prior to decision-making is critical for good CCC, as once a funder has determined a course of action it is difficult for them to then make changes. One example provided was where one funder (X) committed to funding an AOD service. It subsequently became apparent that this would be duplicative, inconsistent, and out of step with funder Y. But it was “too late or too hard for [funder X] to change their course.” Others noted their frustration with finding out about new tenders or contract renewals after the fact (especially where there were arrangements to share this information), which closed off opportunities for funders to engage in combined service planning and coordination. Some perceived that it can be “an afterthought” to consult with other funders, or to consult with the community. Peaks were keen to stress that who gets to be involved in engagement is also important, with the input of service users, community, and services critical for realising co-design and co-production principles.

Many interviewees reflected that there needs to be commitment and understanding of how long relationship-building and CCC in commissioning will take to credibly show results, with a suggestion that appropriate timeframes would be at least 18 months for planning, needs assessment, priorities and service design. “[We’re] lucky to get 12 months to do all this so there’s a race to get it all done”. One suggestion was that CCC needed to be seen as a continuous cycle, or it would always be an afterthought.

Those interviewed for this work noted potential reluctance to invest time and energy into improving CCC when there may be a lack of certainty about the role of funders into the future; as noted by one: we “need to know if they [PHNs] are here for the long-term”. With this kind of uncertainty, investment in CCC may not be prioritised because there is no surety regarding future arrangements.

Appropriate resourcing of CCC was identified as a challenge in carrying out CCC activities, even where there had been agreement. “Lack of resourcing means that getting momentum on a project can be challenging”. Another noted: “how can we do this work if we’re not funded to do it?” There is not currently a separate pot of money provided by one funder or government for CCC, but this work can be time consuming and resource intensive. Greater levels of CCC also require greater resources. Many agencies are not adequately resourced to manage their existing workloads. “Lots of this collaborative work depends on in-kind contributions and needs resources to be realised”.

Gaining additional funds or resources may entail mounting arguments 'up the line' about why CCC is important, how it could improve the treatment service system and the health outcomes for clients, and how it can save funds in the long term, avoid duplication of effort and so on. One idea is for the funders to prepare a briefing note about the rationale for CCC between funders and share this amongst themselves such that each can advocate within their own systems for this activity to be adequately resourced.

An important action is to encourage recognition of the benefits of CCC in reducing costs, administrative burden, and increases to efficiency in planning and funding. There may be the opportunity to put in place financial or other incentives for funders to engage in CCC. One example would be the provision of additional funds to those funding bodies seeking to create an MOU, or the creation of central positions and resources that can assist organisations seeking greater CCC. A national body to drive effective CCC is required.

## References

- ANAO. (2010). *Effective Cross-Agency Agreements*. Australian National Audit Office. Retrieved from Canberra: [https://www.anao.gov.au/sites/default/files/ANAO\\_Report\\_2009-2010\\_41.pdf?acsf\\_files\\_redirect](https://www.anao.gov.au/sites/default/files/ANAO_Report_2009-2010_41.pdf?acsf_files_redirect)
- ANAO. (2012). *Australian Government Coordination Arrangements for Indigenous Programs*. Audit Report 8. Commonwealth of Australia. Retrieved from Canberra: <https://www.anao.gov.au/sites/default/files/201213%20Audit%20Report%20No%208.pdf>
- Audit Office of New South Wales. (2020). *Performance Audit: Their Futures Matter*. Audit Office of New South Wales. Retrieved from Sydney: <https://www.audit.nsw.gov.au/sites/default/files/documents/Their%20Futures%20Matter%20-%20PDF%20Report.pdf>
- Australian Public Service Commission. (2020). *State of the Service Report 2019-2020*. Australian Government. Retrieved from Canberra: [https://www.apsc.gov.au/sites/default/files/aps\\_state\\_of\\_the\\_service\\_report\\_2019-20\\_0.pdf](https://www.apsc.gov.au/sites/default/files/aps_state_of_the_service_report_2019-20_0.pdf)
- Department of Health. (2017). *The Fifth National Mental Health and Suicide Prevention Plan*. Australian Government. Retrieved from Canberra: <https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-fifth-national-mental-health-plan>
- Department of Health. (2020). *Sharing the vision: a mental health policy for everyone*. Government of Ireland. Retrieved from Dublin: <https://assets.gov.ie/76770/b142b216-f2ca-48e6-a551-79c208f1a247.pdf>
- Department of the Prime Minister and Cabinet. (2019). *Our Public Service Our Future: Independent review of the Australian public service*. Commonwealth of Australia. Retrieved from Canberra: <https://pmc.gov.au/sites/default/files/publications/independent-review-aps.pdf>
- Dickinson, H. (2014). Making a reality of integration: less science, more craft and graft: Managing Community Care. *Journal of Integrated Care*, 22(5/6), 189-196.  
doi:<http://dx.doi.org/10.1108/JICA-08-2014-0033>
- Gil-Garcia, J. R., Guler, A., Pardo, T. A., & Burke, G. B. (2019). Characterizing the importance of clarity of roles and responsibilities in government inter-organizational collaboration and information sharing initiatives. *Government Information Quarterly*, 36(4), 101393.  
doi:<https://doi.org/10.1016/j.giq.2019.101393>
- Green, C., Malbon, E., Carey, G., Dickinson, H., & Reeders, D. (2017). *Competition and collaboration between service providers in the NDIS*. Centre for Social Impact & UNSW. Retrieved from Sydney: <http://unsworks.unsw.edu.au/fapi/datastream/unsworks:52725/bin0106efd0-83f1-428d-8973-cf215dcef313?view=true>
- Integrated Regional Planning Working Group. (2018). *Joint Regional Planning for Integrated Mental Health and Suicide Prevention Services: A guide for Local Health Networks (LHNs) and Primary Health Networks (PHNs)*. Department of Health, Australian Government,. Retrieved

- from Canberra: [https://www.health.gov.au/sites/default/files/documents/2020/11/joint-regional-planning-for-integrated-mental-health-and-suicide-prevention-services\\_0.pdf](https://www.health.gov.au/sites/default/files/documents/2020/11/joint-regional-planning-for-integrated-mental-health-and-suicide-prevention-services_0.pdf)
- Lubman, D. I., Manning, V., & Cheetham, A. (2017). *Informing Alcohol and Other Drug Service Planning in Victoria*. Turning Point. Retrieved from Melbourne: [https://researchmgt.monash.edu/ws/portalfiles/portal/294455272/241729915\\_oa.pdf](https://researchmgt.monash.edu/ws/portalfiles/portal/294455272/241729915_oa.pdf)
- Management Advisory Committee. (2004). *Connecting Government: Whole of Government Responses to Australia's Priority Challenges*. Commonwealth of Australia. Retrieved from Canberra: <https://www.apsc.gov.au/sites/default/files/connectinggovernment.pdf>
- National Mental Health Commission. (2020). *Vision 2030; Blueprint for Mental Health and Suicide Prevention*. Australian Government. Retrieved from Canberra: [https://www.mentalhealthcommission.gov.au/getmedia/27e09cfa-eb88-49ac-b4d3-9669ec74c7c6/NMHC\\_Vision2030\\_ConsultationReport\\_March2020\\_1.pdf](https://www.mentalhealthcommission.gov.au/getmedia/27e09cfa-eb88-49ac-b4d3-9669ec74c7c6/NMHC_Vision2030_ConsultationReport_March2020_1.pdf)
- O'Flynn, J., & Wanna, J. (2008). *Collaborative Governance: A new era of public policy in Australia?* ANU Press. Retrieved from Canberra:
- Productivity Commission. (2017). *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services*. Report No. 85. Australian Government. Retrieved from Canberra: <https://www.pc.gov.au/inquiries/completed/human-services/reforms/report/human-services-reforms-overview.pdf>
- Ritter, A., Berends, L., Chalmers, J., Hull, P., Lancaster, K., & Gomez, M. (2014). *New Horizons: The review of alcohol and other drug treatment services in Australia*. Sydney, Australia: <https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/New%20Horizons%20Final%20Report%20July%202014.pdf>
- Royal Commission into Victoria's Mental Health System. (2021). *Final Report: Summary and recommendations*. Parl Paper No. 202,. State of Victoria. Retrieved from Melbourne: [https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS\\_FinalReport\\_ExecSummary\\_Accessible.pdf](https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS_FinalReport_ExecSummary_Accessible.pdf)
- Shergold, P. (2008). Governing through collaboration. In J. O'Flynn & J. Wanna (Eds.), *Collaborative Governance: A new era of public policy in Australia?* Canberra: ANU Press,.
- The Scottish Government Third Sector Division, PricewaterhouseCoopers LLP, & Forth Sector Development. (2014). *Guidelines for the Establishment and Management of Lead Funder Arrangements*. Scotland: <http://www.ccpscotland.org/wp-content/uploads/2014/01/Future-interventions-and-lead-funder-guidance-FINAL.pdf>
- Wanna, J. (2008). Collaborative government: meanings, dimensions, drivers and outcomes. In J. O'Flynn & J. Wanna (Eds.), *Collaborative Governance: A new era of public policy in Australia?* Canberra: ANU E Press,.
- Wilkins, P., Phillimore, J., & Gilchrist, D. (2015). *Working Together: Evidence on collaboration from the reports of independent watchdogs*. ANZSOG. Retrieved from Melbourne: <https://www.anzsog.edu.au/resource-library/research/working-together-evidence-on-collaboration-from-the-reports-of-independent-watchdogs>



Wilkins, P., Phillimore, J., & Gilchrist, D. (2016). Public Sector Collaboration: Are We Doing It Well and Could We Do It Better? *Australian Journal of Public Administration*, 75(3), 318-330.  
doi:10.1111/1467-8500.12183