1

New Horizons: The review of alcohol and other drug treatment services in Australia

Final Report

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Table of Contents

List of Tables and Figures

Disclaimer
This is an independent report.
While many experts provided valuable data, advice and opinions, the views expressed here are solely those of the researchers. The Review Advisory Committee members have not seen the report. The Review Advisory Committee and the Department of Health provided ongoing and thorough feedback but all conclusions have been drawn by the researchers alone.

Acronyms list

AADANT	Alcohol & Drug Association NT
ABF	Activity-based funding
ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
AIVL	Australian Injecting and Illicit Drug Users League
AOD	Alcohol and other drugs
AODTS-NMDS	Alcohol and Other Drug Treatment Services National Minimum Dataset
ATAPS	Access to Allied Psychological Services Scheme
ATDC	Alcohol, Tobacco and other Drugs Council of Tasmania
ATODA	Alcohol, Tobacco and other Drugs Association ACT
AUSBod	Australian Burden of Disease
BEACH	Bettering the Evaluation and Care of Health
Better Access	Better Access to Psychiatrists, Psychologists and General Practitioners Scheme
CAHMA	Canberra Alliance for Harm Minimisation and Advocacy
CALD	Culturally and Linguistically Diverse
CMHC-NMDS	Community Mental Health Care - National Minimum Data Set
COAG	Council of Australian Governments
DA-CCP	Drug and Alcohol Clinical Care & Prevention (now titled: Drug and Alcohol Service Planning Model for Australia)
DAO	Drug and Alcohol Office (WA)
DASSA	Drug and Alcohol Services — South Australia
DHHS	Department of Health and Human Services (Tasmania)
DoH	Department of Health
DPMP	Drug Policy Modelling Program
DRG	Diagnosis Related Group
DSS	Department of Social Services
DTAU	Drug Treatment Activity Unit (Victoria)
DVA	Department of Veterans Affairs
EOC	Episode of care
EOI	Expression of interest
GLBTQI	Gay, Lesbian, Bisexual, Transgender, Questioning, or Intersex
GSD	Grant Services Division (Commonwealth)
HCV	Hepatitis C virus
HHS	Hospital and Health Service (QLD)

HRV	Harm Reduction Victoria
ICD-10	International Classification of Diseases, 10th Revision
IDDI	Illicit Drug Diversion Initiative
IGAFFR	Intergovernmental Agreement on Federal Financial Relations
IGCD	Intergovernmental Committee on Drugs
IHPA	Independent Hospital Pricing Authority
ISI	Improved Services Initiative
ITA	Invitation to apply
KPI	Key Performance Indicator
LHD	Local Health District (NSW)
LHN	Local Hospital Network
MBS	Medicare Benefits Scheme
MH	Mental health
MHDAO	Mental Health and Drug & Alcohol Office (NSW)
NADA	Network of Alcohol and other Drugs Agencies
NDS	National Drug Strategy
NEP	National Efficient Price (under activity based funding)
NFP	Not For Profit
NGO	Non Government Organisation
NGOTGP	Non Government Organisation Treatment Grants Program
NHA	National Healthcare Agreement
NHFP	National Health Funding Pool
NHMD	National Hospital Morbidity Dataset
NHRA	National Health Reform Agreement
NOPSAD	National Opioid Pharmacotherapy Statistics Annual Data
NSMHWB	National Survey of Mental Health and Wellbeing
NTAHC	Northern Territory AIDS and Hepatitis Council
NUAA	NSW Users and AIDS Association
OATSIH	Office for Aboriginal and Torres Strait Islander Health
OSR	On-line Services Report (Office for Aboriginal and Torres Strait Islander)
P4P	Pay-for-performance
PAMS	Pharmacotherapy, Advocacy Mediation and Support
PbR	Payment By Results
PBS	Pharmaceutical Benefits Scheme
PIR	Partners in Recovery

PM&C	Prime Minister and Cabinet (department of)
POCA	Proceeds of Crime Act
QNADA	Queensland Network of Alcohol and other Drugs Agencies
QuIHN	Queensland Injectors Health Network
QuIVAA	Queensland Intravenous AIDS Association
RMHC-NMDS	Residential Mental Health Care - National Minimum Data Set
SACOSS	South Australian Council of Social Services
SACS	Social and Community Services
SAIN	South Australian Intravenous Network
SANDAS	South Australian Network of Drug and Alcohol Services
SFA	Standard Funding Agreement
SMSDGF	Substance Misuse Service Delivery Grants Fund
STO	State / Territory Office (Commonwealth)
VAADA	Victorian Alcohol and Drug Association
WANADA	Western Australian Network of Alcohol and other Drug Agencies
WASUA	West Australian Substance Users' Association

EXECUTIVE SUMMARY

Australia's approach to responding to the harms associated with alcohol and other drugs comprises the three pillars of the National Drug Strategy: reducing supply, reducing harm and reducing demand. This report concerns reducing demand, and specifically alcohol and other drug (AOD) treatment. Treatment for alcohol and other drug problems comprises a series of 'core' service types: withdrawal, psycho-social therapy, residential rehabilitation and pharmacotherapy maintenance delivered in a range of settings including specialist alcohol and other drug (AOD) services, general health services, telephone and on-line interventions and via outreach. Capacity building projects aim to improve the quality and standard of service delivery through organisational and sector development with the goal of ongoing improvement in health outcomes.

AOD treatment is a good investment. For every $1 invested in alcohol or drug treatment, society gains $7 (Ettner et al., 2006). AOD treatment has been shown to:

- Reduce consumption of alcohol and other drugs
- Improve health status
- Reduce criminal behaviour
- Improve psychological wellbeing
- Improve participation in the community.

> "Treatment works and is cost saving" (p. 44).

The savings which accrue to governments from AOD treatment occur largely through direct savings in future health care costs, reduced demands on the criminal justice system, and productivity gains. The well-being gained for individuals and families is immense, as clients reduce the harms from alcohol or drug use and achieve personal, social, and economic goals. Investment by government in evidence-based AOD treatment is therefore worthwhile and represents value for money.

Aims of the Review

This Review, commissioned by the Department of Health, sought to deliver:

- a shared understanding of current AOD treatment funding
- a set of planned and coordinated funding processes
- documentation to assist future Commonwealth funding processes to respond to the needs of individuals, families and their communities.

The program of research undertaken for the Review drew from comprehensive analyses of population and service provision statistics; an extensive series of key informant interviews across Australia to gather policy, research and practice knowledge; comprehensive literature reviews; case examples relevant to particular issues; liaison, discussion, and internal review and analysis. The work was undertaken between July 2013 and June 2014. A separate review was undertaken for the Aboriginal and Torres Strait Islander AOD treatment services (Gray et al., 2014).

Current AOD treatment need and treatment funding

Our research estimated that approximately 200,000 people receive AOD treatment in any one year in Australia (Chapter 7). At the same time, modelled projections of the unmet demand for AOD treatment (that is the number of people in any one year who need and would seek treatment) are conservatively estimated to be between 200,000 and 500,000 people *over and above* those in treatment in any one year (Chapter 8). This has significant implications for treatment planning and purchasing.

> "There is substantial unmet demand" (p. 183).

We valued Australia's current investment in AOD treatment at around $1.26 billion per annum ([Chapter 4](#)). Compared to the unmet demand, along with the prevalence rate of AOD problems in Australia and the estimated social cost per annum ($24 billion: Collins and Lapsley, 2008) the investment in AOD treatment is small.

Of the $1.26 billion total, the Commonwealth contributes 31%; state/territory governments contribute 49% and 20% is contributed through private sources (philanthropy and client co-payments). Removing the private contributions, the Commonwealth's contribution is 39% and the state/territory governments' contribution is 61%, with a total expenditure at just over $1 billion.

> *Of government treatment funding:*
> - *61% State/territory*
> - *39% Commonwealth (p. 67).*

Examining government funding alone ($1 billion), 55% of all government funding is invested in specialist AOD treatment and 45% in generalist AOD treatment. The Commonwealth plays a pivotal role in funding the specialist sector – their contribution represents 21% of all specialist AOD treatment funding in Australia ([Chapter 4](#)).

The Review focussed on two Commonwealth AOD treatment grant schemes, the Non Government Organisation Treatment Grants Program (NGOTGP) and the Substance Misuse Service Delivery Grants Fund (SMSDGF, [Chapter 5](#)). In total, these schemes distribute $130 million per annum (in three year grants), and represent 10% of the total Australian AOD treatment funding. The NGOTGP is an ongoing initiative that provides around $49.3 million per annum. Its core objective is to increase the number of treatment places available and strengthen the capacity of treatment providers to achieve

> *"The Commonwealth purchases core AOD treatment services and capacity building with the NGOTGP and SMSDGF grants schemes" (p. 109).*

improved service outcomes. In the 2012 grant round (for the period 2012/3 to 2014/5), 171 projects were funded, provided by 122 organisations ([Chapter 5](#)). The primary objective of the SMSDGF is to promote and support AOD treatment services to build capacity and effectively identify and treat coinciding mental illness and substance use. Our focus is on Priorities 1, 2, 3, and 5 of the Fund, which are directed towards treatment. From this orientation, the SMSDGF provides around $80 million per annum, with a priority focus on services for Aboriginal and Torres Strait Islander people. In the 2012 grant round (for the period 2012/3 to 2014/5), there were 303 individual projects, provided by 197 organisations ([Chapter 5](#)).

Current planning

There is no consistent approach to AOD treatment planning. In Australia each state and territory assumes responsibility for treatment planning in its own jurisdiction. There is no national strategic plan. There is limited technical planning ([Chapter 9](#)). Planning would help direct resources and services to the areas of highest need.

> *"…the absence of effective planning processes, assessment of need, unmet need, and gap analysis" (p. 193).*

There is a lack of clarity about the respective roles and responsibilities of the Commonwealth and state/territory governments ([Chapter 12](#)). Commonwealth and state/territory governments operate independently of one another, yet in many cases they provide financial support for the same organisations. The majority of organisations funded by the Commonwealth also receive state/territory funding; although 30% of the organisations funded under NGOTGP were funded only by

> *"A delicate balance is required between the precise specification of jurisdictional roles and flexibility for jurisdictions to respond to need" (p. 253).*

the Commonwealth, as were 31% of the organisations funded under the SMSDGF Priority 1 (Chapter 5).

There is no evidence that the Commonwealth's investment is out of step with the states/territories in terms of the types of treatment it purchases. The treatment service types supported by Commonwealth funds (largely counselling and residential rehabilitation) are also supported by state/territory funds.

Priority areas and significant service gaps that we have identified (Chapter 8) include: alcohol treatment; population groups with high need (including young people; Aboriginal and Torres Strait Islander people; families, parents/carers with children, and women; individuals with co-morbid AOD and mental health problems; and those from culturally and linguistically diverse backgrounds); and specific service types (residential rehabilitation; residential withdrawal; pharmacotherapies; counselling and other outpatient services). This list is largely inclusive of all population groups and all service types, which reinforces the evidence on unmet demand for specialist AOD treatment.

Current purchasing

Multiple purchasing mechanisms are in play at present (Chapter 6). For example, the Commonwealth currently purchases AOD treatment through four approaches: competitive processes (grants schemes), fee-for-service (Medicare), activity-based funding (hospital services), and grants to states/territories (special purpose payments).

"With multiple funding sources, which have different timeframes for reporting… it is hard to maintain a rhythm of service delivery" (p. 125).

The way in which NGO-provided AOD treatment is currently purchased by the Commonwealth and states/territories is predicated on models that exist for social welfare services, not those for health. Arguably, alcohol and other drug treatment services have been subject to these social welfare processes because the providers are non-government organisations. However, the usual mechanisms for health funding (such as activity based funding or fee-for-service) may be more appropriate.

Current monitoring and accountability

The multiple streams of AOD treatment funding (Chapter 3) extend to different strategies for monitoring and accountability, just one example of the complexities for organisations in managing multiple sets of funding, with different conditions, timeframes, and reporting requirements. The Commonwealth's contract management, performance and financial monitoring practices are under reform, with the intention to, amongst other things, increase consistency in their practices and reduce the contract management and monitoring burden on funded organisations. There has been

"Data are not used to monitor the performance of funded projects, nor of the grant programs as a whole" (p. 214)

variability in practices in relation to the payment tranches; the extent to which the performance measures are considered as deliverables; and the use of the Alcohol and Other Drug Treatment Services - National Minimum Data Set (Chapter 10). There are inherent difficulties in apportioning outcomes to particular sources of funding within a project, or even particular sources of funding within an organisation. Having the ability and mechanisms to measure and account for both individual project performance and the outcomes of the programs (NGOTGP and SMSDGF) as a whole is vital.

Role delineation: where does the Commonwealth fit in?

Analysis of the existing documentation regarding the role of the Commonwealth in Australian healthcare, the National Drug Strategy, and the perspectives put forward by key informants, along with federalism considerations revealed a clear set of responsibilities for the Commonwealth that clarify its role in AOD treatment ([Chapter 12)](#). These responsibilities are:

1. Advancing national priorities
2. Providing leadership in planning
3. Addressing service quality
4. Supporting equity.

1. Advancing national priorities

The Commonwealth has a unique role and responsibility to advance areas seen as important *across* states and territories. There is no duplication with states/territories in this function. It is the only level of government with a "bird's eye" perspective on AOD treatment priorities across the nation. The provision of funding for treatment services, where those services have demonstrated cost-effectiveness and form part of a national priority, is an important Commonwealth role. Its role may

> *"…national roll-out, national consistency and required frameworks of care" (p. 255)*

also include setting national priorities for specific treatment types, and/or increasing the access of specific population groups to core AOD treatment. In addition, it may set national priorities for sector development through national capacity building initiatives.

2. Providing leadership in planning

The importance of national strategic planning for AOD treatment has been repeatedly highlighted in the Review data, in order to make best use of available resources across two levels of government. In leading national strategic planning the Commonwealth will not duplicate the work of states/territories. The purpose of planning is to maximise the health outcomes of people with alcohol and other drug problems. Good planning will lead to effective, efficient and value for money purchasing decisions, which in turn will lead to the best possible coverage of services, in the places where need is the highest, and articulated with services funded by others.

3. Addressing service quality

Service quality is a key mechanism for ensuring good treatment outcomes are made possible. Key to service quality are treatment providers equipped with the practical resources to respond to priority

> *"…ensuring equity in access across states and addressing an identified gap, or problem" (p. 257).*

groups and concerns, organisational structures within services that support good service delivery and the existence of sound intra- and inter-sectoral systems of care. States and territories share the responsibility for service quality and achieving health outcomes. However, the unique role for the Commonwealth is providing a nationally consistent approach to service quality by ensuring a national quality framework, nationally consistent quality standards and clinical guidelines, and national capacity building projects.

4. Supporting equity

Equity ensures equal or fair delivery of treatment services and equal or fair treatment outcomes. By supporting equity (of access and outcomes), the Commonwealth provides insurance for AOD treatment in Australia. Supporting equity *between* states/territories is required given that some states/territories have greater need with less capacity to raise revenue. Supporting equity *within* states/territories is required because changes in a jurisdiction's investment (in AOD and in other areas) can impact on AOD treatment in that jurisdiction. The Commonwealth has a responsibility, in

this situation, to ensure minimum service levels and to target resources to the most marginalised and vulnerable.

> "The Commonwealth has a responsibility…to ensure minimum service levels and target resources to the most marginalised and vulnerable" (p.257).

The Commonwealth's role in funding core AOD treatment (withdrawal services, psycho-social therapy, residential rehabilitation and pharmacotherapy maintenance) is a direct response to ensuring equity – where those services do not exist, or are insufficiently accessible, or are not targeted to meet areas of high need.

Deciding what to purchase?

The Commonwealth could decide *a priori* about the types of core services that it purchases. If the Commonwealth were to consider defining specific service types for funding, there are four options that emerged from the Review data: a focus on (generalist) primary care alone; a focus on one particular service type; a focus on specialist low intensity treatment; a focus on certain population groups (Chapter 12). None of these could be strongly justified and our analysis failed to deliver a clear option in this regard. To decide *a priori* undermines strategic and technical planning, creates a level of inflexibility in decision-making, constrains the possibility of leverage with the states/territories, fails to engage the sector and current and prospective clients, and conflicts with the Commonwealth's responsibilities in relation to national priorities, equity and service quality.

Instead of making an *a priori* decision, the Commonwealth could engage in the longer-term process of strategic and technical planning (Chapter 13). Planning processes enable purchasing decisions to be grounded in data on need and demand and focus the Commonwealth's effort in those areas that emerge as highest need. In the immediate 2015 grant round, a rapid consultation process could be undertaken (Chapter 16) with submissions from states/territories and input from an

> "Good planning will force discussion and decisions about priority groups, given finite resources" (p. 275).

expert panel (inclusive of service providers and consumers) to establish the specific priority areas for Commonwealth funding (for treatment service types and for capacity building). These actions would both articulate with and commence the longer-term path to establish a strategic plan and engage with states/territories in technical planning into the future.

Duplication in what the Commonwealth and state/territories do?

In an ideal world, duplication could be avoided if governments engaged in separate activities. Hence the option (see above) to differentiate the service types purchased by the Commonwealth from those purchased by states/territories. The significant disadvantages to *a priori* delineation include that it conflicts with strategic and technical planning and it conflicts with the Commonwealth's responsibilities for quality and equity (that is, it reduces the flexibility to respond to the most vulnerable and marginalised). These factors need to be managed in the context of concerns about duplication (Chapter 12).

> "Role delineation cannot be driven solely by the desire to avoid duplication" (p. 262).

Duplication can refer to duplication of funding: that is the same funds being provided for the same service; duplication of administration: that is a doubling up of administrative processes such as grant selection processes; duplication of planning: that is two levels of government engaged in the same level of planning; and duplication of services: that is, multiple AOD services of the same type in the same area. Clearly the last version of duplication is not relevant here: the existence of multiple services is

important to meet unmet demand for treatment and to provide consumer choice, enhancing treatment outcomes.

In the case of 'duplication' of funding, it can be difficult to distinguish between the exact activities funded by each level of government (eg, funding part of a clinical role, or enhanced elements of core services) and the outcomes realised as a result of that funding (ie, where one client benefits from services funded by two levels of government). Indeed, we see co-funding (Commonwealth and state/territory funding of the same organisation) as strengthening organisational viability and sector sustainability (Chapter 5). The critical issue is how to ensure that service delivery can be accounted for according to funders' investment. Governments want clarity about what they are purchasing, that the funds they provide to a service are expended in accordance with the funder's expectations, and that they achieve the anticipated effects. Effective planning, formalised communication mechanisms between funders, good contract management, effective performance monitoring and quality assurance (including ethical behaviour by organisations) are ways of managing concern about funding duplication.

Reduction of duplication in planning and administration can occur if the two levels of government have similar goals and objectives and consolidate their efforts. There is little point in the Commonwealth engaging in planning processes that are replicated at state/territory level: a sensible division of planning responsibilities between strategic and technical planning would avoid duplication (Chapter 13). Likewise, the Commonwealth could outsource provider selection to states and territories (Chapter 14), reducing administrative duplication. There are also opportunities for the Commonwealth to share accountability and reporting functions with states/territories (Chapter 15).

> *"Advancing national priorities, leadership in planning, addressing service quality and supporting service equity, can be achieved without duplication" (p. 265)*

There is another way of managing potential duplication – transfer the funds to the states/territories.

Transfer funds to states/territories

Under this option the Commonwealth transfers the funds to state and territory health departments for them to then plan for and purchase AOD treatment. We conducted extensive analysis of this option (Chapters 6, 14 and 16). On balance, our analysis suggests that the transfer of funds to states/territories is high risk, and compromises the Commonwealth's ability to account for and discharge its responsibilities.

> *"Better service planning could occur under a single purchaser model… [but]… could result in a loss of specified AOD treatment funds" (p. 282-3).*

The main advantage of this option is that states and territories would be able to plan and purchase AOD treatment in an internally consistent way. It would reduce the likelihood of service duplication, eliminate administrative duplication and reduce the possibility of cost-shifting. This is an attractive option where the Commonwealth investment in AOD treatment represents a small proportion of the overall AOD treatment budget in Australia, consistent with the principle of proportionality. But at present the Commonwealth contribution is 39%. This is not a small contribution.

The benefits of this option (reduction in administrative duplication, better jurisdictional planning and streamlining of purchasing and accountability) are lost if the Commonwealth retains some proportion of the funds. Therefore this is an "all-or-nothing" option, which is a significant

disadvantage, limiting the capacity for the Commonwealth to exercise decision-making and acquit its responsibilities in relation to equity.

The transfer could be made through a single (block) grant. Allocations to each state/territory could be based on a formula inclusive of the overall rate of AOD problems, the extent of unmet demand for treatment and the context for service delivery. The Commonwealth could take into account equity issues in its allocations of funds to each state/territory, consistent with its role in ensuring minimum service levels and equity of access to AOD treatment across Australia. At the same time, this option may compromise the mandate to ensure equity in the short-term given that once the three- or five-year allocations are made, the Commonwealth has no further funds to distribute in emergencies or in situations where future inequities arise.

The major concern expressed by key informants (across government and non-government) to the Review is the potential loss of these currently dedicated AOD treatment funds. There is a fear, based on past history, that the funds will be potentially lost within state/territory systems. It would require careful quarantining of the funds and mechanisms to ensure that the funds were expended according to the original Commonwealth intention (that is the purchase of AOD treatment and capacity building). On balance, we consider this to be a high risk option, despite its attractiveness.

An alternative to the single block grant transfer of funds to the states/territories is for the Commonwealth to employ an Activity Based Funding model. Experts have expressed significant concern as to the suitability of the ABF system for non-admitted care and more specifically for AOD treatment. A feasibility study would be required to fully explore the possibilities and implications of an ABF-type mechanism within AOD treatment (Chapter 14).

> *"Multiple funders were seen to improve the survival of the sector….[and] improve sector diversity" (p. 283)*

Overall, the transfer of the funds to states/territories would remove the checks and balances that occur with two separate funders. Having two funders facilitates diversity, it enhances the competitive pressure on governments, it creates opportunities for national priority setting, and it disperses the decision-making power (protecting AOD treatment services against single government funding driven by moral panics or political whim).

On balance, our analysis suggests that the transfer of funds to states/territories as a single block grant is high risk. A move to Activity Based Funding requires feasibility assessment. We thus return to the position where the Commonwealth directly engages in the planning and purchasing of AOD treatment and capacity building.

Planning

As referred to above, we draw a distinction between strategic and technical planning, and delineate the Commonwealth as responsible for strategic planning (in concert with states/territories) and the states/territories responsible for technical planning (in concert with the Commonwealth). To achieve meaningful change across policy and practice, planning should be a partnership between the Commonwealth and the states/territories, which incorporates the interests of both parties and includes real engagement of service providers and current and prospective clients (Chapter 9).

In the longer-term, a nationally endorsed ten-year AOD Treatment Strategic Plan would specify the roles and responsibilities of each funder (state/territory and Commonwealth) and identify the priority service

> *"Planning involves difficult decision-making about the allocation of scarce resources. There is value in having broad engagement and consensus" (p. 200).*

types, population groups and locations for funding (Chapter 13). Under this option, the Commonwealth would fulfil its responsibilities in providing leadership in planning and setting national priorities.

> *"A ten year National AOD Treatment Strategy would provide the framework for future funding decisions that are coordinated …and follow clearly specified role delineation" (p. 277).*

The development of a Strategic Plan would lay the foundation for future comprehensive technical planning built from solid data. We have found that there is a current lack of needs-based planning data (notably the current treatment investment mix and impacts of capacity building). The collection, collation and analysis of planning data will provide a foundation for technical planning into the future.

Purchasing

There are three options for the Commonwealth to select the AOD treatment providers: through competitive selection processes; through individually-negotiated arrangements (often based on historical agreements); or through an accreditation and/or registration process. There are also options for the Commonwealth in relation to how to provide the funds: through a block grant; through a fixed unit cost; through a capitation model; or through payment for outcomes (Chapter 14). Our analysis identified competitive processes and block grants with clearly delineated performance criteria as the pragmatic options.

Competitive selection processes to select the providers of AOD treatment are widely used. These approaches are generally considered to be

> *"Competitive tendering does seem to be the best (of the worst) options". (p. 123)*

advantageous, because of transparency and fairness. There is also a perception that competition is a driver of quality and efficiency. However, there are a number of disadvantages that apply to the AOD treatment sector. A limited number of potential providers exist. Funders risk undermining sector viability through processes that do not account for a) organisational characteristics (eg, size and capacity to write proposals) and b) the vulnerability of organisations to uncertainty regarding future funding. However, the alternatives – such as selecting providers based on historical arrangements and relationships; or accrediting providers and using fee-for-service have more limitations than competitive processes (Chapter 6).

The choice between different types of competitive processes (open, targeted, preferred-provider

> *"Transparency and fairness are paramount" (p. 124)*

panel) can be determined based on what is being purchased and an assessment of the likely number of potential providers (for treatment and for capacity building). The competitive process, if effective, needs to be designed with consideration of the pool of potential providers and it should be well-resourced to ensure astute decision-making. Assessment panels need to include experts with a sound understanding of service delivery and clinical excellence across treatment modalities.

For the payment method, we thoroughly reviewed payment-for-outcome approaches and concluded that there is an absence of evidence, and limitations which preclude it being taken up for AOD treatment funding at this time (Chapter 6). Similarly, capitation models are not feasible. Thus block grants with clearly delineated performance criteria remain as the main mechanism for provider payment.

In the longer-term, there are advantages to the Commonwealth using a fixed unit cost per service type for their purchasing (Chapter 14). This is distinguishable from the activity based funding option

which occurs in the context of grants to states/territories (discussed above). A fixed unit price would facilitate transparency about the price for service types, enabling competitive processes to focus on quality. The development of unit costs will take some time, and would not be available in the short-term.

Accountability

Monitoring processes need to account for the complexities of the funding environment and strive for contract management that is meaningful, respectful, and useful for both services and government, operating in an ongoing cycle of improvement and sector development.

In the situation where organisations are jointly funded by the Commonwealth and state/territory, the contract management and performance and financial monitoring is best undertaken jointly. This reduces administrative duplication for government and reduces the work-load of funded organisations, as well as the potential for mixed messages regarding project objectives (Chapter 15).

> *"Performance monitoring is important at both project and program level" (p. 302).*

There is a pressing need for the Commonwealth to measure its return on investment for individual projects. In addition, in meeting the principle of achieving 'value with public money' the Commonwealth needs also to consider outcomes at the grant scheme level. An outcomes framework may provide a way forward to considering both project outcomes and program outcomes in cooperation with the states/territories (Chapter 15). The objectives of the NGOTGP and SMSDGF schemes are good starting points, and have some parallels with the annual Report on Government Services indicators for health programs.

The length of core treatment contracts is most appropriately matched to a longer cycle, with consideration of an initial fixed term (eg, 3 years), followed by annual extensions for 2 years subject to evaluation (Chapter 15). Contracts for capacity building projects and pilots and innovations should match the time horizon of the project from 1 to 3 years.

The Commonwealth and state/territory governments along with service providers have invested substantial resources in the AODTS-NMDS collection over many years. There are still challenges: there is some duplication of effort with states/territories; and the data are little used by the treatment sector, government and research community. Investment in improving the data systems is worthwhile, including an independent review of how the data could be made 'fit for purpose' for assessing project and program accountability.

Moving forward in 2014/2015

> *"The Commonwealth has a number of options to incrementally improve the planning and purchasing associated with the 2015 grant rounds, while laying the foundation for longer-term reform" (p. 307).*

Much of the analysis in this Review has led to a long-term reform agenda. This will take time and resources. There is an immediate imperative for the 2015 grant round. The steps taken in the 2015 grant round should articulate with the ongoing reform agenda (Chapter 16) and represent incremental improvements to the processes for planning, purchasing and contracting. A short planning process, inclusive of states/territories and an expert panel for 2015, enabling clear specification of the specific priority areas for the 2015 grant rounds could be followed by targeted or selective competitive processes for purchasing, with block grants and clear key performance indicators specified in the contracting.

Where possible, shared contract management with states/territories is worth pursuing, alongside the current reform of contract management processes by the Commonwealth.

Communication, collaboration and partnerships

We want to reinforce that *how* these activities are undertaken is as important as *what* is actually undertaken (Chapter 11). Throughout planning, purchasing and accountability, the development and maintenance of collaborative respectful partnerships needs to be kept in mind. This applies equally to the Commonwealth and to states/territories – that is planning, purchasing and accountability by the two levels of government needs to be engaging of the other level of government. Further, meaningful input from service providers and consumers is crucial; to enable processes that are grounded in the realities of service delivery and account for local context, and to ensure provider support for real change and development in the sector.

> *"A real and meaningful partnership between all the stakeholders" (p. 229).*

Investment of resources in building these working relationships is required. This would include bolstering the resources available to the InterGovernmental Committee on Drugs by increasing the frequency of meetings and improving the communications (assuming that this is the body where a partnership between the Commonwealth and states/territories is best formulated and sustained); establishing mechanisms to consult and coordinate with the NGO treatment sector; and establishing mechanisms to consult with current and prospective clients of AOD treatment.

It is possible to establish these mechanisms for the short-term (focussed on the next Commonwealth funding round for the NGOTGP and SMSDGF), although achieving value for money and improving health outcomes for people with AOD problems in the long-term will require sustained partnership mechanisms and ongoing attention to managing relationships (Chapter 16).

Health outcomes

The focus of this Review has been on the planning, purchasing and contracting of AOD treatment services. As such, the attention has been on institutions and processes, organisations and government. However, all planning, purchasing and contracting is a means to an end – and that end is the reduction in the harms associated with alcohol and other drug use, improved physical, psychological and social well-being for people experiencing problems with alcohol and other drugs and their family and friends. The AOD treatment service system is about the clients – what they might need at any one point in time and how that need can be met. The success of the Review will be judged by the ways in which the analysis of options and subsequent implementation improves the health outcomes of current and prospective clients of AOD treatment.

Chapter 1: Introduction and methodology

The Drug Policy Modelling Program at the University of New South Wales was commissioned in July 2013 to undertake a review of the alcohol and other drug treatment service sector on behalf of the Commonwealth Department of Health, reporting back to the Department by July 2014.

The aims of the review

As documented by the Department of Health (Communique No. 1, Department of Health, July, 2013), the Review aims to achieve:

- "clarity as to the range of services currently funded by governments, their distribution and the demographic groups targeted by these services;
- a common understanding amongst governments and the sector of current and future service needs and where there may be service gaps, either in relation to service type, geographic area and/or demographic groups;
- clarity as to the type and timing of drug and alcohol funding activities undertaken by governments; and
- the development of a resource/tools to help focus future government funding activities to ensure existing levels of resources (and any growth funding) are used as efficiently and effectively as possible to deliver quality, sustainable drug and alcohol services that respond to the needs of individuals, families and communities".

This Review has been commissioned with the purpose to deliver:

1. a shared understanding of current alcohol and other drug (AOD) treatment funding;
2. a set of planned and coordinated funding processes; and
3. documentation to assist future Commonwealth funding processes to respond to the needs of individuals, families and their communities.

'Funding processes' refer to planning, purchasing and accountability measures. Planning involves establishing what to purchase; purchasing involves establishing the most appropriate mechanism(s) to select and fund the provider; and accountability involves performance monitoring and contract management.

We derived a number of questions about the planning, purchasing and accountability of AOD treatment services:

The current situation

- How is AOD treatment funded in Australia?
- What is the size of the current investment?
- What types of treatment services are currently funded?
- Who funds the services?
- How many people currently receive AOD treatment?
- What is the extent of unmet demand?
- Where are the gaps in services?
- What are the current planning processes?
- What are the current purchasing processes?
- What are the current accountability measures, and is there duplication of funding?

The future
- What are the most appropriate planning processes and mechanisms?
- What are the possible purchasing models (e.g. competitive processes, activity-based funding, fee for service)? What are the potential varieties of grant arrangements, including funding accountability (reporting requirements, payment by results)?
- How should Commonwealth funds be best used (e.g. targeted to gaps, special initiatives, adding intervention capacity to existing systems, general)?
- What process of planning, purchasing and contracting services would best meet needs, in terms of efficiency, simplicity and the ability to fill gaps?

Defining the scope of the review

Responses to alcohol and other drugs can broadly fall into three pillars: supply reduction (reducing the supply and availability of alcohol and other drugs); harm reduction (reducing the harmful consequences associated with alcohol and other drug use, without necessarily reducing use per se); and demand reduction (preventing the uptake of alcohol and other drugs and reducing the demand in people who currently consume).

This Review is concerned with demand reduction only. Demand reduction in general has two components: preventing uptake (prevention) and reducing current use (treatment), although it is widely acknowledged that prevention and treatment are part of a spectrum; whereby some prevention aims to intervene with the goal of preventing the development of ongoing and problematic consumption in those who have already commenced substance use. Some frameworks refer to primary, secondary and tertiary prevention, where primary prevention is concerned with preventing commencement of use, secondary prevention is concerned with reducing the likelihood that someone will develop a problem associated with their consumption, and tertiary prevention is treatment for those with an established problem.

For the purposes of the Review, we consider only tertiary prevention (which we refer to as treatment). Originally the Review scope was intended to include prevention (the title of the Request for Quotation was "Review of drug and alcohol prevention and treatment service sector"), however clarification and refinement of the purpose of the Review through the commissioning process and initial scoping resulted in a clear delineation between prevention and treatment and a focus only on treatment. This was also consistent with the intent by the Department of Health to only focus on two grant schemes: the Non-Government Organisation Treatment Grants Program (NGOTGP) and the Substance Misuse Service Delivery Grant Fund (SMSDGF). Both of these are concerned with AOD treatment.

The exclusion of prevention and harm reduction should not be taken to mean that we (or necessarily the Department of Health) consider these aspects of responding to AOD any less important or less effective than treatment. The same is true of research – this Review does not consider the planning or purchasing of research, despite the importance to AOD treatment of the ongoing development of the evidence-base, trials of existing and new interventions, and the development of clinical guidelines as essential activities that underpin an effective AOD treatment service sector. The same is true of the AOD workforce – the Review did not include analysis of planning the AOD treatment workforce yet clearly this is an essential component of any treatment service system.

As a Commonwealth commissioned project, the focus is on the way in which the Commonwealth plans, purchases and monitors AOD treatment. However, it is not possible to consider the Commonwealth in isolation from the states and territories, given the substantial role that states and

territories play in AOD treatment. Therefore the Review has included analysis of the state/territory treatment planning, purchasing and accountability, for the purposes of understanding, analysing and reviewing options for the Commonwealth into the future.

We define AOD treatment as "that which is directed towards an individual regarding changing his/her AOD use" (United Nations Office on Drugs and Crime, 2006). This means that any funding directed towards the following interventions is included:

- Withdrawal[1]
- Psycho-social therapy (counselling, psychotherapy)
- Residential rehabilitation
- Pharmacotherapy maintenance

Integral to the above is assessment, case management and support, information and education, and aftercare. Modes of delivery, such as telephone, outreach, group-based programs, on-line programs and so on are also encompassed within the relevant service type.

We refer to the above service types as 'core' AOD treatment. There are two other important aspects of treatment. These are supporting treatment entry and access functions (that is, not a treatment type per se as above but activities and services which support the individual to enter or remain in treatment); and capacity building of the treatment sector (skills development, sector co-ordination and so on). We include supporting treatment functions and capacity building of the treatment service sector within the scope of the Review.

Holistic care and the broader wrap-around services provided in association with AOD treatment require consideration. The provision of accommodation may be an essential element for someone seeking a reduction in his or her alcohol or other drug use. Access to and support from social welfare agencies, community health services and general medical care may also form an important part of an individual's behaviour change. The Review could not accommodate analysis of the planning and purchasing of these wrap-around services, and hence these are not within scope. We acknowledge that drawing these lines creates an artificial boundary around AOD treatment that does not exist in practice.

A substantial amount of AOD treatment in Australia is provided in association with correctional services – both in-custody and community correctional interventions. This includes interventions provided by the police, the courts, treatment programs in prisons and post-release support programs. All correctional services remained outside the scope of the Review. This was a necessary but significant limitation of the work. We recommend that analysis of the correctional AOD treatment service system be undertaken, following similar methods as used here, such that integration of the analyses can occur in the future.

Aboriginal and Torres Strait Islander services have formed an important part of the Commonwealth's investment in AOD treatment. Specific funding under the SMSDGF is dedicated to specialist Aboriginal and Torres Strait Islander AOD treatment services[2]. There are also a number of Commonwealth initiatives that form part of larger packages to address Aboriginal disadvantage. This includes the Stronger Futures, Breaking the Cycle and Closing the Gap programs. The largest amount of healthcare funding for Aboriginal and Torres Strait Islander services comes through primary health care services funding (largely the Aboriginal Medical Services). These primary health care services, funded through what was then OATSIH, provide primary health care to Aboriginal people, which can include AOD treatment. There are special and specific considerations in the planning for and

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[1] Throughout this report we use the term 'withdrawal' rather than 'detoxification'.
[2] At the commencement of the Review in July 2013, these services were part of the Department of Health. Now they are part of Prime Minister and Cabinet.

purchasing of AOD services for Aboriginal people. As such, a separate team from the National Drug Research institute, Curtin University, inclusive of Aboriginal people, undertook the review of Aboriginal and Torres Strait Islander AOD treatment services. Their report is provided separately.

AOD treatment in Australia is provided across two systems of care: the specialist AOD treatment system and through the generalist health service system. The specialist treatment service system provides withdrawal, psycho-social therapies, residential rehabilitation, and pharmacotherapy maintenance. The generalist service system provides a similar array of treatment types – for example GPs provide pharmacotherapy maintenance and brief interventions; clinical psychologists (funded through Medicare) provide psycho-social therapy (counselling); general hospitals provide withdrawal services; and welfare services (such as homelessness services) can also provide psycho-social therapy. Thus it can be difficult to distinguish the specialist from the generalist system given that service types are not a distinguishing feature. The generalist sector, therefore, tends to be distinguished by its setting – primary care (GP practices) and general hospitals. As will be seen in the coming chapters, we consider both specialist and generalist services together for the first part of this report – that is we examine the funding sources, amount of funds and types of services across both systems. There are two reasons for this: firstly, we want to contextualise the specialist system and consider any options for the Commonwealth in light of the total picture of AOD treatment in Australia. Secondly, it is difficult to firmly distinguish these sectors given the extent of cross-over in service delivery, and the separation may hold less analytic power than has been assumed.

Methodology

The Review[3] involved a program of research that included a number of discrete projects that were embedded in a comprehensive series of consultative and collaborative activities. Underpinning these elements of the Review was the Rapid Assessment Process, which included collaborating with jurisdictional representatives to obtain information from those best placed to contribute to the project; information which has fed into many of the discrete projects. Throughout the program of work we have used a reflexive approach, which included scope for external input into the project findings, to support the development, distillation, and refinement of our analysis. The program of work for the Review is represented in the figure below and then explained briefly. Details of specific methods for each project are included in the associated Working Papers.

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[3] The methodology for the review of Aboriginal and Torres Strait Islander AOD treatment services is reported separately.

Figure 1.1: Approach to the Review

Meaningful communication, consultation, and collaboration throughout
- Extensive discussions with jurisdictional representatives
- Web-based dissemination of Working Papers and opportunity for comment
- Feedback loops on data obtained from Rapid Assessments
- Regular communiqués from the Department of Health
- Ongoing input from the Review Advisory Group and Critical Friends Group

Planning	**Purchasing**	**Case examples**
Working Paper # 9	*Working Paper # 10*	*In-depth illustration in key areas*

Pay 4 performance	**Hidden treatment**	**AOD spending**	**Treatment utilisation**
Working Paper # 5	*Working Paper # 6*	*Working Paper # 7*	*Working Paper # 8*

Need and demand for treatment	**Rural & regional planning**	**Financing Flows for AOD**	**NGOTGP & SMSDGF**
Working Paper # 1	*Working Paper # 2*	*Working Paper # 3*	*Working Paper # 4*

REPORT TO GOVERNMENT

Rapid Assessments

- Meetings planned in consultation with jurisdictional representatives
- Consultations involving 190 participants, from:
  - Commonwealth state and territory government departments
  - AOD peak body staff, boards, and sector reps
  - AOD consumer representatives
- Data validation from those involved
- Supported access to policy documents and service information
- Further liaison for additional information
- Support for case examples where relevant

Separate ethics applications were submitted for project elements that included primary data collection or the use of confidential data sets. In accordance with the National Statement on Ethical Conduct in Human Research (for example, National Health and Medical Research Council, 2007), ethical approval was obtained from the University of NSW Human Research Ethics Advisory (HREA) Panel for the Rapid Assessment Process (Approval No's: 9_13_028 and 9_13_025).

Rapid Assessment

The 'rapid assessment' methodology is a highly consultative and engaged approach to obtaining and analysing large amounts of data over a relatively brief period of time. It is "a way to investigate complicated situations in which issues are not yet well defined and where there is not sufficient time or other resources for long-term, traditional qualitative research" (http://www.rapidassessment.net).

Features of the rapid assessment approach include: speed, cost-effectiveness, practical relevance, strengthening local responses, multiple methods and data sources, inductive perspectives, and extensive use of data triangulation. Key strengths of this approach include the use of techniques for meaningful collaboration that involve a highly intensive and focused set of activities, leading to stakeholder informed outputs. As the WHO technical manual notes, "rapid assessment methods have the potential to generate information which can be used to both plan and develop health policies and programmes, as well as to delivery and improve services. The approach is typically used in situations where data are needed extremely quickly, where time or cost constraints rule out the use of other more conventional research techniques, and where organisations require current, relevant data to develop, implement, monitor or evaluate health programmes" (World Health Organization, 2003).

Before the consultation visits, a 'Rapid Assessment Kit' was prepared for each jurisdiction. The kit covered five areas:
- A draft version of the funding flows diagram (see Working Paper 3)
- A draft list of AOD services in the jurisdiction
- A summary of findings from national administrative data on treatment episodes
- Areas to be covered during consultations (explained below)
- A list of key policy documents relevant to the jurisdiction

Rapid assessment relies on the strength and analytic capacity of the team, and is best undertaken by experienced researchers with substantial content knowledge. Our team included senior researchers with many years' experience working in alcohol and drug policy and services research in Australia, and internationally.

One member of the Review team was each assigned to the Commonwealth and to states and territories. This team member subsequently liaised with stakeholders and undertook the rapid assessments. Team members spent an average of five days in each state / territory, consulting with state and territory health and other departments (e.g., finance) and Commonwealth state and territory offices, AOD peak body representatives, and other stakeholder groups (services, consumers). Consultations with Commonwealth participants involved a series of visits to Canberra with both individual and group meetings with representatives from various departments.

Preparation for the consultations involved:
- Identifying key contacts and approaching them to discuss the rapid assessment process and who should be involved

- Providing background information on the Review and forwarding the Rapid Assessment Kit for the jurisdiction
- Becoming familiar with the policy context for the jurisdiction, including major reforms that may be under way
- Organising a suitable time for the consultations to take place.

As noted above, the Rapid Assessment Kits included a list of questions and areas of inquiry. This involved five broad areas, on services and funding, service types, needs-based planning and gap analysis, funding arrangements, and other areas not covered. The list is shown in Table 1.1.

During the consultations, Review team members met with key informants and worked through the questions. In some cases, the consultations were recorded as back up however the primary means of data collection was note taking. During the consultations, participants provided (or pledged to obtain and forward) various policy documents, local reviews, and other planning and service documents which were relevant to the Review.

Notes from the consultations were then transcribed and sent back to participants for comment regarding their accuracy and comprehensiveness. Participants had the opportunity to speak with the Review team, use track changes in the document provided, or forward separate comments to improve the quality of the data. The final data set from the consultations was, therefore, validated by participants as an accurate account of discussions.

Table 1.1: Areas of inquiry for the Rapid Assessments

Services and funding
- List of all AOD services (organisations, programs, services, interventions)
- Current funding: who funds each service, for what, and funding amounts?
- Federal, State/territory, other funds: How are these allocated? How do they flow? Are they tied to specific uses?
- Other funding sources not already covered?

Service types
- Types of services funded (withdrawal, counselling, pharmacotherapy maintenance etc)
- Quantum of services funded (# beds, treatment spots etc)
- Maps/locations of services

Needs-based planning and gap analysis
- How is planning undertaken?
- What are the current funding priorities (What sort of clients? Treatment settings? Treatment types? Geographical locations? Treatment design priorities? Other?). How are the priorities identified: are they translated into funding decisions?
- Is the need for AOD treatment being met in your state/territory? Is AOD treatment meeting other needs?
- Are there sufficient services; is there an oversupply of particular service types, an under-supply of particular service types.
- What are the perceived service gaps?
- Could planning be improved? In what ways?
- What principles should be used to determine the treatment priorities?
- Who should the priority groups be?
- For state/territory services? State/territory funding of NGO[4]s? Commonwealth funding?

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[4] We use the generic term NGO in this report, however we are aware that a preferable term may be Not- For- Profits, given that NFP includes hospitals and government-run AOD treatment services.

Funding arrangements
- Procurement arrangements and tendering processes – how it works, timelines for tendering/procurement; current, proposed, under reform
- Contracting arrangements (how are services funded, what models are in existence; length of contracts); current, proposed, under reform.
- KPIs and monitoring of funding – requirements
- Types of funding: capital v. recurrent grants; targeted etc?
- Are there a number of funding (grant) schemes with different types of arrangements in place? What are the implications of these different arrangements? For you? For the NGO sector?
- Challenges associated with having multiple funding sources, eg Government, philanthropic, donor, Federal and State
- Impacts of funding processes: what works well, what doesn't work well. Issues and concerns.
- Thinking more generally about funding models and procurement arrangements, what are some of the advantages/disadvantages of the funding and procurement arrangements you currently have? Are there better models that could be used?

Other areas not covered

Components of the review

1. Service funding (Chapters 3, 4, 5)
This component of the Review involved obtaining a comprehensive understanding of the services that are currently funded by the Commonwealth, and the sources and types of funding. Early in the project a description of all AOD treatment funding flows was developed (see Chapter 3) in order to understand and contextualise the Commonwealth investment. A comprehensive analysis of the amount of AOD treatment funding in Australia was undertaken, using a methodology detailed in Chapter 4. The two specific Commonwealth schemes (the NGOTGP and SMSDGF) were analysed in detail (see Chapter 5).

2. Gap analysis: current service utilisation compared to projected demand (Chapters 7 and 8)
This component of the Review was concerned with identifying areas of unmet need. Thorough analysis of current service utilisation was undertaken: the types of treatment provided, how many and what types of people used treatment (the methodology is given in Chapter 7). Secondary analyses of treatment data were undertaken, involving the Alcohol and Other Drug Treatment Services-National Minimum Dataset (AODTS-NMDS), the National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD), the National Hospital Morbidity Database (NHMD), and Bettering the Evaluation and Care of Health data (BEACH). To examine unmet demand two methods were used. First, a pre-existing decision-support tool for systems planning (the Drug and Alcohol Service Planning Model for Australia (2013) [formerly DA-CCP]) was used to identify the extent of need for treatment in Australia. Our analyses included conducting sensitivity analysis of the DA-CCP model, and generating plausible estimates which could account for such things as polydrug use. The second approach involved the qualitative analysis of data from the rapid assessments to identify the extent of unmet demand, along with priority areas for attention; in terms of population sub-groups and service types.

3. Service planning analysis (Chapters 9 and 13)
This component of the Review involved collecting data about both current planning and future planning possibilities through the rapid assessments, plus comprehensive literature reviews. It also involved documenting the current jurisdictional planning processes, contractual arrangements and tendering timelines, along with reforms that may be planned or underway. The major data source

for this element was the literature and the rapid assessments and these data have been supported by the analysis of publically available policy documents. Service provision in rural and regional areas brings a particular set of challenges and considerations for systems planning. To ensure these issues were addressed, we commissioned a team from Monash University to undertake a specific review of the literature in this area.

4. Funding models review (Chapters 6 and 14)
This component of the Review involved an extensive literature review and analysis of funding models. Conceptual clarification of the components of funding: the mechanisms for choosing providers and mechanisms for payment were devised. Analysis of a broad literature was undertaken to derive strengths and challenges for each approach. Rapid assessment data included the key informant perspectives on funding mechanisms as well as describing how funding is distributed, the grants processes, timelines and contracting schedules, by jurisdiction.

5. Accountability analysis (Chapters 10 and 15)
This component of the Review entailed examination of the current contracting and performance management arrangements, review of the relevant literature and analysis of key informant perspectives on accountability: contract management, and performance monitoring.

6. Case examples (throughout and Part 3)
For the purposes of the Review, cases were chosen to illuminate aspects of the Review under investigation and provide detailed illustrative examples. The cases were not designed to be broadly representative, but rather were selected as single-case examples to add depth to analysis. Details of the approach used for the case examples are shown below.

7. Analysis, interpretation, conclusions (Chapters 12, 13, 14, 15 and 16)
This final component of the Review involved drawing the information together from across the analyses of service funding, current service utilisation, projected unmet demand for treatment, planning processes, funding arrangements, grant timelines, and case examples. An iterative process of analysis, critical review, and refinement has been used to arrive at the findings. Details of the consultation processes and governance arrangements supporting this approach are included below.

Consultation processes
Consultation and collaboration with the range of stakeholders to AOD treatment has been essential to the success of the project. While these terms are commonplace in policy, research and practice discourse, they are often misused. 'Consultation' may be tokenistic and 'one-off' with little opportunity for participants to learn about findings from their involvement or how they have been used. 'Collaboration' may rest on a power imbalance that similarly constrains the formation and implementation of research processes. Put simply, it is not enough to meet with stakeholders; true collaboration is a complex endeavour founded on voluntarily sharing organisational processes and resources to reach a common purpose (O'Flynn, 2008). It relies on a shared appreciation of the goal of an activity, a willingness to be involved, and a thoughtful approach to the demands of the activity, for example by providing information and advice, problem-solving difficulties and identifying potential solutions, and providing practical input to facilitate access to quality data.

Each state and territory has an AOD peak body and these organisations were enlisted to support the project. In effect, the peak bodies were 'partners' to the project. They received a one off payment to provide advice and practical support to the Review, with a particular focus on the rapid assessments. Examples include providing advice on jurisdictional concerns and events and arranging rapid assessment consultation sessions with board members and service providers.

We worked collaboratively with the Commonwealth Department of Health, and the Review Advisory Committee (described below) to enable the successful completion of data collection activities in a timely fashion. This involved both formal meetings and information liaison as the project unfolded. Jurisdictional representatives from Departments of Health provided invaluable support for the project.

An expert advisory committee was established by the Department to provide advice and guidance to the Review (see Appendix A for a list of members). The committee met three times during the project period; early, mid, and late. The initial meeting was an orientation to the Review and the various components involved. Subsequent meetings focused on interim findings regarding specific elements of the Review and problem-solving oriented discussions to 'workshop' the interpretation of findings.

The Review was also supported by a group of 'critical friends'; senior experts with extensive policy knowledge who were tasked to provide frank, blunt, and profound advice on the Review approach and on difficult areas as they arose (Appendix A includes a list of these members). The group met once during the project and they provided advice and feedback electronically and via telephone on an informal basis.

Participants in the rapid assessment consultations

We combined this collaborative approach to data collection with the careful consideration of stakeholders best placed to facilitate our access to information important for the Review along with professional experience to enable astute commentary on the issues under study. Their expertise informed the inclusion of representatives in areas critical to the Review and they provided advice on the tentative list of participants that had been formulated.

Participants in the rapid assessment consultations were from:
- The Commonwealth Department of Health and other Australian Government agencies
- State and territory government Departments of Health and other Departments
- AOD peak body staff and board members, and services nominated by the peaks
- AOD consumer groups.

The number of participants and consultations undertaken during the Rapid Assessments is shown in Table 1.2.

Table 1.2: Participants in the rapid assessment consultations

Background of participants	Number of participants
Commonwealth departments	30
Commonwealth state and territory offices	37
State and territory departments	52
Peak bodies, services, consumer representatives	71
Totals	190

It is important to note that the consultations were extensive. In some cases, multiple sessions were held with the same participants because of the scope of the areas being explored. In addition, many sessions involved groups of participants. The Review team spent about 53 working days in the field conducting the rapid assessment consultations. Follow-up contact, to obtain feedback on the consultation data and seek clarification or further information, was undertaken by email / telephone subsequent to the site visits.

Communication

In addition to formal data collection and governance aspects of the Review, there were two major strategies for sharing information and receiving feedback from the broader AOD constituency. The first involved the preparation and dissemination of a series of ten working papers, as shown in Figure 1.1, above. Each working paper focused on a particular aspect of research for the Review, for example on funding, current service utilisation, or pay for performance (a full list is provided in Table 1.3). Following feedback on draft papers from the Commonwealth the papers were updated and posted on the Drug Policy Modelling Program (DPMP) website, with an invitation for comment. In addition, a database of those with a particular interest in the Review (including participants in the rapid assessments and others who requested involvement) was used for personal notification regarding the Working Papers. Postings were made on major AOD listservers as each paper became available. Following feedback on the papers, addenda were prepared and added to the website. The second strategy for sharing information involved regular communiqués from the Commonwealth Department of Health, which were also made available on the DPMP website.

Table 1.3: Titles and outlines of the Review Working Papers

Working Paper # 1 Estimating need and demand for treatment – highlighting the importance of understanding need and demand for treatment in systems planning, along with the complexity of this area and the challenges involved. Related work that is underway and which can inform the approach to analysing met and unmet need and demand.

Working Paper # 2 Planning in rural and regional areas – exploring issues relevant to the availability and geographical accessibility of AOD treatment services in rural and regional Australia, along with evidence of frameworks for planning in these areas, and a review of what is known about the use of service delivery models to address known spatial barriers to access.

Working Paper # 3 Financing of AOD treatment in Australia – identifying types of service providers and service settings, sources of funding, and funding flows.

Working Paper # 4 NGOTGP and SMSDGF – a descriptive overview of the two Commonwealth funding schemes, on objectives, priority areas, decision-making processes and funds distribution, monitoring and accountability, and current funding.

Working Paper # 5 Pay-for-performance – a literature review on this approach to purchasing, including a summary of findings on the design and impacts of pay-for-performance schemes used in health.

Working Paper # 6 'Hard to count' or unrecorded treatment utilisation for alcohol and drugs – a documentation of AOD treatment provision that would remain unaccounted for in any official estimate of treatment utilisation, which relies on official statistics.

Working Paper # 7 AOD spending in Australia – providing an estimate of the total spending on AOD treatment and the respective contribution of different funders.

Working Paper # 8 AOD treatment utilisation in Australia – an estimate of the amount of treatment and number of people in AOD treatment.

Working Paper # 9 Planning for AOD treatment – a description of planning processes, including strategic and technical planning, 'joined up' planning, and the issue of localism. Key informant perspectives on planning activities and directions are incorporated with findings from the literature.

Working Paper # 10 Purchasing models for AOD treatment – the consideration of various approaches to purchasing and how they may be applied in Australia.

The Working Papers are referenced throughout this report, and are provided as attachments to the main report.

Literature sourcing

A literature search was undertaken to locate peer-reviewed research articles and key grey literature documents relating to planning, funding and contracting of the alcohol and drug treatment field (October 2013). Three main groups of search terms were used:

- Alcohol and drug disorder related terms
- Treatment-related terms
- Terms relating to funding, grants, contracting and economics.[5]

Searches were made of both title and abstracts and also by identifying relevant database indexing terms in six broad-based databases and citation indexes: PubMed, EconLit, Scopus, PsychINFO, Australian Public Affairs Information Service (APAIS), and University of NSW library search platform, which searches across multiple academic databases. Searches were also made of three databases which concentrate on collating reviews of health and social services sector evidence: the Cochrane Library, the Campbell Collaboration, and Health Systems Evidence. In addition searches were made using relevant index terms in four drug and alcohol specific databases: The National Drug and Alcohol Research Centre Library (Australia), Project Cork Online database, the National Drugs Sector Information Service (NDSIS) Drug Database, Virginia Commonwealth open source alcohol and drug database.

More than 2,500 potentially relevant articles were identified initially. The abstracts of these articles were printed and reviewed by two reviewers. Following this process, and removing duplicates, 224 articles were identified as relevant initially.

Additional articles were later located by 'snowball' searching of reference lists, and use of the "related articles" feature in Google Scholar and "related citations feature" in PubMed and tracking of citations using citation matching features or visual examination of article reference lists. Several additional searches were undertaken during the course of the project for information on specific topic areas that emerged as particularly relevant for the report. These searches used both academic databases and internet resources, and included searches for both peer-reviewed research using the academic databases above, UNSW library search, and Google Scholar, and also grey literature articles such as reports, briefings and presentations using Google. These searches were not confined to the alcohol and drug and health literatures, but sourced relevant information from such topic areas as: public sector funding, contracting, and governance, business and economics, public policy, social services, and employment services.

Case examples

Case studies are an established social science method that provides an in-depth investigation of complex social phenomena (Yin, 2009). They are useful for describing and understanding 'how' or 'why' something works in a contemporary context (Yin, 2009). For the purposes of the Review, nine cases were chosen to illuminate aspects of the Review under investigation and provide detailed illustrative examples. We have chosen to call these studies 'case examples' as they do not involve a large-scale data collection approach and, for some case examples, the principal source of data was publically available information.

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[5] Some examples of the types of search terms used under each topic include 1. Alcohol and other drugs topic — 'alcohol and other drug', OR 'drug and alcohol', OR 'substance misuse', OR 'substance abuse', OR 'drug depend*', OR "addict*' OR 'cannab*' OR 'heroin' etc. 2. Treatment — search terms included 'treatment', OR 'service', OR 'program', OR 'rehab*', OR 'detox*', OR 'pharmaco*', OR 'methadone' OR 'opioid' etc 3. Finance/funding/contracting — search terms included 'purchas*' OR 'fee' OR 'pay*' OR 'finan*' OR 'resourc*' OR 'incentiv*' OR 'grant' OR 'procur*' Or 'purchas*' OR 'reimburs*' OR 'econ*'etc. The * respresents a wild card character which will locate any combination of letters in a word following the relevant stem, for example 'finan*' would locating 'finance', 'financial', 'financing' etc.

The Review case examples focus on planning mechanisms, funding mechanisms, sector capacity building and supporting treatment functions, and the experiences of non-government organisations (NGOs) in relation to government funding, multiple funders, reporting issues, logistics of seeking funding, timelines for tendering and so on. Table 1.4 provides a list of the case examples. The cases were not designed to be broadly representative, but rather have been selected as single-case examples to add depth to analysis.

Table 1.4: Case examples

Case	Illustrative example
Department of Veterans' Affairs	Funding mechanisms - preferred providers
Drug user organisations	The role of drug user organisations in supporting treatment
Partners in Recovery	Funding mechanisms - competitive grants
WA AOD sector reform	Partnership approaches
Victorian AOD sector reform	Funding mechanisms - activity-based funding
Medicare Locals	Planning and needs assessment
NGO Organisation A	Experiences of a non-government organisation in relation to government funding
NGO Organisation B	Experiences of a non-government organisation in relation to government funding
AOD state/territory peak bodies	The role of AOD state/territory peak bodies in sector capacity building

To document and analyse the case examples, multiple methods of data collection were utilised including documentary sources, semi-structured interviews and focus group interviews. Relevant documents (including reports, research papers, policies, position papers, annual reports, tender documents etc.) were collated from online public sources with a view to gaining knowledge about the case under examination. Documents discussed by participants in interviews were also requested.

For six of the nine case examples completed for the Review, semi-structured interviews or focus group interviews were conducted with key personnel associated with the case example under examination. An interview guide was developed and adapted for each of the cases. Although the interview guide directed conversation towards key topic areas, a flexible approach to interviewing was taken whereby probing and follow-up questions were used to yield rich data and uncover new insights (Minichiello, Aroni, & Hays, 2008). In this way, the interview guide was used as a framework to elicit information about key topic areas from participants, but the researchers also played an active role in building conversation about a particular issue, responsively changing the wording or ordering of questions, and allowing for the emergence of individual perspectives (Patton, 1990). Individuals or organisations were approached and invited to participate. The participants approached were identified as having relevant experience and expertise, who could speak knowledgeably about the subject matter under investigation. No inducements were offered and participation was entirely voluntary. Interviews were conducted via telephone or in person (where possible) by members of the research team. Each semi-structured interview was approximately 1 hour in duration, and focus group interviews ranged in length from 1 hour to 3 hours. Interviews were digitally audio-recorded for accuracy.

Each case example was then written up incorporating both descriptive and thematic analysis. A written draft of each case study was provided to participants for their review, reflections, amendment, and to generate further consultation.

Two case examples relating to the experiences of NGOs in receipt of Commonwealth funding have been anonymised, with the names of the two organisations remaining confidential throughout this report.

Analysis, reflection, resolution

The project team includes senior researchers with expertise in clinical psychology, health policy, and services systems research and economics, who have been supported by researchers with skills in large-scale survey work, epidemiological analysis, literature reviews, and qualitative research. The team approach has been critical to fully understanding the significance of findings from individual project elements. Our approach included allocating discrete tasks (e.g., jurisdictional rapid assessments, estimates of current service utilisation) to team members according to their expertise. Preliminary findings were subject to internal review and subsequently refined. To synthesise findings from individual elements, we held a number of team workshops where individual members led the discussion around particular issues, to arrive at conclusions regarding the nature and strength of findings. This included formulating and critiquing solutions, to identify advantages and shortcomings. A progressive iteration of options was developed and rejected / adjusted. The final meeting of the Review Advisory Committee focused on findings and their translation into options.

Given that each aspect of the Review is intertwined, it has been essential to critically reflect on the significance of findings in combination to address major questions for the Review. As a team, we considered options raised by the literature, key informants or case examples and examined the relative advantages and disadvantages for all options. Combining options led to additional insights regarding context-oriented issues and benefits.

Finally, it is important to note that the Review team maintained an independent stance in the analysis and interpretation of data for the project. We listened carefully to the perspectives put forward by stakeholders to the project and used this information during critical reflection on the accuracy of the work. However, the ultimate determination of project findings resides with the team.

Other significant Commonwealth projects

Aside from commissioning this Review, the Commonwealth has three other significant projects, all concerned with better health outcomes for the AOD treatment investment.

The *Quality Framework for Australian Government funded drug and alcohol treatment services*, being conducted by Turning Point Alcohol and Drug Centre aims to complement work completed or currently underway by governments within the drug and alcohol treatment services sector to better understand and improve service quality and inform future planning needs. The project aims to develop a quality framework for alcohol or other drugs (AOD) treatment services that:
- complements other models/frameworks that services currently comply with;
- is adaptable, flexible and suitable for a range of service types and settings, including Indigenous-specific services;
- considers clients with comorbidity and the need to build and/or maintain capacity of services to appropriately manage these clients;
- considers all funding sources for services including client/patient contributions;
- clearly describes the expected quality standards for each service type;
- has clear guidelines, policies and procedures to support the achievement and maintenance of these quality standards;
- allows incorporation of accreditation models that services currently have in place or may

> have in place in the future; and,
- considers related aspects such as accreditation and minimum qualifications. (http://www.turningpoint.org.au/Research/Clinical-Research/CR-Projects/The-AOD-Quality-Framework-Project.aspx. Accessed 22.04.2014)

The *Patient Pathways* project at Turning Point Alcohol and Drug Centre describes patient journeys through alcohol and other drug treatment, hospital admissions, emergency department contacts, and contacts with the broader social services and legal sector; and describes interventions and linkages between specialist alcohol and other drug systems and primary/community care.

The *National Drug and Alcohol Mapping Project* being undertaken by Monash University, aims to map drug and alcohol services throughout Australia in accordance with geographical location, referral pathways and treatment services offered. This work will result in a webpage and a smartphone application aimed particularly at consumers, carers and clinicians, to facilitate better understanding of and access to AOD treatment.

Principles

Any review of funding processes needs to be guided by a set of principles, which can then be reflected on in the analysis. We have considered the research literature (for example Barbazza & Tello, 2014; Duckett & Willcox, 2011) and national health documents (for example, Council Of Australian Governments, 2008b, 2011a, 2011b; Steering Committee for the Review of Government Service Provision, 2014) alongside the requirements of the Review to arrive at an appropriate set of principles for this purpose.

Effectiveness, efficiency, and equity
The three overarching principles we use in this work are effectiveness, efficiency and equity. The Commonwealth operates within a legislative and policy framework which requires efficient, effective, economical and ethical use of Commonwealth resources that is not inconsistent with Commonwealth policies.[6] As the reader may appreciate, the principles are commonly used terms that can have different meanings. For the purposes of the Review, we define effectiveness, efficiency and equity as follows:

> **Effectiveness** is the principle that the Commonwealth achieves what it intended to achieve with AOD treatment funding; that the stated objectives are met. Those objectives may range from the general goal of improving the health of the community, to more specific goals associated with particular funding rounds (Productivity Commission, 2013). Regardless, this principle highlights the importance of establishing well-articulated objectives.

> **Efficiency** is concerned with how wisely Commonwealth funding is used in securing the goals of AOD treatment funding. A distinction can be made between allocative efficiency and technical efficiency. Allocative efficiency is a complex principle. It relates to a number of questions ranging from whether the right forms of treatment are being provided to whether the appropriate level of Commonwealth resources is being dedicated to AOD treatment in comparison with other uses of Commonwealth resources. In the context of this review it is perhaps more pertinent for the Commonwealth to frame the principle in terms of each of its funds; the principle being that the mix of forms of treatment purchased through the fund produces the maximum benefit in terms of treatment outcomes for that level of investment. Technical efficiency, on the other hand, describes the principle of minimising the cost of

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[6] See section 44 and Regulation 9 of the Financial Management and Accountability Act 1997.

producing the chosen outputs, regardless of the value of those outputs in relation to achieving outcomes (Smith & Papanicolas, 2012).

Equity is to do with the fundamental right of opportunity for all individuals; the right of every individual to have a fair chance to live a full and healthy life (Whitehead, 1992). In relation to AOD treatment this principle can be expressed as equal or fair delivery of treatment services and equal or fair treatment outcomes. Equality should be considered between individuals as well as between sub-groups of the population defined, for example, in relation to socio-demographic characteristics like gender and ethnicity; as well as characteristics related to the capacity to access and benefit from treatment. This principle is usefully split into two parts. Substantive equity is concerned with treatment outcomes. Procedural equity is concerned with access to treatment services and use of treatment services (Begley, Lairson, Morgan, & Rowan, 2013). In health care, procedural equity tends to be judged in relation to whether people with the same level of clinical need receive the same level of health care (Smith & Papanicolas, 2012). For equity of access, the adequacy of 'the system' is critical and requires a level of acceptability "from the perspectives of patients, communities and providers" (Duckett & Willcox, 2011 p.7) and responsiveness to "the population's legitimate expectations of non-health aspects of health care provision" comprising "dignity, prompt attention, autonomy, choice of health care provider, clear communication, confidentiality, quality of basic amenities, and access to social support networks" (Valentine, de Silva, Kawabata, Darby, Murray, & Evans, 2003).

Principles of grants administration
The Commonwealth Grant Guidelines[7] (Department of Finance and Deregulation, 2013) establish the policy framework for grants administration. This document sets out seven key principles of good practice for grants administration. Government departments have scope to determine the most appropriate way to implement these key principles for each of their granting activities (Lewis, Grimes, & West, 2013).

'Grants administration' includes the entire process of making of a grant, i.e. planning and design, selection and decision-making, making a grant, managing grant agreements, the ongoing relationship with grant recipients, reporting, and review and evaluation (Department of Finance and Deregulation, 2013 para 2.6).

The seven principles are:

    i)   Robust planning and design
Agency staff should work together with stakeholders to plan, design and undertake granting activities. Agency staff should have regard to all relevant planning issues; including identifying and engaging with risk. Agencies should ensure that the entity best placed to manage a specific risk is identified, the risks are assigned to that entity, and that they manage those risks.

    ii)   Collaboration and partnership
Without detriment to the other principles, agencies should develop and maintain constructive and cooperative relationships with grant recipients and other stakeholders (including other government entities and grant beneficiaries).

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[7] The Commonwealth Grant Guidelines (CGGs) are a legislative instrument issued by the Finance Minister under section 64 of the FMA Act and FMA Regulation 7A. Regulation 7A requires staff members to act in accordance with the CGGs when performing duties in relation to grants administration.

iii)   Proportionality

Agencies should design a granting activity so that it is commensurate with the scale, nature, complexity and risks involved in that activity. The grant processes should appropriately reflect the capabilities of grant recipients and accommodate the Commonwealth's need for robust and accountable processes, consistent with the risks involved.

iv)   An outcomes orientation

Agencies should focus on achieving government policy outcomes. Granting activities should be designed and implemented so that grant recipients focus on outcomes and outputs for beneficiaries while seeking the most efficient and effective use of inputs.

v)   Achieving value with public money

Agencies should undertake a careful comparison of the costs, benefits, options and risks associated with a granting activity to ensure that value is achieved. The achievement of value with public money involves "efficient, effective, economical and ethical use that is not inconsistent with Commonwealth policies"

vi)   Governance and accountability

Agencies should develop all policies, procedures and guidelines necessary for sound grant administration, including:
- defining the role of each party in the granting activity (including the minister, agency officials, the grant recipient and other stakeholders) to achieve the desired policy intent
- ensuring that any grants governance framework is underpinned by the mandatory requirements in Part 1 of the CGGs
- conducting all grant selection processes in a defensible manner
- negotiating grant agreements that clearly document the expectations of both parties in the delivery of the granting activity and enable the agency and recipient to be accountable for the grant funds
- maintaining accurate records on grant-giving activities, including recording decisions made by approvers under FMA reg 9
- supporting grant-giving activities with appropriate financial and performance monitoring frameworks. Agency staff involved in developing and/or managing granting activities should have the necessary grants management, stakeholder liaison and financial management skills.

vii)   Probity and transparency

This involves complying with public sector values of honesty, integrity, impartiality and accountability. The CGGs provide that probity and transparency are achieved by ensuring:
- that decisions are impartial, appropriately documented, publicly defensible and lawful
- compliance with the public reporting requirements as per Part 1 of the CGGs
- that agency grants administration incorporates appropriate safeguards against fraud, unlawful activities and other inappropriate conduct on the part of agency staff and grant recipients.

The three earlier principles align well with the grant administration guidelines. *Effectiveness* is addressed in collaboration and partnerships, value for public money, proportionality, outcomes orientation and governance/accountability. *Equity* is addressed in proportionality, outcome orientation, governance/accountability and probity. *Efficiency* is addressed in value for public money, probity and transparency.

We use the three principles (effectiveness, equity and efficiency) as overarching and the seven grant administration principles for specificity, and in the Part 2 chapters examine the alignment of our analysis with these principles.

Our values

Research is not value neutral. Each of us brings a particular set of knowledge and experience to our research work that shapes the approach taken and the interpretation of findings. In the interests of transparency, we have summarised the values held by the project team. This is an important way to raise our awareness of possible bias and to be clear regarding the context impacting the research endeavour.

The values that underpin our approach to the Review are concerned with the conduct of research and with the focus and nature of AOD treatment. In relation to our values for research, we believe that:
1. Projects should be designed according to international standards on ethical behaviour in research
2. Consultation is essential, to guide the research process, facilitate access to needed information, and enhance the usefulness of project deliverables
3. Research should make a positive difference, in terms of adding to knowledge and providing guidance regarding practical implications
4. Those most involved in the research subject (service providers, purchasers, clients, and would be clients) have wisdom and experience that is important, valued and should be heard
5. We should be willing to consider all ideas, and hold a reflective stance, questioning our own assumptions throughout the analysis
6. We should do the best job possible given the resources
7. The process of research should be beneficial to the stakeholders (irrespective of, and independently from, the outputs or outcomes)
8. There is value in multiple types of evidence
9. Analysis is the responsibility of researchers, having taken multiple evidences and perspectives into consideration
10. Recommendations should be pragmatic and achievable, taking account of the context in which they will be implemented.

It is our belief that research into AOD treatment should have improved health outcomes as its primary end goal - that is, health outcomes are the paramount consideration, ahead of outcomes affecting the NGO sector, agencies, structures, or professional groupings.

In relation to alcohol and other drug treatment, we believe that:
1. Treatment should be available to all people, according to their needs
2. Consumer choice is paramount (people should be free choose whether or not to be in treatment)
3. Treatment should be evidence-based and tailored to individual need, drawing on research knowledge and practice wisdom
4. Equity of access to treatment is critical. There should be equity of access to treatment for people and population subgroups with comparable needs and wants
5. Health outcomes as well as social outcomes should be considered together as the two are intertwined
6. Equity of outcomes is important. This perspective acknowledges that people have different capacities to achieve the health and social outcomes that they might value; relating to their psychological, physical and social environment. It is the responsibility of AOD funders,

      purchasers and providers to cater for those capacities. Resources should be provided in such a way that differences are taken into account in treatment funding and delivery, to reduce disparities in health and social outcomes between individuals and subgroups

7. Treatment is not standalone, but should be provided in the context of broader social services
8. Treatment is one response to AOD problems and we see it as part of a broad harm minimisation approach inclusive of harm reduction, prevention and supply reduction.

Being client-centred

The focus of the Review is on the planning, purchasing and contracting of AOD treatment services. As such, much of the focus is on institutions and processes, organisations and government. But we want to press home the point that all planning, purchasing and contracting is a means to an end – and that end is the reduction in the harms associated with alcohol and other drug use, improved physical, psychological and social well-being for people experiencing problems with alcohol and other drugs and their family and friends. The AOD treatment service system is about the clients – what they might need at any one point in time and how that need can be met. Our goal is to review the ways in which the Commonwealth plans, purchases and contracts AOD treatment services and related functions. The success of the Review will be judged by the ways in which the analysis of options and subsequent implementation improves the health outcomes of people with alcohol and other drug problems.

Outline of structure to report

We present this report in three parts. Part 1 covers the current situation; Part 2 presents our analysis of options; Part 3 provides the case examples.

Part 1 covers the current landscape. All data that are subsequently used in Part 2 are reported herein. The chapters cover the current context, funding flows, amount of funding, funding mechanisms, current service utilisation, projected demand for services, planning and contract management. Chapter 11 is a summary chapter for Part 1.

Part 2 presents our analysis of options. These chapters are deliberately more brief as they rely on the reader having read Part 1 or being very familiar with the data underpinning the AOD service system in Australia. Part 2 commences with analysis of the appropriate role and responsibilities for the Commonwealth, then moves to planning processes, purchasing mechanisms and accountability arrangements. Consistent with our brief, we have not provided recommendations, but rather analysis of options.

Part 3 provides each of the nine case examples. While these are used in text boxes throughout Parts 1 and 2 as illustrative examples of particular points, each case is presented fully in Part 3.

PART 1: THE CURRENT LANDSCAPE

Chapter 2: Context

This chapter considers some important contextual points for the Review:
- The history of AOD treatment funding in Australia
- AOD treatment value-for-money and the importance of funding processes
- Public sector management
- Federalism and the structure of Australian healthcare

History of AOD treatment funding

There are few documented histories of alcohol and other drug treatment in Australia (Rankin, 2003; Room, 1988). This brief summary has been prepared with input from a number of experts and with reference to the two papers but is an unofficial and un-validated account. 'Alcoholism' treatment as we know it today (which was preceded by Inebriates Acts and institutional solutions between 1870 and 1950) appeared bifurcated. In the non-government sector, the "Foundations" (such as the now Australian Drug Foundation) were established in the 1950s and saw the beginning of counselling and support services (along with community education and research functions). For example, in the 1970's the Victorian Foundation on Alcoholism and Drug Dependence (now the Australian Drug Foundation) ran a counselling and referral service in partnership with the Church of England. At the same time, government hospital services provided 'alcoholism clinics'. In many states, alcohol and other drug treatment was largely provided as part of government-funded psychiatric services. AOD treatment was under the auspices of the Chief Psychiatrist and there were government-run inpatient centres in most jurisdictions. Residential treatment was the norm. Charitable organisations, such as the Sisters of Charity also played an essential role in providing services, as did specialist not-for-profit AOD organisations. For example, Odyssey House Victoria was established in Melbourne in 1979, as a therapeutic community for long-term residential care of people with alcohol and drug problems. (It continues today). Thus both government and non-government AOD treatment services have comprised the treatment service system in Australia since the 1950's. Room (1988) noted that "the main mushrooming of the treatment and service network for alcohol and drug problems occurred in the mid-1970's" (p. 429). With the advent of the National Campaign Against Drug Abuse (NCADA) in 1985, cost-shared funding between federal and state/territory governments for AOD treatment resulted in growth in AOD treatment (although Room, 1988 notes this as "modest").

Each state/territory jurisdiction in Australia had its own unique blend of AOD treatment services, largely dependent on state government policies regarding government versus non-government treatment funding, the extent of philanthropy and charitable institutions in operation, and the degree to which general medicine embraced alcohol and other drug problems. State/territory AOD treatment planning for and funding approaches were driven by the prevailing ethos of health planning. In the main, historical funding was the basis for ongoing funding decisions.

In the early to mid 1990's, health reform in various states led governments to consider 'purchaser-provider' distinctions, increasing the reliance on services purchased from non-government providers. Victoria was arguably the state that took this the furthest, and by mid 1990, all government-run AOD services had closed and services were provided (through tendering processes) by an array of NGO providers. In contrast, NSW has retained a central focus on government hospital/medical services as primary providers of AOD treatment with the non-government sector playing a vital but less substantial role than in states like Victoria. Around the same time (mid 1990's) research evidence was demonstrating that residential or inpatient care was less cost-effective than outpatient care, and that the same treatment outcomes could be achieved at less cost. Additionally, the move towards early intervention, engagement with primary care providers (GPs) and prevention

began to be a clear focus. In this context, GPs became important providers; funded by the Commonwealth through Medicare.

It is difficult to accurately ascertain the history of Commonwealth funding for AOD treatment, but it appears that it goes back to 1995 when the Commonwealth allocated $36 million per annum to reduce drug related problems through the then National Drug Strategy (at that time called NCADA). Of the then NDS budget, half was allocated through cost shared programs to states and territories for programs and services in the broad areas of drug education, treatment and rehabilitation. State governments were required to match the amount of support given to them, and provide additional funding as they deemed necessary. The Non Government Organisation Treatment Grants Program (NGOTGP) commenced in November 1997. Launched as part of Howard's Tough on Drugs initiative, this program "aimed to fund the establishment, expansion, upgrading and operation of non-government alcohol and other drug treatment services".

Another of the Tough on Drugs initiatives was the Commonwealth funded Community Partnerships Initiative which promoted and supported the establishment of community driven drug prevention and early intervention initiatives. In addition, the Howard government also made a substantial investment in diversion – funding for treatment services to provide interventions to those referred from the criminal justice system (November, 1999, $110 million).

Between 1999 and today, the Commonwealth government has continued to support AOD treatment through funding associated with the Illicit Drug Diversion Initiative (IDDI), and two primary grant schemes: the Non Government Organisation Treatment Grants Program (NGOTGP) and the Substance Misuse Service Delivery Grants Fund (SMSDGF). These two grants schemes are the specific focus for this Review. In Chapter 5 we provide the details of the two grant schemes as at the 2012 funding round.

AOD treatment – a worthwhile investment

AOD treatment is well-grounded in evidence. Of the three 'pillars' of drug policy – supply reduction, harm reduction and demand reduction – the most extensively researched and evidence-based is demand reduction. In particular, the treatment component of demand reduction has been subject to extensive research across the globe. The efficacy and the effectiveness of alcohol and other drug treatment has been well established. For example, for every $1.00 invested in alcohol or drug treatment, society gains $7.00 (Ettner, Huang, Evans, Ash, Hardy, Jourabchi, & Hser, 2006). AOD treatment has been shown to:

- Reduce consumption of alcohol and other drugs
- Improve health status
- Reduce criminal behaviour
- Improve psychological wellbeing
- Improve participation in community.

The savings which accrue to governments from AOD treatment largely accrue through direct savings in future health care costs, productivity gains and savings in the criminal justice system. Any investment in AOD treatment is worthwhile and represents value for money: treatment works and is cost saving.

Does the way in which treatment is funded actually matter? Yes. Research has shown that funding processes can influence:

1. The way in which drug dependence is understood (and problematised)
2. The types of services offered (eg outpatient vs inpatient, pharmacotherapy)
3. Treatment processes, eg retention in treatment
4. Quantity and quality of treatment

5. Treatment outcomes.

Research evidence has shown a relationship between funding processes (including the source of the funds and the way they are distributed) and AOD treatment outcomes. For example Ghose (2008) examined external organisational environment, program level factors and individual level factors in predicting relapse in clients. The funding source (in this case managed care) was the strongest correlate of post-treatment drug use, stronger in fact than well-established individual level factors such as client time in treatment and treatment completion. In another example from the USA, having a higher proportion of funding from government sources (Medicaid or Medicare) was associated with improved rates of reduction in drug use and abstinence (Heinrich & Fournier, 2005). This suggests a powerful effect of funding source. Changing funding sources, in this case between two types of managed care arrangement, appeared to have a large effect on service use and the mix of services offered at a treatment system level (Stein, Reardon, & Sturm, 1999).

Another way in which the system of funding matters is in relation to service types. There is evidence that the way in which funds are allocated/distributed makes a difference to the kinds of services that AOD treatment agencies offer. For example, Knudsen & Roman (2012) found that agencies which received a higher proportion of Medicaid funding were more likely to have introduced an opioid pharmacotherapy program after controlling for organisational in workforce factors (Knudsen & Roman, 2012). In contrast services receiving a higher proportion of funding from criminal justice sources were less likely to have introduced a pharmacotherapy program (Knudsen & Roman, 2012). In another example, the uptake of naltrexone to treat alcohol problems was more likely in agencies which were funded by managed care (Fuller, Rieckmann, McCarty, Smith, & Levine, 2005).

Funding systems can also influence services for specific populations. For example, Soman, Brindis, & Dunn-Malhotra (1996) concluded that barriers to optimal delivery of services to women and children resided in the historical funding sources (which focussed on individual clients), and having multiple funding streams (which were not readily integrated across multi-disciplinary teams required for women and children).

These examples attest to the importance of the way in which AOD treatment services are funded. This is why this Review is important. We know that AOD treatment is a good investment and represents value for money. The way in which the Commonwealth government plans its investment, purchases services and monitors service delivery can be highly influential in determining the extent of health outcomes. And as noted in Chapter 1, the end goal is health outcomes. The purpose of funding and the ways in which services are planned and purchased are for the achievement of better health outcomes, not an end in themselves.

Public sector management

The provision of AOD treatment is a citizen entitlement. Governments' responsibilities to ensure the provision of AOD treatment that is effective, efficient and equitable is discharged through either the direct provision of care (government services) or through purchasing those services from non-government providers. The ways in which public sector management has evolved over time reflects the shifts between these two mechanisms for ensuring citizens entitlements are met and public value maintained.

'New public management' (NPM) is the term used to describe a significant philosophical shift in Anglo-American democracies from bureaucratic government towards one based on "managerial techniques and practices common in the private sector" (Wilson, 2004, p. 49) associated with the public-management reforms of the late 1980s and early 1990s. With those reforms, the new government procurement regimes emphasised "improving the quality of service, reducing or

covering costs, offering flexible channels and introducing contestability, competition and contracts for service provision, performance reporting and accountability for results" (Lindquist, 2008, p. 151).

NPM has been applied to public institutions under the assumption that services will become more efficient if subject to challenges faced by the private sector (Willis, Young, & Stanton, 2005). In simple terms, a market-oriented approach has been seen as the vehicle for achieving increased benefit from expenditure and clarity regarding exactly what is being delivered, and to what effect. In this context, community services have become just another bidder for service; competing with private organisations and with one another. Government came to treat not-for-profit organisations (NFPs) similarly to for-profit organisations and NFPs found themselves in competition with each other and with for-profit organisations for government funding. In Australia, the "Job Network stands out as perhaps the most potent and most recognised indicator of the Howard government's commitment to new public management (NPM)" (Ramia & Carney, 2010, p. 263).

Substantial concerns have been identified regarding the application of NPM techniques to complex social phenomena (O'Flynn, 2009; Osborne, Radnor, & Nasi, 2012). The not for profit experience of NPM oriented reforms have seen NFP being pushed towards a business oriented way of operating and towards a contract culture, as governments adopt competitive tendering and contracting regimes (Rainnie, 2012). There have been changes in the identity and fabric of some organisations as well as service amalgamations, closures, and changes in working relationships and agency networks (Lindquist, 2008). The independence and advocacy role of NFPs has sometimes been compromised, effectively silencing an important voice in discussions informing policy development.

Along with the shift to NPM has emerged strong interest in the concept of social capital and the importance of strengthening communities, lending weight to the notion that working with community organisations is "about more than service delivery and performance" (Lindquist, 2008, p. 151). This reflects a democratically oriented understanding of the consumer as citizen (Denhardt, 2007; Shergold, 2008), with associated implications regarding the knowledge, skills and other capacities that stakeholders (whether consumers, providers or others) may contribute to service quality and access. This perspective holds that community organisations have specialist knowledge and resources, as well as a unique place within and as part of community (Putnam, 2000). It also holds that the dual accountability of community organisations, which are accountable not only to government but to their community stakeholders, is a positive influence on the organisations commitment to and nature of service delivery. As expressed by Lindquist (2008, p. 151):

> A bottom-up perspective led to the conclusion that non-profits worked 'in' and were often 'of' communities, that successful delivery of services often relied on building trust and understanding local developments and that non-profits, through direct contact and engagement with citizens and communities, had a role and capability as street-level delivery agents to observe on-the-ground results, issues and opportunities, and that they had a responsibility to convey them to governments and other funding organisations, which often meant challenging existing policies.

This orientation has major implications for the processes governments use to plan and purchase services. For some years now, calls for a 'new public service' have emphasised the role of government administrators in engaging with the community, to build a "collective, shared notion of the public interest" (Denhardt, 2007). Improved communication has been identified as a critical way to help prepare public managers to contribute to this process (Candler, 2010). There is considerable interest in improving ways of working together, to engage in strategies that improve services and thus provide benefits for governments, organisations, and, ultimately, broader society. These improvements arise from participant learning through opportunities to encounter alternative ways

of operating, cultural change in and across organisations that foster new and better ways to provide services, and the creation and management of knowledge and innovation (Shergold, 2008). There is considerable capacity for the co-creation of public value through collaborative approaches (Shergold, 2008). Rather than leaving the market to shape public interventions, public policy is developed and delivered through a relationship-based model of participatory governance, where "the exercise of power is becoming more diffuse and opaque" (Shergold, 2008, p. 19).

Key to the Review is an understanding of how these engagement processes may look and who should be involved. Most obvious is the need for both levels of government to work together, to make the best use of public monies in a coordinated manner. In addition, services offer a unique perspective on models of care and service delivery based on their knowledge of local conditions and their treatment expertise. By working cooperatively and collaboratively, there is increased scope to identify and implement meaningful change for AOD treatment sector development and support for sector sustainability. As will be seen throughout this report, communication, co-operation and collaboration emerge as key across planning, purchasing and accountability measures. This is the responsibility of not just the Commonwealth government but also state/territory governments, service providers and other stakeholders to the Australian AOD treatment system.

The cooperation and collaboration between the two AOD treatment funders: the Commonwealth government and state/territory governments is underpinned by federalism, to which we turn to next.

Federalism and the structure of health care in Australia

According to the Australian Institute of Health and Welfare (Australian Institute of Health and Welfare, 2012, p. 16) (AIHW) (2012, page 16)

> The Australian health system comprises a set of public and private service providers in multiple settings, supported by a variety of legislative, regulatory and funding arrangements, with responsibilities distributed across the three levels of government, non-government organisations and individuals. This web of public and private providers, settings, participants and supporting mechanisms is nothing short of complex. Those who provide health services include medical practitioners, nurses, allied and other health professionals, hospitals, clinics, and government and non-government agencies. Funding is provided by all levels of government, health insurers, non-government charitable organisations and individual Australians.

Central to an understanding of the split between Commonwealth and State/Territory financing is the Commonwealth's financial relationships with the states-territories in relation to healthcare services. The Council of Australian Governments (COAG) agreed to the InterGovernmental Agreement on Federal Financial Relations - IGAFFR (Council of Australian Governments, 2008a) in November 2008, establishing a new framework for financial relationships between the Commonwealth and State/Territory governments. According to COAG:

> Rather than seeking to control how States deliver outcomes, the IGAFFR aims to improve the quality and effectiveness of government services by reducing Commonwealth prescription, aligning payments with the achievement of outcomes and/or outputs and giving States the flexibility to determine how to achieve those outcomes efficiently and effectively (http://www.coag.gov.au/the_federal_financial_relations_framework).

Under this new framework the Commonwealth agreed to provide the states/territories with:

- general revenue assistance (including GST payments), to be used by the States for any purpose;
- National Specific Purpose Payments (National SPPs) and National Health Reform funding to be spent in the key service delivery sectors; and
- National Partnership payments to support the delivery of specified outputs or projects, to facilitate reforms or to reward those jurisdictions that deliver on nationally significant reforms.

Under the IGAFFR, there are two main types of agreements between the two levels of government: National Agreements and National Partnership Agreements. According to the Standing Council on Federal Financial Relations,

> National Agreements define the objectives, outcomes, outputs and performance indicators, and clarify the roles and responsibilities that will guide the Commonwealth and the States and Territories in the delivery of services across a particular sector.[8]

Currently there are six National Agreements which cover key service areas - healthcare, education, skills and workforce development, disability services, affordable housing and Indigenous reform. Each National Agreement, except the National Indigenous Reform Agreement and the National Healthcare Agreement (NHA)[9], is associated with a National SPP. These agreements require that the payments be spent in the relevant sector. States have budget flexibility to allocate funds within that sector in a way that ensures they achieve the mutually agreed objectives and outcomes of the associated National Agreement.

Healthcare services are covered by two umbrella agreements, the 2012 National Healthcare Agreement (with no money attached) and the associated National Health Reform Agreement (with money attached, ie National Health Reform Funding). The National Health Reform Agreement was entered into by all states, territories and the Commonwealth in August 2011.[10]

The overarching objective of the National Healthcare Agreement is to 'improve health outcomes for all Australians and ensure the sustainability of the Australian health system' (National Healthcare Agreement para. 12). The National Health Reform Agreement[11] sets out governments' commitments in more detail in relation to public hospital funding, public and private hospital performance reporting, local governance of elements of the health system, policy and planning for primary health care, and rearrangement of responsibilities for aged care (National Health Reform Agreement para. 3).

National Partnership agreements set out mutually agreed performance benchmarks in relation to the achievement of reforms or improvement in service delivery. [12] These sit attached to the National Healthcare Agreement.

Underneath the broad objectives of the National Healthcare Agreement sit the following National Partnerships on healthcare. Most of these have money attached: National Partnership Payments.
- National Partnership on Improving Public Hospital Services (2/8/11 to 30/6/17)
- National Partnership on Preventive Health (1/1/09 to 30/6/15)

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[8] http://www.federalfinancialrelations.gov.au/content/national_agreements.aspx
[9] http://www.federalfinancialrelations.gov.au/content/npa/healthcare/national-agreement.pdf
[10] While we focus on agreements relating to healthcare services the National Affordable Housing Agreement is also of relevance. It funds specialist homelessness services, a precursor to these being the Supported Accommodation Assistance Program (SAAP).
[11] http://www.federalfinancialrelations.gov.au/content/npa/health_reform/national-agreement.pdf
[12] http://www.budget.gov.au/2013-14/content/bp3/html/index.htm

- National Partnership on Essential Vaccines (1/7/09 ongoing)
- National Partnership on Hospital and Health Workforce Reform (20/2/09 to 30/6/13)
- National Partnership on Health Services (7/12/9 ongoing)
- National Partnership on Health Infrastructure (7/12/9 ongoing)
- National Partnership on e-Health (7/12/09 to 30/6/12)
- National Partnership on Closing the Gap in Indigenous Health Outcomes (1/7/09 to 30/6/13).[13]

Under the IGAFFR, all National SPPs and National Partnership Payments are paid by Commonwealth Treasury to each State Treasury on a monthly basis. State Treasuries are then responsible for distributing the funding within their jurisdiction.[14] The Commonwealth's contribution to National Health Reform funding is paid to the National Health Funding Pool, the term for the combined pool accounts of all states and territories.[15]

Thus it is clear that healthcare in Australia is a joint responsibility of governments. The issue of federalism is vexed however, as this quote (in relation to school education) shows: "degree to which federal activity in schooling overlaps, competes or complements with state activity, and degree to which it enhances, obstructs or otherwise influences state policy autonomy or intergovernmental relations has not been rigorously investigated" (http://www.bronwynhinz.com/wp-content/uploads/2009/06/Hinz-2010-CPSA-paper-Aussie-federalism-school-funding-arrangements-v61.pdf). The same is true of AOD treatment services, and indeed was noted by the then Minister Mark Butler in relation to the challenges of planning and purchasing AOD treatment.

Conclusions

- Alcohol and other drug treatment in Australia is provided by both government and non-government organisations
- The investment in AOD treatment represents value-for-money. For every dollar invested in treatment, the community saves seven dollars.
- Treatment produces positive health outcomes: reduced consumption of alcohol and other drugs; improved health status; reduced criminal behaviour, improved psychological wellbeing; and improved participation in community.
- Research has shown that the way in which governments purchase AOD treatment has an impact on treatment outcomes.
- With two levels of government engaged in AOD treatment funding, and the shift to purchasing from non-government organisations, attention is now being focused on communication, co-operation and collaboration in the 'co-creation of public value'.
- By working cooperatively and collaboratively, there is increased scope to identify and implement meaningful change for AOD treatment sector development and support for sector sustainability. This is the responsibility of not just the Commonwealth government but also state/territory governments, service providers and other stakeholders to the Australian AOD treatment system.

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[13] http://www.coagreformcouncil.gov.au/agenda/healthcare
[14] http://www.federalfinancialrelations.gov.au/content/funding_framework.aspx
[15] The Pool is administered by the National Health Funding Pool Administrator, an independent statutory office holder distinct from Commonwealth and State/Territory governments.

Chapter 3: Funding flows – what are the AOD treatment funding sources?

Introduction

This chapter documents our understanding of funding flows as they pertain to AOD treatment in Australia. Further details are provided in Working Paper # 3. The funding flows are complex and we acknowledge the potential for confusion in the diagram and its explanatory text, which arises from the complexity of the system we are attempting to portray. This is the first attempt to describe the AOD funding system. There were few diagrams of funding flows in the health system to guide us.

One notable finding of this exercise was that we were not alone in struggling to accurately depict the AOD funding system. There is much confusion and lack of clarity. Another notable finding was the tendency for money to flow around the system before distribution to treatment providers. The obvious example is money that flows from the Commonwealth to state and territory governments for distribution. Another more complicated example is where a state or territory government receives money from several different sources and provides those funds to a third party for it to distribute to service providers.

Along the top of the diagram are blue boxes representing AOD services provided through Australia's health system. There is a mixture of non-government, government, and mixed government and non-government service providers. These include public hospital services, medical practitioner services, pharmacy services, government AOD services, NGO services and so on. The services may be provided in a range of locations. For example, a private medical practitioner may provide her services in a private practice, at a public hospital, at a private hospital, or at an NGO. Likewise NGO services may be associated with a government funded community health service and so on. The diagram's purpose is not to describe governance arrangements or settings for AOD treatment but to describe the flows of funding from various funding bodies (as listed in subsequent tiers of the diagram) to a range of service providers.

Below the blue boxes in the top row are yellow and pink boxes representing the various sources of funding that we have identified. The pink boxes represent the ultimate funding source and the yellow boxes represent intermediary funders. In the diagram, the flow of funds follows the arrows, and as can be seen, there are multiple complex funding flows. We have focussed on what we believe are the primary funders and funding flows for AOD treatment. We note that the diagram reflects the status of funding bodies as at December 2013. The May 2014 Federal Budget included changes to some of the funding bodies listed in the diagram, as footnoted in the chapter

There have been some necessary simplifications to the arrows. For example we are aware that some state governments provide funds to community pharmacies for opioid pharmacotherapy maintenance treatment, but this arrow has been omitted for simplicity. Similarly, the Commonwealth Government contribution to private health insurance is not documented. Nor are philanthropic funds directed towards Government AOD services. Finally, Medicare Locals also receive funding from state/territory Governments and manage the Commonwealth funded Access to Allied Psychological Services program (ATAPS), for example.[16]

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[16] The May 2014 Federal Budget announced that Medicare Locals will be replaced with Primary Health Networks: http://www.health.gov.au/internet/budget/publishing.nsf/Content/2014-2015_Health_PBS_sup1/$File/2014-15_Health_PBS_2.05_Outcome_5.pdf.

Public hospital services

Medical practitioner, private psychologist and psychiatrist services

Pharmacy services

Private hospital services

Community Health Services

Government AOD Services

Non- government AOD Services

Local Hospital Networks

Individuals (fee for service), including private health insurance

Medicare Locals

Grants schemes

National Health Funding Pool and state managed funds

State/Territory Health Departments

National Partnership payments

Grant schemes (eg NGOTGP, SMSDG)

State/Territory Governments: Treasury, Justice, Attorney-Generals, etc

Pharmaceutical Benefits Scheme

Commonwealth Government: Treasury, DoH, Attorney Generals, DSS, PM&C

Medicare

Philanthropy, Foundations, Lotteries, Fund raising, Bequests, Church funds

51

The text below provides some context and detail for the various funding flows depicted in the diagram. We start with examination of the bottom left hand corner of the diagram, the Commonwealth AOD treatment funding flows.

Commonwealth Government funding of AOD treatment

As noted in the diagram, we identify Commonwealth Government[17] funding sources as including:
- The National Health Funding Pool (which states/territories also contribute to) and Local Hospital Networks
- National Partnership payments
- Grants Schemes
- Pharmaceutical Benefits Scheme
- Medicare Benefits Scheme

Each of these is described in turn.

National Health Funding Pool[18]

Under the National Health Reform Agreement the states, territories and the Commonwealth are jointly responsible for funding public hospital services, using activity based funding (ABF)[19] where practicable and block funding in other cases. The first two years of the new National Health Reform Agreement funding arrangement (2012–13 and 2013–14) are transitional. In the transition period, the Commonwealth's contribution to public hospital services funding will be equivalent to what would otherwise have been payable through the former National Healthcare Special Purpose Payment. From 2014/15 the level of funding will be directly linked to the level of services delivered by the public hospital.[20] Commonwealth contributions flow to the National Health Funding Pool, as do the portions of the states' contributions to public hospital services which are distributed on an activity funding basis.

The scope of public hospital services that are funded on an activity or block grant basis and are eligible for a Commonwealth funding contribution currently includes:
- All admitted and non-admitted services
- All emergency department services provided by a recognised emergency department
- Other outpatient, mental health, sub-acute services and other services that could reasonably be considered a public hospital service.

These are inclusive of AOD treatment.

The care for patients admitted to public hospitals for AOD treatment is funded through ABF funding. Non-admitted patients receiving alcohol and other drug treatment from an allied health professional or clinical nurse are funded on a similar basis, costed in relation to Outpatient Clinic definitions (40.30 AOD). ABF funding applies to acute admitted public, acute admitted private, non-admitted, and emergency department service categories.

Block funding provides for mental health services, small rural and metropolitan hospitals, sub-acute, teaching, training and research, and other categories, which are funded through state managed funds and subsequently paid to local hospital networks.

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[17] The Commonwealth Government also funds the Australian Defence Force and the Department of Veterans Affairs, both of which purchase/provide AOD treatment.

[18] The May 2014 Federal Budget announced the merging of various bodies including the National Health Funding Pool administrator into a new Health Productivity and Performance Commission (see section 1.1 para 4 (p.404) http://www.health.gov.au/internet/budget/publishing.nsf/Content/2014-2015_Health_PBS_sup3/$File/2014-15_Health_PBS_4.12_NHFB.pdf.

[19] Activity based funding means that providers are funded based on the activity they undertake.

[20] http://www.budget.gov.au/2013-14/content/bp3/html/index.htm

Local Hospital Networks (LHNs) have been created as independent legal entities in each of the states/territories, with varying degrees of reorganisation of health service administration. They comprise single or small groups of public hospitals with a geographic or functional connection. LHNs manage public hospital services and may, at the discretion of States, also be responsible for delivering other health services. They receive Commonwealth and State financial contributions for delivery of services, as agreed under the Service Agreement entered into with the State (National Health Reform Agreement, Schedule D).

For example, in NSW there are 15 Local Health Districts. Similarly, in Queensland there are 17 Hospital and Health Services, ie statutory bodies with Hospital and Health Boards.[21] Tasmania has established three Tasmanian Health Organisations, the geographic boundaries mirroring the old Area Health Services.[22] While technically these are not an alternate funding source to the National Health Funding Pool, they can then in turn fund non-government organisations (and/or manage contracts for NGO service provision). Hence some AOD NGOs in Australia appear to receive funding from a Local Hospital Network.

The Commonwealth also delivers block funding through the National Health Funding Pool for non-hospital public health activities managed by states and territories. The States have "full discretion" over the allocation of these funds within the bounds of the National Health Agreement.[23] For example, Commonwealth funds attached to the Illicit Drug Diversion Initiative and Needle and Syringe Program funding[24] flow through the National Health Funding Pool.

National Partnership Payments

The Commonwealth also provides funding to the States under National Partnerships, some of which may be directed to AOD treatment. It is difficult to trace specific AOD treatment funding that flows through the National Partnerships payments, but review of the 2013-14 Budget Papers revealed some relevant projects.

Examples from the National Partnership on Health Services are:
- Early Intervention Pilot Program, under the National Binge Drinking Strategy: $0.2 million provided to NSW in 2012-2013 for early intervention and diversion programs for young people under the age of 18 years who are at risk of developing alcohol-related problems.
- Innovative flexible funding for mental health component: $4.2 million provided to Tasmania over four years from 2012-13 to fund packages of care to support people not served well by mainstream care approaches, including those affected by alcohol, drug and other complex mental health issues.

An example from the National Partnership on Stronger Futures in the Northern Territory:
- Tackling alcohol abuse: $18 million provided to the NT over 5 years from 2012/13.

A raft of other National Partnership Agreements may have relevant AOD treatment funding, especially those in the Aboriginal and Torres Strait Islander area (for example, National Partnership Agreement on Indigenous Early Childhood Development).

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[21] http://www.health.qld.gov.au/hhsserviceagreement/

[22] http://www.dhhs.tas.gov.au/about_the_department/our_plans_and_strategies/national_health_reforms/local_hospital_networks

[23] http://www.budget.gov.au/2013-14/content/bp3/html/index.htm

[24] NSP funding is not in scope for this project.

Grants Schemes

The Commonwealth also contracts the non-government sector to provide AOD treatment services. The purchase and contracting of these services has occurred through the Department of Health (DoH), the Department of Social Services (DSS) and the Attorney-General's Department (AG's).

The recent Machinery of Government changes have brought together many of the Indigenous policies and programs under the Department of the Prime Minister and Cabinet (PM&C). PM&C now has responsibility for some of the DoH and DSS programs which had purchased AOD treatment, as noted below (https://www.pmc.gov.au/indigenous-affairs).

DoH operates two grants programs which directly fund treatment provision, support, and capacity building of the treatment sector[25]:

- The NGO Treatment Grants Program (NGOTGP)

The "objective" of the fund is to "improve drug and alcohol treatment service outcomes; increase the number of treatment placements available; fill geographic and target group gaps". Grants can be provided to NGOs (and in some cases has been provided to state government departments of health for government treatment services) and may include but are not limited to: "counselling, outreach support, peer support, home detoxification, detoxification and withdrawal, rehabilitation, therapeutic groups or communities".

- The Substance Misuse Service Delivery Grants (SMSDGF)

The priority areas of this fund (as listed in the Fund Guidelines) are:

> Priority 1: "support non-government drug and alcohol treatment services to deliver quality, evidence based services and build capacity to effectively identify and treat coinciding mental illness and substance misuse"
> Priority 2: "assist indigenous communities to provide service delivery"
> Priority 3: "support those services targeting ATSI people"
> Priority 4: "reduce the prevalence and impact of petrol sniffing"
> Priority 5: "support people from culturally and linguistically diverse backgrounds"
> Priority 6: "support the development and implementation of a range of social marketing campaigns"

These two funds are extensively described in Chapter 2. PM&C now has responsibility for Indigenous Drug and Alcohol Services, which could include some of the priority areas of the SMSDGF program.

Pharmaceutical Benefits Scheme (PBS)

The Commonwealth Government:
- Subsidises the price of prescription drugs used for AOD treatment (incorporating the cost of the drug and dispensing) listed on the Australian Government's PBS. Low income earners have access to cheaper prescription medicines.
- Funds methadone and buprenorphine for the treatment of opioid dependence through the PBS. Both drugs are provided free of charge to the body responsible for dispensing (public clinic, private clinic, hospital or community pharmacy).

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[25] There are other flexible funds, such as the Substance Misuse Prevention and Service Improvement Grant, however this does not provide any funds for AOD treatment per se.

Medicare Benefits Scheme

Through the Medicare Benefits Scheme, the Commonwealth Government covers a fee it has scheduled for a list of health services that it deems to attract a Medicare Benefit, if the service is provided by a health provider registered with Medicare. Relevant health service providers are private General Practitioners (GPs), psychiatrists and psychologists. Many GPs provide counselling/advice for AOD problems, and psychologists access Medicare under the Better Access Scheme which can include AOD counselling interventions. GPs' role in Australia's opioid maintenance program (prescribing methadone and buprenorphine) is funded through Medicare.

Other Commonwealth funding

As a hybrid of service delivery, coordination, planning and purchasing, Medicare Locals are uniquely situated in Australia's health system.

The Department of Social Security (DSS) (formerly the Department of Families, Housing, Community Services and Indigenous Affairs) operated some grants programs which could be funding AOD treatment, for example:

- Breaking the Cycle of Alcohol and Drug Abuse in Indigenous Communities.[26]

The Commonwealth Government committed $20 million over three years from 2011–12 to this program, which is intended to assists communities in remote and regional areas to develop and implement local solutions to alcohol and substance misuse issues through the development and implementation of Community Alcohol and Substance Abuse Management Plans.

- Alcohol Management Plan Community Fund (part of Stronger Futures in the Northern Territory)[27]

The Commonwealth Government allocated $23.6 million over eight years (from 2013-2014) in the Alcohol Management Plan Community Fund for community-based projects to support harm reduction and supply and demand reduction strategies as part of an alcohol management plan, and for governance and leadership support for people involved in alcohol management planning. Types of activities funded may, for example, include support for greater uptake and participation in alcohol rehabilitation and treatment services and assessment services, and early intervention, harm reduction and prevention activities (page 4).

Both these programs have been transferred to PM&C.

Another DSS funded program is "Kids in Focus", which provided intensive support services to families, including parents /carers and children dealing with substance-using parents in the community; support for parents to parent more effectively and overcome their substance misuse; support for children to normalise their lives (school, sport, and other regular routines) and build resilience; targeted counselling and intervention through the child protection system where necessary; and support other services funded by the program to identify and support children at risk.[28]

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[26] http://www.fahcsia.gov.au/breaking-the-cycle-of-alcohol-and-drug-abuse-in-indigenous-communities-activity

[27] http://www.fahcsia.gov.au/sites/default/files/documents/06_2013/alcohol_cope_ip_final_approved_by_minister_2.pdf

[28] http://www.formerministers.dss.gov.au/14392/kids-in-focus-helping-drug-affected-families/

The National Crime Prevention Fund has funded AOD treatment. Subsection 298(1) of the *Proceeds of Crime Act 2002* allows the Australian Government to use money confiscated under the Act and the proceeds of confiscated assets (held in the Confiscated Assets Account) to fund crime prevention and law enforcement measures, measures relating to drug addiction treatment and diversionary measures relating to illicit drug use. While the Australian Government has continued to draw on the Confiscated Assets Account to make a series of small grants, it deferred payments of: $32 million in the 2011–12 Budget and $58.3 million in the 2012–13 Budget so funds could be diverted to other priorities. The 2013–14 Budget allocated $40.9 million to be spent on grants for projects aiming to prevent street crime and gang violence over the four years to 2015–16.

The last year that an AOD specific project was funded was 2007. Since then the focus of funding has shifted to crime prevention and law enforcement measures. An example of an AOD specific project that received funding under this scheme was Triple Care Farm (Mission Australia), which was funded to expand the farm's residential rehabilitation program for young people with AOD.[29]

Both the Department of Veteran's Affairs and the Australian Defence Force purchase treatment directly for current and past members of Australia's defence force.

Aboriginal Hostels Limited (a Commonwealth owned company) contributes to the accommodation costs in some residential rehabilitation services for Indigenous Australians[30], for example FORWARRD in the Northern Territory.[31]

State/Territory Government funding of AOD treatment

State and Territory governments provide treatment services themselves and contribute funds to
- community health services
- mental health programs
- public hospital services.

They also purchase treatment services from NGO treatment providers.

National Health Funding Pool and State Managed Fund
The state or territory government contribution to the funding of public hospital services and functions is calculated on an activity basis or provided as block funding. As the system managers of the public hospital system, states and territories determine the amount they pay for public hospital services, and the mix and functions of those services. They also meet the balance of the cost of delivering public hospital services and functions over and above the Commonwealth contribution.

Community Health Services
State/territory governments cover the cost of AOD treatment provided through publicly funded Community Health Services, even when provided by medical practitioners and registered psychologists.

Government-provided treatment
The bulk of government AOD treatment services are provided by state and territory departments of health; some of whom contract their Local Hospital Networks to plan and deliver those services.

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[29] http://www.ag.gov.au/CrimeAndCorruption/CrimePrevention/Documents/POCA%20Funded%20Projects.PDF
[30] http://www.ahl.gov.au/
[31] http://www.forwaard.com.au/Treatments.html

NGO Services

Departments of Health in each state/territory provide funding to NGO treatment providers through grant programs. In some states and territories the Department of Health contracts Local Hospital Networks to undertake the job of purchasing NGO services; in others there is direct contracting/purchasing between the state government and the NGO; in some states both arrangements exist.

State/territory departments other than Health also fund NGOs to provide treatment. For example, diversion funding can flow from Attorney-General's & Justice Departments, Police Departments etc. In NSW, the Department of Attorney General and Justice fund community-based AOD treatment for offenders.

Individuals

Treatment recipients can also contribute to the financial cost of treatment through:
- Paying the difference between what treatment providers (medical practitioners, other allied health services and hospitals) charge for treatment and what private health funds and Medicare cover.
- Paying a service fee for treatment provided by NGOs. For example, it is common for income support recipients in residential rehabilitation facilities to be charged a significant proportion of their income support entitlement as contribution towards their accommodation and food costs.
- Buying private health insurance.
- Paying dispensing fees for medications.

Philanthropy

Philanthropy and other such funding sources, including bequests, NGO fund-raising, lotteries, Clubs Australia and foundations all contribute to AOD treatment, although the amount of funding is very difficult to ascertain.

For example, the Sir David Martin Foundation contributes to Mission Australia's Triple Care Farm, which runs a residential rehabilitation service for young people.[32] A recent mapping of the grants of 12 leading philanthropic foundations over the three year period 2009-2011 identified funds directed towards "addiction and substance abuse" (Anderson, 2013). Nine in ten of all the grants (91%) were for less than $100,000.

Another example of a non-government funding body, Lotterywest provided funding to Hope Community Services Inc in Western Australia to assist transitional support homes for clients moving out of residential rehabilitation (https://www.lotterywest.wa.gov.au/grants/approved-grants).

Other aspects of the provision of AOD treatment through the NGO sector not commonly thought of as philanthropy are voluntary labour and unfunded infrastructure provided by the sector. One example of the use of voluntary labour is peer based services such as the Family Drug Helpline.[33] It is not uncommon for NGOs, even governments themselves, to provide infrastructure in the form of buildings to house treatment services, for example, as in-kind contributions to treatment provision.

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[32]http://www.sdmf.org.au/
[33] http://www.familydrughelp.org.au/Volunteering.htm

Other funding sources

The diagram represents the major funding sources and those which we can confirm as funders of AOD treatment. Other funding sources, however, have been mentioned to us (without any details as to the specificities of the funding). These include:

- Mental health funding
- State-based mining royalties
- Local government.

While Mental Health funding is not separately represented in the diagram, all the relevant funding bodies in the diagram also represent mental health service funding flows. There is overlap between mental health services and AOD services to the extent that individuals receive care for the AOD problems via Mental Health funded services. Examples of relevant Mental Health services are those funded through state/territory governments; those funded through the Partners in Recovery initiative; private hospitals that provide mental health services (with funding accessed via the national health funding pool, and so on.

There are mining "royalties for regions" programs in WA, Qld and NSW.[34] There is also the Aboriginal Benefits Account.[35] The account is responsible for distributing mining royalties from mining on Aboriginal Land in NT to Aboriginal people

Summary: funding flows

Another way of considering funding flows is to examine it from the perspective of the provider. As the diagram makes clear, non-government organisations which provide AOD treatment can receive funds from a number of funders via a range of funding schemes, leading to numerous contracts and associated accountability relationships. For example, an organisation could be receiving grant funding from the Commonwealth Government via both the NGOTGP and SMSDGF grant schemes. If the organisation had a GP or psychologist on site it could also receive Commonwealth funding through Medicare and Access to Allied Psychological Services funding delivered through a Medicare Local. At the same time the organisation may receive state funding through health department grant funding, delivered through a Local Hospital Network, as well as sourcing funds through a philanthropic funding scheme and its own fund raising. Clients themselves might also be paying service fees to the organisation.

Two organisation case examples describe the complex web of funding sources.

Case example: Organisation A
(The full details can be found in Chapter 17)

Description of the organisation and AOD treatment services
The organisation has a long history of residential rehabilitation service delivery (particularly within the therapeutic community model) and is a large, well established, specialist AOD treatment provider within its jurisdiction. Since its initial establishment as a residential rehabilitation treatment service, the organisation has expanded its service delivery purview and aims to "provide a comprehensive range of community-based treatment and support services to address alcohol and other drug problems, along with any associated mental health, vocational, health, relationship and family issues". The organisation currently has 110 residential

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[34] for example: http://www.dsdip.qld.gov.au/about-the-program/regional-development/about-the-royalties-for-the-regions-program.html
[35] http://www.dss.gov.au/our-responsibilities/indigenous-australians/programs-services/land-native-title/aboriginals-benefit-account-aba

rehabilitation treatment beds (at two locations across the state, one short-term and one longer-term program). The organisation also has 50 supported accommodation beds (in 25 houses across the state). In addition to residential services, the organisation provides a range of outpatient programs both in the central city and in urban growth corridor areas.

The organisation provides a range of community-based treatment and support programs including financial and gambling counselling services, and child and family support programs (including home visits with parents and family therapy programs for families with children who have a dual diagnosis). A youth and family team provides outpatient counselling services as well as outreach across community schools (including counselling services, curriculum delivery, youth camps etc.). The organisation is also engaged in prevention work in multiple ways (for example in conjunction with sports clubs and schools). The organisation is also a Registered Training Organisation (RTO) and provides training for approximately 250 students (mainly professionals seeking qualifications for work in the AOD and mental health sector, as well as clients who may be engaged in courses such as hospitality training or business administration).

The organisation partners with universities to develop and evaluate new programs, and regards building the evidence base for what they do as part of their role within the sector.
The organisation also plays a key role in policy and advocacy within the AOD sector by supporting committees and sector reform processes (including quality framework development).

Funding
In the interviews conducted, it was estimated that 55% of the organisation's activities are state funded (primarily through the state Department of Health, but sometimes also Department of Education and Justice etc.); around 25% of activities are Commonwealth funded (historically and variously through the Department of Health and Ageing, DSS, and AGs proceeds of crime funding); 10% of activities are funded through fee for service (primarily through clients' Centrelink contribution to treatment in residential programs, as well as fee for service for training programs which are nonetheless heavily subsidised); and 8-9% of activities are funded through donations, trusts and foundations, philanthropic/corporate support. Participants noted that this final category of funds "fills gaps" and is used to supplement programs and resource capital works, as well as fund discrete programs and innovations (e.g. employment programs; financial counselling; community school programs). The organisation very occasionally receives consultancy funds, but participants were of the view that these services were mainly provided in-kind as part of their contribution to the development of the sector.

The organisation is in receipt of both NGOTGP and SMSDGF funding. The NGOTGP funds equate to approximately $1.1 million a year which fully funds a 15 bed residential rehabilitation program (in a country area, which has approximately 20% Aboriginal and Torres Strait Islander clients). The funding available to the organisation through the NGOTGP has grown over time through the various funding rounds. Initially, the funding provided allowed the program to be open only 6 months within 2 years, and only funded 8 beds (as a 24/7 residential service, there are some fixed operational costs, including planning requirements that 2 staff be present at all times). One participant said there was "community uproar" that the service was only open 6 months a year, due to the perceived need within the community. It was said that the partial funding of the program "worked for the residents for that period of time, but it was a terrible way to run it". In each subsequent funding round the organisation has made a case to government to build on the program with additional funding. Over time the program was built up to 12 beds, then 15, and moved to continuous funding (11 months of service delivery per year, with a close down over Christmas/New Year period). The program remains "sustainable at that level".

The organisation is also in receipt of capacity building funding through the SMSDGF. The organisation has used this funding to build on earlier dual-diagnosis (comorbidity) work that had been unfunded at a state level, but which had been initially developed through philanthropic funds. This was a perceived need as 80-90% of the organisation's clients have a dual diagnosis. One participant noted that the first round of SMSDGF capacity building funding "really helped us set a bench mark" and "lift the bar". The second round of funding has since extended the initiative into GLBTQI, culturally and linguistically diverse (CALD) and Aboriginal and Torres Strait Islander capacity building initiatives. This has included, for example, supporting the activities of an Aboriginal Advisory Group, employing an Aboriginal Consultant who works part time to improve links at a systems level, as well as employing a young Aboriginal woman to give her work experience in this area. These activities were

undertaken so as to extend capacity building beyond mental health and into areas where there was need for staff development. It was said that this capacity building funding had been "fantastic and critical" for the organisation – because state funding is so limited, this capacity building funding as well as trust and foundation money supplement staff development and supervision across the organisation (which should be basic requirements).

Within the organisation's financial management system different accounts are used to separately manage the range of different programs, and the organisation tries to reflect the true costs of that program in the account. It was noted that in the past the organisation used to "pull money" into programs from across the organisation, but now a more streamlined accounts management system is used to see how much each program actually costs. This system also ensures consistent quality standards across the organisation; regardless of how the program is funded, expectations of quality standards stay the same. Although programs are funded discretely, participants noted that flexible funding from trusts and foundations is used to "plug some of the gaps". Capacity building funding is also used "right across" the organisation to enhance professional development, supervision and training.

Although programs may be discretely funded, there is a sense of "cobbling together" the wrap-around services for the client. The organisation aims to provide services in a holistic way for clients. It is the organisation's general practice to engage clients in other specialist community services where possible, and to provide in-house services for those clients who are unable to negotiate external networks/resources and transition them to community supports over time. The organisation works with a complex group of clients, and in the organisation's experience they have seen better outcomes in terms of long term recovery if more services can be delivered in-house for complex clients. This said, the organisation aims to integrate into the community and partners with other services and co-locates to provide holistic and integrated care for clients.

Case example: Organisation B
(The full details can be found in Chapter 17)

Description of the organisation and AOD treatment services
The organisation is located in an inner city area in one Australian capital city. The organisation provides primary health care and welfare services to marginalised inner city populations including homeless and disadvantaged men and women, many of whom have comorbid mental health and AOD issues. The participants consulted described the service as 'medium sized', and as engaging in health promotion, harm reduction and health education activities.

Within the broader activities of the organisation (which include accommodation services and holistic care and case management) the organisation runs two specific AOD treatment activities: an AOD counselling service (run by a clinical psychologist), and a capacity building program to enhance the capacity of staff and managers to more effectively work with clients who have comorbid AOD and mental health issues. This program includes training, training audits, and evaluation. Although these two services were described by participants as AOD treatment specific services, they noted the holistic nature of their services and that AOD treatment and harm minimisation are integrated across all of the organisation's activities (for example, through the case management model used within a crisis centre for clients with complex needs which operates using a harm minimisation model, and the organisation's AOD/HIV integrated care program). The organisation is also a member of the state AOD peak organisation and is active in policy forums undertaken by the peak.

Funding
The organisation receives funding from multiple government departments including the state Department of Family and Community Services (for homeless service), the state Health Department (e.g. for residential rehabilitation services), and the Commonwealth Medicare branch (for a medical clinic for homeless people).

The two specific AOD treatment services are both fully funded by the Commonwealth; the counselling service by the NGOTGP and the capacity building program by the SMSDGF (both relatively small grants, each funded

over three years). The organisation also receives income through client fees for other programs, and occasional donations corporate donations (but does not have any fee for service programs).

The organisation's programs are funded separately, by distinct pockets of money, and separate financial statements are produced for each funding agreement. Participants noted however that "While we don't cross over the funds, we certainly cross over the activities". To explain this, participants noted that clients participate across multiple programs within the organisation, although the client would not realise this due to the integrated approach of the organisation. The organisation also works in an integrated way with other organisations and agencies to care for clients: "we all have to work together". Clients are referred to the organisation's AOD counselling service from other agencies as well.

The organisation maintains discrete funding streams for its various programs. The costs associated with accreditation and quality improvement activities are pulled from management fees and reserves which have been built up over the years.

Conclusions

- AOD treatment is provided by a range of service providers in a range of locations
- There are multiple funders of AOD treatment services; including both Commonwealth and state/territory governments, philanthropists and the clients themselves
- Commonwealth funds go to all the service providers that we identified; and state/territory funds are also directed to many of those service providers, illustrating the importance of federalism in AOD funding,
- Funding is not only delivered directly to service providers, via grant funding of treatment services and Medicare for example, but indirectly through intermediaries via often convoluted pathways. For example, Commonwealth funding is delivered to hospitals via the National Health Funding Pool, and can travel to service providers through state/territory governments via National Partnership payment, and via other intermediaries such as Medicare Locals and Local Hospital Networks.
- NGOs providing AOD treatment rely on multiple sources of funds at the same time; for example a number of departments in both levels of government, philanthropy, clients and fund raising.
- The combination of multiple sources of funds and both direct and indirect funding pathways can result in NGOs having multiple funding relationships at the same time with multiple agencies.

We now turn to the actual amount of funding for AOD treatment services in Australia.

Chapter 4: The amount of AOD treatment funding in Australia

Introduction

This chapter provides an estimate of the total spending on alcohol and other drug (AOD) treatment in Australia and the respective contributions of different funders. This has not been attempted before – and hence should be seen as a first attempt which can be built on in subsequent research. As with any such exercise in estimating expenditure, the data are often missing, or come in ways that are not directly comparable. Despite the methodological challenges, it is an important research task and provides fundamental information for any analysis of AOD treatment funding in Australia. The full details can be found in Working Paper # 7.

The estimate of total AOD treatment funding includes both AOD treatment funding for the generalist sector (hospital services (public and private), primary care services through GPs, the Better Access and ATAPS programs and the Pharmaceutical Benefits Scheme) and AOD treatment funding for the specialist sector (both government specialist and NGO specialist).

Our intention is to contextualise the Commonwealth investment in relation to all AOD treatment funding – whether that be funding provided to the specialist sector, or funding provided to general health services for the treatment of AOD problems[36]. We can separately identify the specialist sector expenditure (see below), within the context of total expenditure.

The spending estimate pertains to our definition of treatment, as "that which is directed towards an individual regarding changing his/her AOD use" (United Nations Office on Drugs and Crime, 2006). This means that any funding directed towards the following interventions is included:
- Withdrawal
- Psycho-social therapy (counselling, psychotherapy)
- Residential rehabilitation
- Pharmacotherapy maintenance

(Integral to the above is assessment, case management and support, information and education, and aftercare). In the main, this refers to face-to-face services; however telephone and online services which are funded by state/territory health departments and considered part of their overall AOD treatment budget are included.

We had originally intended to collate all funding for AOD treatment irrespective of government department – that is across health departments, correctional services, Departments of Social Services and so on[37]. This would then have been consistent with the work in Chapter 3 describing all

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[36] We note that this work refers only to the Commonwealth's *treatment* investment. The Commonwealth also invests in the AOD sector through other avenues. One example is the investment made through the Substance Misuse Prevention and Service Improvement Grants Fund (outside the scope of the Review) which provides a flexible pool of funding to assist organisations supporting prevention of substance misuse and other national activities under the National Drug Strategy. This has included funding the activities of the national AOD research centres, the Australasian Professional Society on Alcohol and other Drugs (APSAD), and the Foundation for Alcohol Research and Education (FARE) for example. An answer to a written question on notice submitted to Senate Estimates provides the current funding amounts provided by the Commonwealth to a range of AOD organisations including national peak bodies, national centres, state and territory peak bodies, and research centres
(http://www.aph.gov.au/~/media/Estimates/Live/clac_ctte/estimates/sup_1314/DoH/Answers/168.ashx.
[37] We collated a list of all possible funders (see Working Paper # 3) as well as a list of possible treatment settings to think through the potential data sources for this project and to attempt to ensure that we did not forget a treatment funding source. The funding sources we explored can be found in Working Paper # 3. The treatment settings we explored included: public hospitals; non-government organisations; pharmacies; primary care (GP); mental health services (psychiatry and allied health); private hospitals; government clinics not elsewhere classified; and other charitable institutions. In addition,

the funding flows. It quickly became apparent that such an analysis would require substantial resources. As such, we have had to restrict our analysis only to Health. This means that a number of AOD treatment services are not counted here. This includes:

- Prison-based AOD treatment (largely funded by Departments of AG/Justice, but in some instances by Departments of Health). We have no current estimate of the amount of funds directed towards prison-based AOD treatment across Australia.
- Correctional Services AOD treatment. We have no current estimate of the amount of funds directed towards AOD programs in non-custodial correctional settings.
- There are a number of Commonwealth initiatives that a form part of larger packages to address Aboriginal disadvantage. This includes the Stronger Futures, Breaking the Cycle and Closing the Gap programs. We did endeavour to identify specific AOD treatment funding within these various initiatives – however it proved too difficult.
- The largest amount of healthcare funding for Aboriginal and Torres Strait Islander services comes through the primary health care services funding. These are largely the Aboriginal Medial Services. These primary health care services, funded through what was then OATSIH, provide primary health care to Aboriginal people. It may cover the full range of primary health care needs, including AOD treatment. Some of these services receive MBS funding (which we have included through our analysis of MBS) and/or have other funding sources in addition to their base funding. The specific Substance Use Services, funded through the SMSDGF are included in this analysis, but funding that may flow to AOD treatment within the Aboriginal Medical Services could not be separately identified.
- The Department of Veterans Affairs purchases AOD treatment through the hospital system – this is included in hospital section. However, a new budget announcement (in 2013) indicated that $14m over the next 4 years (approximately $3.5m per annum) would be allocated to AOD treatment. We have not included this amount here as it was not applicable in 2012/2013, and is yet to commence at time of writing (March 2014).
- The Kids in Focus program funded by Department of Social Services provides intensive support services to families, including parents / carers and children dealing with substance-using parents in the community; provide support for parents to parent more effectively and overcome their substance misuse; support children by normalising their lives (school, sport, and other regular routines) and building resilience; provide targeted counselling and intervention through the child protection system where necessary; and support other family supports services programs to identify and support children at risk. In 2012/2013 the Kids in Focus funds were $3.6 million.
- The Proceeds of Crime Act (POCA) provides a scheme that allows the confiscated funds to be given back to the Australian community in an endeavour to prevent and reduce the harmful effects of crime in Australia. Subsection 298(2) provides that funding can be approved for one or more of the following four purposes: 1. crime prevention measures; 2. law enforcement measures; 3 measures relating to treatment of drug addiction; and 4. diversionary measures relating to the illegal use of drugs.
  http://www.ag.gov.au/CrimeAndCorruption/CrimePrevention/Pages/ProceedsofCrimeAct.aspx. Since October 2004, there have been 29 AOD projects funded under POCA. These projects totalled $13,203,265 funds to AOD prevention/treatment activities. Since 2007, however, few AOD projects have been funded, and the focus of the fund has shifted from priorities 3 and 4, to priorities 1 and 2 (crime prevention and law enforcement measures). Indeed, 2007 was the last year that an AOD specific project has been funded.
- The Illicit Drug Diversion Initiative (IDDI) funds police, courts and AOD treatment services to intervene with individuals detected for drug offences, and to divert them away from the

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interviews during the rapid assessments in each jurisdiction allowed us to identify various possible funders of AOD treatment.

criminal justice system and into appropriate education, information and counselling services. The analysis of IDDI is complicated. There are three reasons why it is not possible to include IDDI in this analysis: 1. A proportion of the funds go to police and courts and are not expended on treatment per se; 2. The funds are transferred treasury to treasury and not separately identifiable with the national health funding pool; 3. States and territory governments also fund diversion programs, and double counting becomes problematic when state/territory contributions cannot be distinguished from commonwealth contributions. For these reasons, this analysis excludes IDDI. (Appendix B provides further details).

The constriction to health-related funding/expenditure is an important limitation to the current study and should be borne in mind when interpreting the results.

As described in Chapter 3 we identified the many funders of AOD treatment in Australia. The four main funders were: Commonwealth government, state/territory government, individuals and philanthropy (which included foundations, lotteries, fund raising, bequests, church funds).

For the purposes of this chapter, therefore, we focus on four health 'funders':
- Commonwealth government;
- State/territory government;
- Individuals; and
- Philanthropy.

We have included philanthropy because it provides a substantial contribution to AOD treatment. Likewise, we cannot omit the funds provided by individual clients (whether that is through medication dispensing fees, co-payments to GPs or fees in residential services).

In summary there are 10 funding sources included in this analysis:
1. Commonwealth AOD treatment grants (NGOTGP and SMSDGF)
2. State and territory health department AOD treatment funding
3. Public hospital admitted patients
4. Private hospital admitted patients
5. Primary care services (GPs; Medicare)
6. Pharmaceutical Benefits Scheme
7. Allied health services (ATAPS and Better Access)
8. Department of Veteran's Affairs, alcohol and drug services
9. Client contributions (excluding those covered under private hospitals)
10. Philanthropy

Overview of methodology

Financial data can come in various forms –commitments by government to spending (budget appropriations); or grants provided; or the actual amounts spent. Budget appropriations can be misleading and are almost impossible to trace at the required level of detail for our purposes. Actual spending by individual services would require detailed survey of all providers, beyond the scope of the current project. Therefore, the most parsimonious method is to generate estimates from data on grants, fees paid and government program expenditure estimates.

A number of the figures we obtained for this report were derived from confidential data, and cannot be reported in full. One example is the individual state/territory AOD treatment spending – we do not provide details for each jurisdiction as these data were obtained under the condition that they not be reported in an identifiable way.

The analysis pools across all types of treatment, ie it does not distinguish between the 'expensive' treatment types and the less expensive treatment types. We assume these are spread somewhat evenly, but no assumptions can be made, nor conclusions drawn about service type proportional allocations.

It is also important to recognise that some estimates pertain to expenditure items that are (relatively) uncapped whereas others pertain to capped expenditure items. The Commonwealth grants programs (the NGOTGP and SMSDGF), for example, are funds limiting the supply of treatment (ie fixed amount), whereas the GP and hospital funds are uncapped (ie no pre-determined fixed amount but based on quantity delivered). This means that by default some estimates will be smaller (such as grants programs) whereas other estimates will be larger (GP and hospitals) not because of a deliberate investment mix strategy but arising from the difference between capped and uncapped. Thus, one cannot interpret the expenditure figures as *deliberate* or representing a planned or considered mix.

The reference year for the analysis is 2012/2013 wherever possible. In some instances data for 2012/13 was not available. A standard CPI adjustment has been applied (where appropriate) to those estimates derived from earlier years than 2012/2013. The CPI rates were taken from: http://www.ato.gov.au/Rates/Consumer-price-index/. There is an argument that healthcare costs rise more sharply than the CPI. For example, Duckett & Willcox (2011) note an annual growth rate of 13.8% per annum in healthcare spending in Australia. In another example, the evaluation of the Better Access Scheme, noted (Harris, Pirkis, Burgess, Oleson, Bassilios, Fletcher, Blashki, & Scott, 2010, p. 60) that between 2007 and 2008, an increase of 34.8% in expenditure and from 2008 to 2009 an increase of 22.8% (see Table 4.1). These annual increases in costs (between 13% and 30%) are substantially higher than the CPI rate (3-4%). For simplicity we apply only CPI, but note that this under-estimates spending for those figures derived from years other than 2012/13.

We did not include infrastructure funding, nor capital works funding, nor government management costs (eg the costs of staff at government departments involved in procurement etc.). This means that the figures below represent *underestimates* of the costs of providing AOD treatment services in Australia.

We undertook various verification processes. Many of the figures in this analysis are derived from multiple assumptions. We endeavour to, where possible and appropriate, provide a verification or cross-check of our estimates against any other available data. We hope we have provided sufficient level of detail for the derivation of all estimates such that they can be replicated by a third party if required.

The full details of the methodology for each estimate are provided in Working Paper # 7. It should be noted that each estimate has limitations.

Results

The table below provides the summary results of our analysis. As can be seen, the total estimated spending on AOD treatment in Australia by health departments for 2012/2013 was $1,261,329,980. This represents $58.70 per person.

Table 4.1: Estimated total AOD treatment spending in Australia, 2012/2013

	Amount	**%**
State/territory AOD treatment funding	$ 499,561,630	39.6%
Public hospitals - admitted patients	$ 189,120,132	15.0%
Private hospitals - admitted patients	$ 141,417,520	11.2%
Commonwealth AOD treatment grants	$ 130,281,000	10.3%
Pharmaceutical Benefits Scheme	$ 98,805,759	7.8%
Client contributions (fees and co-payments)	$ 85,341,283	6.8%
Primary care services - GPs	$ 53,650,750	4.3%
Allied health services	$ 32,151,907	2.5%
Philanthropy	$ 31,000,000	2.5%
TOTAL	**$ 1,261,329,980**	**100%**

The highest proportion is state/territory AOD treatment funding (39.6%), followed by public hospitals (15%), then the private hospitals (11%) followed by the Commonwealth AOD treatment grants (10%). This 10% is the NGOTGP and the SMSDGF grants programs.

A more detailed analysis of the same figures provided in Table 4.1 above is given below (Table 4.2) which identifies the separate contributions of the different funders (Commonwealth; state/territory; private).

Table 4.2: Estimated total AOD treatment spending in Australia by funder type (2012/2013)

	Funder type	**Amount**	**%**
State/territory AOD treatment	S/T	$ 499,561,630	39.6%
NGOTGP – Commonwealth grants program	CW	$ 49,000,000	3.9%
SMSDGF – Commonwealth grants program	CW	$ 80,000,000	6.3%
SACS payment (Fair Work Australia ruling)	CW	$ 1,281,000	0.1%
Hospitals admitted patients - public Activity Based Funding	CW	$ 59,032,035	4.7%
Hospitals admitted patients - public Activity Based Funding	S/T	$ 102,699,567	8.1%
Hospitals admitted patients - public block grant	CW	$ 9,996,813	0.8%
Hospitals admitted patients - public block grant	S/T	$ 17,391,716	1.4%
Private hospitals - admitted patients, excluding Department of Veterans Affairs (DVA)	private	$ 137,011,118	10.9%
Private hospitals DVA only	CW	$ 4,406,402	0.3%
Medicare	CW	$ 53,650,750	4.3%
ATAPS – Allied Health services	CW	$ 5,756,826	0.5%
Better Access – Allied Health services	CW	$ 26,395,081	2.1%
Pharmaceutical Benefits Scheme	CW	$ 98.805,759	7.8%
Philanthropy	private	$ 31,000,000	2.5%
Client contribution	private	$ 85,341,283	6.8%
TOTAL		**$ 1 ,261,329,980**	**100%**

Table 4.3 summarises these data by funder type. Examination of the split between different funders (Commonwealth; state/territory; private) reveals that the Commonwealth funds 31% of all AOD treatment (through the AOD treatment grants program, primary care (GP), contribution to public

hospitals, the PBS and allied health programs – Better Access and ATAPS). The state/territory government funds 49% through the AOD treatment funding plus the public hospital funding. Private funding includes philanthropy, client fees and private hospitals and represents 20%.

Table 4.3: Split between three funders: Commonwealth; state/territory; private

Funder type	Amount	Percentage
Commonwealth subtotal	$ 388,324,665	31%
State/territory subtotal	$ 619,652,914	49%
Private	$ 253,352,401	20%
TOTAL	**$ 1,261,329,980**	**100%**

Examination of only the split between government levels (that is taking out the private funding), the Commonwealth funds 39% of the government contribution to AOD treatment and the states/territories fund 61% of the government contribution to AOD treatment. (See Table 4.4).

Table 4.4: Commonwealth and state/territory government contributions relative to each other

Level of govt	Amount	Percentage
Commonwealth	$ 388,324,665	39%
State/territory	$ 619,652,914	61%
TOTAL	**$ 1,007,977,579**	**100%**

Relative to other areas of health care, the Commonwealth proportion is smaller for AOD. The latest SCRGSP (2014) reports a 60:40 split between the Commonwealth and state/territory in the opposite direction, that is 64.4% of all government funding for health care is from the Commonwealth and 35.6% is from states/territories (Steering Committee for the Review of Government Service Provision, 2014, p. E5).

Examination of the distinction between generalist AOD treatment and specialist AOD treatment is instructive. As noted in Chapter 1, this is a difficult distinction in practice and is largely made based on the service setting. Generalist AOD treatment was regarded as that which is delivered through the hospitals (public and private), primary care services (Medicare), the PBS, DVA and ATAPS and Better Access. Specialist AOD treatment was regarded as the specific Commonwealth grants schemes (NGOTGP and SMSDGF) along with the state/territory health department funding. This division is based solely on the notion of the setting (either a specialist AOD provider or a generalist provider). We note that this does not reflect the complexity, where generalist providers do provide specialist AOD interventions. Thus the specialist proportion is likely to be an underestimate. An example of the complexity is the Australian opioid pharmacotherapy maintenance program – this is largely provided through primary care settings (GP prescribers) yet is definitively a specialist program[38].

Despite these significant caveats we have calculated the split between the specialist and generalist sectors as described above. The results are given in Table 4.5. At a minimum (given the limitations to the analysis) the specialist sector represents 55% of the total AOD treatment funding.

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[38] The funding for the opioid pharmacotherapy maintenance program is represented in three sections of this analysis: specialist programs funded by state health departments (eg clinics) are included in the state health department estimates; the funding associated with GP prescribers is included under Medicare; and the cost of the medications (methadone and buprenorphine) is included in the PBS figure.

Table 4.5: Expenditure split between generalist AOD treatment settings and specialist AOD treatment settings

Sector	Amount	Percentage
Specialist	$ 629,842,630	**55%**
Generalist	$ 515,146,067	**45%**
	$ 1,144,988,697	

Note:
"Specialist" includes: state/territory health department AOD funding, Commonwealth NGOTGP and SMSDGF funding
"Generalist" includes: hospital funding (public and private), primary care funding (Medicare), PBS, DVA, ATAPS, and Better Access.

Finally, if we take the specialist sector expenditure only ($629,842,630), 21% of this is funded by the Commonwealth ($130,281,000) and 79% funded by states/territories ($499,561,630).

Reflections on the results

Clearly the states/territories make a substantial financial contribution (49% of all funding; 61% of government funding, and 79% of the specialist funding). The hospitals are the second largest contributor (see Table 4.1, 26.2%). Perhaps surprisingly the primary care (Medicare) and medications (PBS) spending is relatively small when compared to the other estimates (4.3% and 7.8% of the total, Table 4.1). The lower amounts for primary care, though, reflect the relatively lower costs of primary care treatment compared to hospital-based settings. Further analysis which combines the cost estimates with the number of patients or episodes would be required to evaluate the investment mix.

The NGOTGP and SMSDGF investment (combined) is greater than Medicare ($53m; 4.5%) and PBS ($99m; 7.8%). This is somewhat of a surprise, but reinforces the critical importance of these two funding sources for the provision of AOD treatment in Australia. Clearly AOD treatment relies on both Commonwealth and state/territory investments through the specific AOD treatment programs.

Client contributions (fees and co-payments etc) at $85m are a significant source of funds for AOD treatment. However, relative to other health care in Australia, they may represent a smaller proportion than expected. Duckett & Willcox (2011) reported that 17% of total Australian healthcare spending was individual out-of-pocket expenditure. Although they go on to note that "this funding distribution varies widely across different types of health services" (Duckett & Willcox, 2011, p. 41).

How much is $1.26 billion dollars relative to all Australian healthcare spending? Where the total Australian healthcare expenditure is $140.2billion (Steering Committee for the Review of Government Service Provision, 2014) this means that AOD treatment represents 0.9% of total health care spending. One way to interpret this percentage is to look at the relative burden of disease. The burden of disease for alcohol and illicit drugs is 1.9% (Begg, Vos, Barker, Stevenson, Stanley, & Lopez, 2007). This is a reasonable comparator because the burden of disease takes into account all health disorders. If one assumes that healthcare resources should in some way be loosely distributed according to the weight of the burden of disease (a significant assumption), then AOD treatment should represent about 1.9% of the total healthcare budget, which would amount to $2.5 billion dollars (effectively a doubling of the current expenditure).

How does the $1.26 billion estimate compare to the social costs of alcohol and other drugs? Collins seminal work, last calculated for 2004/2005, estimated annual social costs to be $56 billion. This included tobacco. If we remove the tobacco estimate, the resulting social cost for alcohol and other

drugs was $24 billion (page xi). The Australian AOD treatment spending therefore represents a mere 5% of the social costs.

It is useful to draw some comparisons with Mental Health (MH) funding. The data are summarised in Table 4.6.

Table 4.6: Expenditure comparisons between MH and AOD

	Mental health treatment	AOD treatment
Expenditure estimate	$7billion	$1.26billion
Per person spending	$309.00	$58.70
Prevalence rate (NSMHWB)	20%	5%
Burden of disease	11.3%	1.9%
% of total Australian healthcare expenditure ($140.2billion)	5%	0.9%
% of expenditure by Commonwealth (compared to states)	36.5%	39%

For 2011/2012, MH funding was $7 billion dollars (government recurrent expenditure, Steering Committee for the Review of Government Service Provision, 2014) ie seven times greater than that spent on AOD treatment. MH spending per person was calculated at $309.00 (Steering Committee for the Review of Government Service Provision, 2014). The population prevalence of MH disorders is higher than AOD disorders, so one would expect a greater investment in MH. But it is not seven times higher. Indeed, according to the 2007 National Survey of Mental Health and Well Being (Slade, Johnston, Oakley Browne, Andrews, & Whiteford, 2009a) it is only four times higher.[39] This suggests that there is significant under-invested in AOD treatment, relative to population prevalence and MH funding. Using the burden of disease analysis as noted above, the MH budget represents 5% of the total healthcare expenditure - $140 billion (Steering Committee for the Review of Government Service Provision, 2014), yet represents 11.3% of the burden of disease (Begg et al., 2007).

We used these data to suggest that given AOD has a burden of disease at 1.9% it should loosely approximate 1.9% of the health expenditure. The same argument could be applied to MH and the above figures demonstrate that both areas arguably require substantially more investment (both in the order of a doubling, if you agree with our assumptions about healthcare spending being in some way matched to burden of disease). It is possible that this assumption is not valid (as noted by one respondent). The burden of disease refers to death and disability arising from the condition; it makes no reference to expenditure. Our argument is merely that those health states that are more burdensome should receive more of the healthcare dollar.

The comparison between MH and AOD is however complicated by the substantial overlap between these two conditions. As noted by one respondent to the Review: "some MH funding is used to treat some AOD disorders (especially those co-occurring with MH diagnoses) (in GP, some hospital and other settings and through the Better Access scheme for example). This means the separation between MH and AOD treatment funding for the purposes of this comparison creates the implication that MH funding is used to treat only non-AOD related MH problems and is therefore potentially artificial and misleading".

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[39] 6.2% of the general population had any affective disorder, 14.4% any anxiety disorder (20% in total, notwithstanding dual diagnosis), whereas the population prevalence of any substance use disorder was 5% (Slade et al., 2009a).

It is salutary that despite the substantial difference in the quantum of funding between MH and AOD, the split between the source of funding (two levels of government) is almost identical. Commonwealth spending on MH represents 36.5% and state/territory spending on MH 63.5% (Steering Committee for the Review of Government Service Provision, 2014). In this instance both MH and AOD differ from health care spending more generally across Australia; as noted earlier Steering Committee for the Review of Government Service Provision (2014) reports a 60:40 split between Commonwealth and states/territories. Duckett & Willcox (2011) likewise report that the Commonwealth government investment (at 43%) is larger than the state and local government investment (26%).

For those interested in how Australia compares to other countries in relation to the split of funders, data are available for the USA regarding AOD treatment funding. Horgan & Merrick (2001) reported that, for 2003, the US federal government contributed 15% (through block grant programs), the public insurance schemes (Medicaid and Medicare) contributed 23%, private insurance contributed 10% and state governments contributed 40%. The European Monitoring Centre for Drugs and Drug Addiction (European Monitoring Centre for Drugs and Drug Addiction) report on financing of drug treatment services in Europe shows the diversity of funding sources. Some countries such as Portugal fund all drug treatment through the central government; other countries such as the Czech Republic fund drug treatment through central government, local/regional government, social health insurance and private sources (see Figure 2, page 10). Given the diversity of arrangements across the globe, it is difficult to draw any definitive comparisons between Australia's funding arrangements and those of other countries.

This is the first attempt to analyse the amount of money spent on AOD treatment in Australia. As such it should be seen as the beginning of a research agenda. Clearly MH services have had a much more sophisticated and comprehensive approach to measuring the MH expenditure in Australia than AOD has (as reported in the Steering Committee for the Review of Government Service Provision, 2014). We can aspire to such reporting in the future. We are not able to comment on:
- The effectiveness or efficiency of the investment mix
- Trends in the investment amount over time (or trends in the investment mix).
This requires a different research agenda.

We reinforce that while extensive work has gone into the estimates provided here to facilitate better understanding of AOD treatment funding in Australia, it is a first attempt. We strongly encourage further research to enable improved estimation of the amounts of funding for AOD treatment in Australia, not confined to health and built from better data sources when they become available.

Limitations
As extensively detailed in Working Paper # 7, there are a number of caveats and limitations to this analysis. We summarise the most important ones here, but the reader is referred to Working Paper # 7 for the full details. The limitations include:
- The various estimates may include activities broader than treatment. For example, the NGOTGP and SMSDGF include capacity building and supporting treatment functions.
- The individually collected state and territory data represented a variety of methods. In some instances, detailed information about every grant, or program was made available. In other cases total AOD treatment spending was made available. Thus, there may be some inconsistencies in what was included.
- The hospital estimates relied on DRG codes rather than the ICD-10 codes in order to try and separate out hospitalisations where AOD was the principal diagnoses from those where AOD treatment was actually provided. We are not sure whether this strategy has worked. It is

- possible that our figures remain over-inclusive, and hence the hospital funding estimates are greater than in reality.
- The medical service estimates not funded by state health departments focussed on GPs in primary care and excluded specialist Medicare services provided by psychiatrists and physicians. Many clients with AOD problems see a psychiatrist or physician, rather than a GP. These are not captured here
- The analyses using the BEACH data (Medicare estimates, PBS estimates, pathology estimates and client co-payments based on healthcare card holder status) assume that the BEACH sample is representative of GP presentations for AOD.
- Not all private costs could be included
- Estimates for philanthropy were difficult. Detailed analysis of the extent to which AOD services, and which types of services rely on private donations and philanthropy is an important consideration for the viability and sustainability of the AOD treatment sector in Australia.
- The above estimates do not include capital works funding, yet capital works is a vital part of providing AOD treatment, especially for residential services. Future assessment of AOD treatment funding in Australia should consider how to appropriately estimate capital works costs. On a related but distinct point, housing services are another cost associated with the provision of AOD treatment services (where the capital asset is not owned by the agency). Housing services provide funds to enable residential care for people in AOD treatment. These have not been included.
- As noted elsewhere, private hospital services (not recorded within the national hospital minimum dataset) have not been able to be included. Likewise AOD treatment funded by Department of Social Services (federally) or state-based departments of social services/family services/community services.

We reinforce that while extensive work has gone into the estimates provided here to facilitate better understanding of AOD treatment funding in Australia, it is a first attempt. We strongly encourage further research to enable improved estimation of the amounts of funding for AOD treatment in Australia, not confined to health and built from better data sources when they become available.

Conclusions

We have found that:

- Compared to the prevalence rate of AOD problems in Australia and the extent of the burden of disease from AOD problems, the investment in AOD treatment appears small.
- The overall expenditure on AOD treatment in Australia, inclusive of both specialist and generalist AOD treatment was estimated at $1.261 billion.
- From this total, the Commonwealth's contribution is 31%; state/territory governments' contribution is 49% and private contributions is 20%.
- If we remove the private contribution (philanthropy and client co-payments), the Commonwealth contribution is 39% and the state/territory contribution is 61%, and the total expenditure is $1,007,977,579.
- Examining just government funding ($1 billion), 55% of all government funding is in specialist AOD treatment and 45% is in generalist AOD treatment.
- The Commonwealth plays a vital role in funding the specialist sector – their contribution represents 21% of all specialist AOD treatment funding in Australia (the states/territories 79%).

Chapter 5: The Commonwealth AOD treatment grant schemes – the NGOTGP and SMSDGF

As noted earlier, the Review aims to deliver options for a set of planned and coordinated funding processes for future Commonwealth AOD funding rounds. The focus is on the NGOTGP and the SMSDGF. As seen in Chapters 3 and 4, the Commonwealth invests in alcohol and other drug treatment through a number of programs: GPs and allied health professionals providing alcohol and other drug interventions (funded under Medicare); medications used in the treatment of alcohol and other drug problems (funded through the Pharmaceutical Benefits Scheme); and hospital AOD treatment (funded through the National Health Funding Pool). These other funding sources provide an important context for understanding the specialist AOD treatment investment by the Commonwealth through the NGOTGP and the SMSDGF. This chapter provides the details of the two grant schemes.

The NGOTGP and SMSDGF combined represent 10% of the total Australian investment in AOD treatment. As a proportion only of the Commonwealth investment, it is around 33% - this is surprisingly large when one considers that the other Commonwealth investment includes Medicare, PBS, and hospital funding directed towards AOD treatment. This makes the NGOTGP and SMSDGF significant contributors to the Commonwealth's commitment to AOD treatment.

The descriptions of the NGOTGP and SMSDGF provided in this Chapter focus on a particular point in time – the 2012 funding round for the NGOTGP and SMSDGF. We detail the documentation at that time and the current grant amount details. The data sources used for this work included: information from the Department of Health website; the respective fund Guidelines and Invitation to Apply (ITA) documents[40]; media releases and research reports; the publically listed grant holders records (for example Senate Order (Murray Motion): http://www.health.gov.au/internet/main/publishing.nsf/Content/health-contracts-index.htm and DoH grants reporting: (http://www.health.gov.au/internet/main/publishing.nsf/content/pfps-grantsreporting); and data obtained from the Commonwealth. Details can also be found in Working Paper # 4.

We note that since the Review commenced, there have been changes to the machinery of government. At the commencement of the Review (July 2013), the two grant schemes were managed by the Substance Misuse and Indigenous Wellbeing Branch. The current arrangements are that the NGOTGP and the non-Aboriginal and Torres Strait Islander components of the SMSDGF are managed by the Drug Strategy Branch, and the Aboriginal and Torres Strait Islander components of the SMSDGF (Priorities 2, 3 and 4 of the Fund) have been transferred to Prime Minister and Cabinet (PM&C). An additional change has been the establishment of the Grant Services Division within the Department of Health, which is now responsible for grants management. Prior to this the Branch oversaw the implementation of the grant schemes, with the Commonwealth state and territory offices (STOs) managing the contracts.

This chapter proceeds as follows:
- Overview of the NGOTGP fund amounts and grant processes;
- Overview of SMSDGF fund amounts and grant processes;
- Analysis of organisational co-funding between Commonwealth and states/territories;

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[40] As we understand it, Guidelines to the funds are general documents which cover the fund purposes, objectives, and some of the application processes. The ITA's, however, are specific to a certain funding round, even though they cover some of the same material as appears in the Guidelines. The two ITA's referred to herein were the ones used for the 2012 rounds.

- What is being purchased: description of treatment and capacity building;
- Investment mix by the Commonwealth; and concluding with
- Relationship between the Commonwealth and state/territory investments

The Non Government Organisation Treatment Grants Program (NGOTGP)

The NGOTGP "funds non-government drug treatment services across Australia to increase the number of treatment places and improve treatment for people with drug and alcohol problems" (Department of Health website: 19/8/13).

The NGOTGP has been in operation since 1997. There were three funding rounds prior to the 2012 round. The first funding round (1998-2002) allocated $58m over four years (representing about $14.5m per annum). The second funding round (2003-2008) allocated $99.4m (approximately $19.8m per annum); the third round (2008-2011) allocated $134.4m (approximately $44.8m per annum)[41].

The NGOTGP is an "ongoing initiative" (as noted on the Department of Health website: https://www.health.gov.au/internet/main/publishing.nsf/Content/drugtreat-ngotgp, accessed 24/1/14) and as specified in the NGOTGP Guidelines (nd)[42]. The Guidelines note that the amount available "for 2012/13 to 2014/15 is $125 million". This suggests approximately $41.6m per annum is available funding "at the discretion of the Department" (NGOTGP Guidelines, p. 3).

We used five data sources to analyse the current NGOTGP funding: data provided by the Commonwealth Department of Health (organisation name, funded amount, location); data received from the State/Territory Commonwealth offices (as above but included service types funded and further details by individual organisation); the publically listed NGOTGP grant recipients on the Health website; the list of grantees provided publically (organisation, amount) in the Murray motion (http://www.health.gov.au/internet/main/publishing.nsf/Content/health-contracts-index.htm); and the Department of Health published grant list (http://www.health.gov.au/internet/main/publishing.nsf/Content/pfps-grantsreporting). Unsurprisingly, none of these data sources accord perfectly with each other – this is likely due to slight contract variations, timing of the data availability, whether GST is included or excluded, whether per annum amounts or three year lump sums are reported, and so on. Given that the data sources provide different types of data, we have combined and analysed the most appropriate data source for the area of analysis. This means that ranges are reported in some instances, and the exact figures (to the dollar) are not readily ascertainable.

That being said, the NGOTGP has provided funding to the value of between $48,013,938 and $60,377,024 for 2012/2013 (See Table 5.1). One of the reasons for the variation in amounts may simply be due to timing associated with the data (for example, the spreadsheets provided to the review team in August 2013 would not include grants which had been approved but not yet formally contracted). An additional complexity is that some of the NGOTGP grants were listed as SMSDGF because this was the source of the funds (even though they are part of the NGOTGP scheme).

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[41] The figures for the previous NGOTGP funding rounds were taken from the Siggins Miller Evaluation of the NDS Vol 2, page 33. There are various figures available which do not necessarily match those in the text, hence the figures should be read as approximations only.

[42] The NGOTGP Guidelines have no date on them, but the version we refer to here is the one that was used in the 2012 funding round.

Table 5.1: NGOTGP funds for 2012/2013

Data source		Notes
Original spreadsheet provided to the review team (Aug 2013)	$49,476,157	
Data provided to review team by the STO's	$48,013,938	
As listed on the Murray motion (pro rata yrs)	$49,306,020	$54,236,622 incl GST
As listed on the DoH grants list	$60,377,024	$66,414,726 incl GST

Given that the majority of contracts are for three years, it is expected that the amounts for 2013/2014 and 2014/2015 would remain in the same range (suggesting a total of $147,000,000 over three years).

One hundred and seventy-one individual projects were funded under the 2012 NGOTGP round and these projects are provided by 122 unique organisations (23 organisations received more than one grant – in most cases these organisations received 2 or 3 grants). The average (mean) size of each NGOTGP project grant is $289,000 per annum.

The proportion of the NGOTGP 2012 funding round distributed between the jurisdictions is shown in the Table below:

Table 5.2: Jurisdictional distribution of NGOTGP funds (2012/13)

Jurisdiction	% of NGOTGP funds	% of Aust population (ABS data – 2011 census)
CW	4%	n.a. (100%)
NSW	32%	32%
NT	3%	1%
QLD	17%	20%
ACT	5%	2%
SA	9%	7%
TAS	4%	2%
VIC	20%	25%
WA	7%	10%
	100%	100%

Source: Commonwealth data; also available through Murray motion.

In the 2012 funding round, every jurisdiction received some NGOTGP funding, consistent with a national mandate. The distribution by jurisdiction was not driven by an explicit formula (as was the case in past NGOTGP rounds), although there appears to be some concordance between the distribution and the Australian population (as shown in last column of Table 2.1).

The overall objective of the fund is to increase the number of treatment places available and strengthen the capacity of treatment providers to achieve improved service outcomes (NGOTGP Guidelines). Key objectives are listed as:
"1. Improve drug and alcohol treatment services outcomes
2. Increase the number of treatment places available
3. Fill geographic and target group gaps." (NGOTGP Guidelines, page 5).

The guidelines further specify that "projects funded under the NGOTGP must:
- Provide capacity for reducing and treating illicit drug use;
- Be informed by evidence and use models of good practice;

- Improve physiological and psychological health; and
- Improve social functioning for people attending treatment for substance misuse" (NGOTGP Guidelines, p. 5).

The funding guidelines have some internal inconsistency, for example (p. 5) "Projects funded under the NGOTGP must: provide capacity for reducing and treating illicit drug use" which suggests the fund is focused on illicit drugs rather than alcohol. However later the key objectives specify "improve drug and alcohol treatment service outcomes" (p. 5) and the fund is clearly inclusive of alcohol and other drugs.

Grants may cover, but are not limited to, "counselling, outreach support, peer support, home detoxification, detoxification and withdrawal, rehabilitation, therapeutic groups or communities" (NGOTGP Guidelines, p. 4).

Specific priority areas for funding were not listed in the Guidelines. The priority areas/objectives of the fund were not revised in the 2012 round of competitive tendering.

The NGOTGP Guidelines specify that, "funds will be made available through an open grant round" (p. 3). There are no alternate funding mechanisms (such as targeted rounds) listed in the Guidelines, which is an important difference to the guidelines for the flexible funds that include the option of open, targeted, one-off and procurement mechanisms.

There are mandatory requirements in the Guidelines (p. 10), which comprised the first level of assessment in the 2012 funding round. These mandatory requirements were:
- That the application addresses all procedures for submitting an application;
- The application is from an organisation that is eligible for funding (see below);
- The capacity of the applicant and of the proposed project meets the key objectives and aims of the NGOTGP Program;
- That the applicant exhibits financial viability – through provision of the applicant's audited financial statement and profit & loss statement for the previous financial year;
- That the applicant identifies the type(s) and level(s) of insurance held by the applicant.

The NGOTGP Guidelines specify that an eligible organisation must be a "non government organisation" (p. 4). The examples provided in the Guidelines comprise, "a non government organisation; an incorporated body under state/territory legislation; or a community based not-for-profit organisation" (p. 4). However in the more detailed ITA, and specific to the 2012 grant round, applicants had to select the most appropriate descriptor for their organisation. The list included:
- Incorporated associations
- Incorporated cooperatives
- Companies – "may be not-for-profit or for-profit proprietary company"
- Aboriginal corporations
- Organisations established through a specific piece of commonwealth or state/territory legislation
- Partnerships
- Trustees on behalf of a Trust
- State/territory or local government
- Where there is no suitable alternative, an individual or jointly or separately individuals
- Other

There may have been confusion in the sector about eligibility under NGOTGP (see also summary of questions asked in the Addenda, Working Paper # 4).

Three assessment criteria were provided in the ITA for the 2012 round: need; organisational capacity; and sustainability.

> Criterion 1. Need: within this first criterion, applicants were asked to provide details of the project aim, type of treatment (residential treatment program; non-residential treatment program; counselling, outreach, aftercare, referral, abstinence only: ITA p. 4) and respond to the question "How will the treatment service meet the needs of the target group" (limited to 500 words). Other questions under Criterion 1 concerned project objectives, activities and indicators, as well as the identification of the catchment area and other AOD service availability; consistency with the National Drug Strategy; and consistency with state/territory treatment guidelines.

> Criterion 2. Organisational capacity: this criterion required applicants to outline organisational governance, accreditation, staffing and recruitment; and outcomes from previous service delivery grants.

> Criterion 3. Sustainability: applicants were required to provide comment on whether the proposal was dependent on other funding applications; and how the proposed project outcomes would be sustainable and "can be continued after the NGOTGP funding is expended".

The assessment process documented in the NGOTGP Guidelines for the 2012 round involved three stages. The first stage was a compliance check (see mandatory requirements above); the second stage was a Departmental "Application Assessment Panel" which assessed applications against the NGOTGP objectives and outcomes. The third stage was a Departmental Delegate consideration of whether the application makes an "effective, efficient, ethical and economical" use of Commonwealth resources. The final decision for NGOTGP funds allocation is made at a Departmental (not Ministerial) level.

The standard contract for NGOTGP grants conforms to the usual Commonwealth Government Deed for Multi Project Funding. The Schedules within this Deed cover each individual project. The project period specified in the template for the 2012 round was 1 July 2012 to 30 June 2015.

The 2012 open round was for contracts "initially for one year with an option to extend for a further two years, at the discretion of the Department" (p. 3, NGOTGP Guidelines). Despite the one-year funding, applicants were required to submit a three-year budget in their applications. The contracts as listed on Departmental websites are in the main for three years of funding (with some minor exceptions for one-off projects and a number of 3.5 year grants). The competitive tendering process for the latest round effectively conformed to the process undertaken with the SMSDGF (see details below). This varied from previous NGOTGP funding rounds (as documented in the Siggins Miller case study of the NGOTGP, Evaluation of the NDS, Volume 2, p. 30-46: http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/consult-eval-vol1) where both national and state reference groups oversaw the competitive tendering processes, and state/territory representatives were engaged in the selection processes.

The timelines for the last NGOTGP funding round (ITA No 106/1112) were as follows:
Tenders opened on: Monday 14th November 2011
Tenders closed on: Friday 23rd December, 2011 at 2.00pm

After the funding round concluded and organisations were advised of the outcomes in early 2012, the sector voiced concern; it appeared that sector gaps had been created as some submissions from

existing services were not successful. The processes that occurred at this time to redress this, with some services in this category being refunded, was very complicated. Based on the data we collected and interviews conducted, the Review team could not readily describe the processes that were undertaken. The grants provided to these previously unsuccessful applicants were referred to as "extensions" to existing funding, and were noted to be essential in filling gaps that had inadvertently been created through the competitive grants process.

The Guidelines stipulate that "the performance of organisations will be assessed against the funding agreement requirements and the objectives and aims of the NGOTGP" (NGOTGP Guidelines, p. 5).

The Guidelines detail the reporting requirements for funded services. The Guidelines state that the timing of progress reports and associated milestones "will be negotiated and form part of the final contractual arrangement" (p. 6). They may include:
- Annual plan and budget, program activities and associated budget allocations;
- Reporting against program objectives and outcomes;
- Progress reports (3 or 6 monthly);
- Audited financial reports; and
- Evaluation reports.

Provision of data to the Alcohol and Other Drug Treatment Services – National Minimum Data Set (AODTS-NMDS) is "compulsory for all funding recipients", and this is specified in the ITA and in the Deed.

The services that were funded under the 2012 grants round for the NGOTGP largely commenced contracts 1st July 2012, although there are a range of commencement dates between July 2012 and December 2012. In terms of end dates, for the NGOTGP, the vast majority (114 projects) conclude on the 30th June, 2015, however 49 projects (Victorian) conclude in January, 2016. (There are also a few projects that were for shorter periods than three years).

The Substance Misuse Service Delivery Grants Fund (SMSDGF)

The SMSDGF was created in 2011. The establishment of the 'flexible funds' (n=18) in 2011 across all areas of the then Department of Health and Ageing sought to consolidate the 159 different health and ageing programs, with a goal to "reduce red tape, increase flexibility and more efficiently provide evidence based funding for the delivery of better health outcomes" (Department of Health and Ageing website, flexible funds, accessed 19/8/13). The creation of two flexible funds for substance misuse (SMSDGF and SMPSIG) consolidated a number of pre-existing programs.[43]

The funds that were combined to create the SMSDGF were:
- COAG Mental Health - Improved Services for People with Drug and Alcohol Problems and Mental Illness;
- National Illicit Drugs Strategy – Community Education and Information Campaign;
- National Illicit Drug Strategy - Indigenous Programs;
- National Tobacco Campaign – More Targeted Approach;
- Substance Use:
    - Base Funding
    - COAG Substance Use 06 Program
    - COAG Substance Use 07 Program
    - Opal Fuel Rollout.

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[43] The NGOTGP remains outside the flexible funding pool structure at this time.

Source: http://www.health.gov.au/internet/annrpt/publishing.nsf/Content/annual-report-1112-toc~11-12part3~11-123.6 (accessed 24/1/14).

The SMSDGF priorities reflect the above amalgam of previous programs. The priority areas (as listed in the SMSDGF Guidelines, p. 3-4) are:

> Priority 1: "supporting non-government drug and alcohol treatment services to deliver quality, evidence based services and build capacity to effectively identify and treat coinciding mental illness and substance misuse"
> Priority 2: "assisting indigenous communities to provide service delivery"
> Priority 3: "supporting those services targeting ATSI people"
> Priority 4: "reducing the prevalence and impact of petrol sniffing"
> Priority 5: "supporting people from culturally and linguistically diverse backgrounds"
> Priority 6: "supporting the development and implementation of a range of social marketing campaigns".

The amount in the SMSDGF was given as $559.4m over 4 years (SMSDGF Guidelines, 2011, p. 5). Given that the flexible fund includes some non-treatment related funds (as per above: Community education and information campaign – Priority 6; tobacco campaign – Priority 6; opal fuel rollout – Priority 4), for our purposes, we consider only those parts of the SMSDGF that are directed towards treatment: that is Priorities 1, 2, 3 and 5[44] (or from the fund history: COAG Mental Health ISI; NIDS Indigenous programs, COAG Substance Use 06 and COAG Substance Use 07). If the Community Education and Information Campaign, Tobacco Campaign and Opal fuel rollout are excluded from the fund quantum, it results in approximately $100m for treatment per annum, with a priority focus on services for Aboriginal and Torres Strait Islander peoples[45]. The Guidelines themselves also make clear that existing activities have already been committed from the SMSDGF and as such "approximately $392.4m is already committed for the period 2001/12 to 2014/15" (p. 7).

As with the NGOTGP analysis above, five data sources were used to analyse the current SMSDGF funding: data provided by the Commonwealth Department of Health (organisation name, funded amount, location); data received from the State/Territory Commonwealth offices (as above but included service types funded and further details by individual organisation); the publically listed SMSDGF grant recipients on the Health website; the list of grantees provided publically (organisation, amount) in the Murray motion (http://www.health.gov.au/internet/main/publishing.nsf/Content/health-contracts-index.htm) and the Department of Health published grant list (http://www.health.gov.au/internet/main/publishing.nsf/Content/pfps-grantsreporting).
As for the NGOTGP, none of these sources accord perfectly with each other. That being said, the SMSDGF has provided AOD treatment funding (Priorities 1, 2, and 3) to the value of between $77,852,081 and $83,365,856 for 2012/2013, as shown in Table 5.3.

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[44] No Funds were allocated under Priority 5 in the 2012 funding round.

[45] This amount can be cross-checked via examination of the original allocations to the various pre-existing programs that were combined to form the Fund. Thus, the MH ISI was $73.9m over five years (from 2006/7 budget papers: http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2006-hfact14.htm). The COAG 06 amounts were $130m + $49.3m over four years; and $50m for COAG 07: http://www.comorbidity.org.au/sites/www.comorbidity.org.au/files/OATSIH%20Substance%20Use%20Program_0.pdf. If we take into account the numbers of years for the various initiatives and sum across them, the annual amount comes to $109.58 per annum, in the ballpark of the $100m p.a. listed in text. It is not possible to more accurately detail the original funding amounts and the subsequent amounts by SMSDGF priority areas.

Table 5.3: SMSDGF 2012/2013 funding amounts

Data source	Amount	Notes
Original spreadsheet provided to the review team (Aug 2013)	$79,994,748	
Data provided to review team by the STO's	$77,852,081	
As listed on the DoH grants list	$83,365,856	$91,702,441 incl GST

Within the relevant treatment priority domains, the proportion of funds between the Priorities is 70% Priorities 2 and 3 – Aboriginal and Torres Strait Islander AOD services (consistent with the pre-existing fund sources (COAG 06 and COAG 07) and 30% to Priority 1, as shown in Table 5.4.

Table 5.4: SMSDGF Funds by Priority

Priority	Amount	%
Fund P 1	23,461,284	29%
Fund P 2&3	56,312,052	71%
	79,994,748	100%

There are currently 303 individual projects, which include those funded under the 2012 funding round and those funded via unsolicited proposal and targeted approaches to market since the 2011 SMSDGF establishment. 127 projects are listed for the Priority 1; and 176 listed for Priorities 2, 3 and 4. Projects are provided by 197 unique organisations (the majority of organisations with more than one SMSDGF grant are Aboriginal and Torres Strait Islander services, under Priorities 2 and 3). The average (mean) size of each SMSDGF project grant is $264,000 per annum.

The spread of SMSDGF funding across jurisdictions is shown in Table 5.5.

Table 5.5: Distribution of SMSDGF funding between jurisdictions (2012/2013)

	% of SMSDGF funds (Priorities 1,2,3 and 5)	% of Aust population (ABS data – 2011 census)
CW	1%	n.a.
NSW	22%	32%
NT	18%	1%
QLD	20%	20%
ACT	1%	2%
SA	8%	7%
TAS	3%	2%
VIC	12%	25%
WA	15%	10%
	100%	100%

Source: Commonwealth data

Every jurisdiction received SMSDGF funding, consistent with a national mandate. As would be expected given that the majority of the SMSDGF fund are dedicated to Aboriginal and Torres Strait Islander AOD services, the proportion to the NT is substantially higher than population distribution.

The Guidelines note that the SMSDGF is "an ongoing initiative available from 1 July 2011" (p. 6).

The primary objective of the SMSDGF is to "better promote and support drug and alcohol treatment services across Australia to build capacity and to effectively identify and treat coinciding mental illness and substance misuse" (p. 3, Guidelines, 2011).

The six priority areas (see above) were referred to in the 2012 funding round; and they reflect the history of the flexible fund establishment, rather than considerations of new or alternative priorities[46]. The Guidelines also note that priorities and activities for the SMSDGF are not limited to the above six priority areas. This is consistent with the intention that the flexible funds frameworks must have the scope to be flexible.

The Minister is able, annually, to determine the priority areas (SMSDGF Guidelines, p. 7).

The mechanisms that are available for the distribution of funds (from Flexible Fund Guidelines, Nov, 2011) include:
1. Open competitive grant rounds, which are expected to be "the main funding avenue".
2. Targeted grant rounds; used "from time to time" open to "a small number of potential funding recipients" based on specialised requirements.
3. One-off/unsolicited funding, for example emergency payments and one-off unsolicited proposals (given that they meet fund objectives).
4. Procurement: "procurement of work directly related to the purpose of the Fund" (the example given is program evaluation); "Procurement processes will be conducted independently of any grant process".

Since the creation of the SMSDGF, it appears that open, targeted and 'one-off' approaches have all been used, although the distinction in practice between targeted and 'one-off' may be difficult to tease out. For Priority 1, it appears that all these funds were subject to open tendering processes. For Priorities 2 and 3 (Aboriginal and Torres Strait Islander AOD treatment services) it appears that these funds were targeted/one-off. This is because the majority of the Aboriginal and Torres Strait Islander funded services had been previously funded (before the flexible fund process was established), hence contracts were rolled over/extended/continued under the new SMSDGF (note: existing commitments under all the flexible funds have been maintained).

Not all SMSDGF funds were distributed in the 2012 round of re-contracting or competitive tendering. The flexible funds were created to ensure that government had the capacity for flexibility. Some existing grants were continuing and some funds were retained to use as contingency when gaps and unmet needs were identified. Capital works for Aboriginal and Torres Strait Islander services were also funded out of SMSDGF - only where related to drug and alcohol treatment services. The SMSDGF Guidelines (p. 9) note that under-expenditure will be monitored and funds may be made available through unsolicited proposals, one-off grants or grants to services that had not been successful previously.

Eligible applicants for the SMSDGF are both government and non-government entities, and may include:
- Incorporated associations
- Incorporated cooperatives
- Companies – "may be not-for-profit or for-profit proprietary company"
- Aboriginal corporations
- Organisations established through a specific piece of commonwealth or state/territory legislation

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[46] It is not clear whether the funds allocated to each priority area were quarantined based on the original funding source.

- Partnerships
- Trustees on behalf of a Trust
- State/territory or local government
- Where there is no suitable alternative, an individual or jointly or separately individuals.

In the SMSDGF Guidelines, it notes that applicants in an open funding round for SMSDGF need to demonstrate:
- Identified need
- Relevance to current government policies and priorities
- Value for money
- Capacity to deliver quality outcomes.
  (Fund Guidelines, Nov 2011, p. 9).

The Fund Guidelines (p. 10) note that Assessment panels will be established to assess applications and then provide advice to the "Funding Approver", who will consider whether the proposal makes an "efficient, effective, ethical and economical use of Australian government resources" (p. 10). The final decision for SMSDGF grants is made by the Minister (or his/her departmental delegate).

Threshold Criteria specified in the ITA (p. 18) for the 2012 round were the demonstration of the organisation's "capacity, expertise and infrastructure to effectively undertake the proposed project". In 2012, each application was rated (on a five point scale) against the threshold criterion, with a minimum score of 2 (out of 5) representing "good quality", and allowing the application to proceed to the next stage of assessment.

There were four assessment criteria: Need; Capacity to deliver; Sustainability and Organisational capacity.

1. Need. Applicants had to describe existing alcohol and other drugs services that they provide, nominate the activities proposed to be funded, the target population group and how the proposal "meets the needs of the target group" (500 words). As with the NGOTGP there were also questions in relation to consistency with the National Drug Strategy; consistency with state/territory treatment guidelines; and other organisations and stakeholders. The SMSDGF also included questions about "unmet community need(s)" that the proposal would address; how those needs have been assessed and how the proposal "complements other similar services, activities and resources in the Applicant's local area".

2. Capacity to deliver the project. Applicants were asked to provide information about the project objectives, activities, timelines and measures to achieve the objectives as well as their financial management expertise and monitoring and reporting activities.

3. Sustainability. This criterion required applicants to identify if the proposal was dependent on other funding submissions and to identify how the "project outcomes are sustainable and can be continued after the SMSDGF funding is expended".

4. Organisational capacity. To address this criterion, applicants had to describe the governance of their organisation, accreditation, staffing (qualifications) and staff recruitment, outcomes of previous grants and the organisation's capacity to comply with reporting requirements.

In addition to the specific assessment criteria as detailed in the application form, the ITA also stated (p. 8) that "In assessing an Application ... the Fund Assessment Panel may consider the Applicant's financial viability and the risk of the Application", and that the Panel may seek any information from

any other source, whether or not the individuals or organisations are nominated as referees (p. 8). Contact details for two referees were requested from applicants for the 2012 SMSDGF funding round.

Attachment A1 of the Fund Guidelines (Nov 2011)[47] provides more details of the priority areas, including potential activities, the broad assessment requirements, and "specified" selection criteria.

> *Potential activities.* In the case of Priorities 1 and 5, the documentation notes that activities can range across any number of capacity building activities, such as workforce development, engagement of consumers, policy and procedural review and implementation, secondary consultation, and strengthened partnerships. For Priorities 2 and 3 the range of activities includes all possible alcohol and other drug interventions (e.g. detoxification, treatment and rehabilitation programs, community education, sobering up services, family-based therapy) and capacity building activities.

> *Specified selection criteria.* The 'specified' selection criteria for Priority 1 & 5 are "proven performance in providing evidence-based treatment to people with alcohol or other drug problems"; and "ability to undertake capacity building, service and/or quality improvement activities…". The 'specified' selection criteria for Priorities 2 and 3 are "proven performance in providing evidence based treatment to Aboriginal and Torres Strait Islander people" and "able to competently implement and manage the funded activities".

A particular focus for the SMSDGF under Priority 1 was capacity building. The guidelines specified a range of potential capacity building activities including:

- A range of capacity building, service and/or quality improvement activities (to effectively identify and treat coinciding mental illness and substance misuse) for implementation within non-government drug and alcohol treatment services such as:
    - workforce training and development (for both clinical and non-clinical staff);
    - accessing professional support (e.g. clinical review, case conferencing, secondary consultation, access to clinical psychological services);
    - revising and implementing relevant policies and procedures including screening and assessment, intake and referral, and occupational health and safety; and
    - involving consumers in treatment planning.
- A range of activities to develop sustainable partnerships with the broader health network such as:
    - developing and/or strengthening linkages/partnerships with the wider health, social and community service network, such as GPs, mental health, and supported accommodation organisations; and
    - dissemination of best practice policies and procedures (through drug and alcohol non-government peak bodies) (p. 13).

The Invitation to Apply (ITA) used for the 2012 round covered some of the same material as the SMSDGF Guidelines (not repeated here) and it noted that organisations could only apply for one grant under the 2012 funding round (ITA, p. 5). This clause was subsequently deleted (Addendum No. 1, issued 21/11/2011). In the 2012 round, SMSDGF funds were available for up to three years.

The standard contract for SMSDGF funding conforms to the usual Commonwealth Government Deed for Multi Project Funding. The Schedules within this Deed cover each individual project.

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[47] As footnoted earlier, the Guidelines appear to be the more generic document, whereas the ITA provided specific details for the 2012 funding round.

For the 2012 funding round, applications opened on 14 November, 2011 and closed on 23 December, 2011. No information sessions were held regarding the 2012 SMSDGF funding round.

The SMSDGF Guidelines state that, "payments will usually be made on achievement of agreed milestones" (p. 11). The milestones in the template Deed for Multi Project Funding include a project plan, progress reports and annual reports (on execution; receipt and acceptance of project plan, progress reports and annual reports, p. 40-41 Deed for Multi Project Funding).

Provision of data to the AODTS-NMDS is noted in the ITA – applicants were asked whether the organisation can collect the AODTS-NMDS (there is an option for *not applicable*). In the Deed template, the Schedule specifies that participants will collect AODTS-NMDS (Clause A.7.1).

Statements of income and expenditure are required every six months and audited financial statements are required annually (Deed for Multi-Project Funding).

For the services that were funded under the 2012 grants round for the SMSDGF, examining Priority 1 funds only (i.e. excluding the Aboriginal and Torres Strait Islander services), contracts largely commenced in July, 2012 (with a few commencing August and September of that year), with most concluding in June 2015, with the exception of what appear to be Victorian projects which conclude in January, 2016. (The contract dates were taken from the public domain Murray motion). We note that many of the Aboriginal and Torres Strait Islander services funded under SMSDGF P2 and P3 have contract end dates in June 2014.

Extent of organisation co-funding: Commonwealth and state/territory

These analyses attempt to examine in more detail the extent to which Commonwealth funded organisations under the NGOTGP and SMSDGF are also funded by state/territory health departments. We sought to examine the number (proportion) of individual organisations who are co-funded by both Commonwealth and states/territories and if possible examine the relative amounts of funding.

These analyses speak to several issues:
- The financial viability of individual organisations
- Sector sustainability
- 'Duplication' of funding.

At the outset it is important to note that according to our key informants in principle the Commonwealth has no concerns with jointly funding an organisation with the state/territory government. This is commonplace within the not-for-profit sector, especially amongst organisations that provide a range of health and/or social services. It is also the case that state/territory governments are responsible for and should provide the full array of AOD treatment services for their jurisdiction. Thus, in theory there should not be evidenced-based service types that are not funded by the states/territories.

It is important for the Commonwealth to invest in organisations that are financially viable. We take as an assumption that organisations that are co-funded by the state/territory health departments are more likely to be financially viable. The risk is shared between two levels of government. Notwithstanding the management and administrative challenges for an NGO, key informants advised that two funding sources are preferred (consistent with the notion that business viability is associated with diverse income streams). Co-funding also suggests that an organisation is providing effective services, to the extent that the decision by two separate government bodies to purchase

services from the same organisation reflects some quality assurance. Finally, co-funding provides Commonwealth leverage in relation to state/territory planning and purchasing. Thus , we view co-funding of an organisation as the preferred arrangement for the Commonwealth.

However, an alternate perspective is that there is higher risk with co-funding if the state/territory government withdraws its funding. This would leave the Commonwealth with the responsibility of maintaining the service (by substituting Commonwealth funds for state/territory funds) or funding the service to close down. The financial impact increases the larger the state/territory investment[48]. In the organisational co-funding scenario there is also a risk of over-burdening the organisation with dual-reporting requirements (inconsistent with Commonwealth Grant Guidelines – proportionality principle). Thus there are both relative advantages and disadvantages to co-funding between the Commonwealth and states/territories. Where the Commonwealth is the sole funder, there are also risks: if the Commonwealth decides not to continue funding the organisation it risks attracting the wrath of the public if the service closes as a consequence. The likelihood of closing depends on the ability of the organisation to source other funding; which likely depends on the size of the organisation and the amount of Commonwealth investment.

A related issue for co-funding is sector sustainability. We assume that it is important to have a clearly defined and high quality specialist AOD sector in Australia. To achieve that end, funds should be concentrated within specialist services and it is therefore sensible for both the Commonwealth and state/territory to fund the same organisations.

Two of the case examples undertaken as part of the Review (see Chapter 17) were with non-government organisations (Organisation A and Organisation B) both of whom are contracted to provide AOD services funded under the NGOTGP and SMSDGF. In these case examples (see Chapter 17 for full details) comments were made about the co-funding arrangements and the ways in which these organisations managed the process, as detailed in the text box below.

Case example: Organisation A and Organisation B – co-funding between the Commonwealth and state/territory
(the full case examples can be found in Chapter 17)

Organisation A
Within the organisation's financial management system different accounts are used to separately manage the range of different programs, and the organisation tries to reflect the true costs of that program in the account. It was noted that in the past the organisation used to "pull money" into programs from across the organisation, but now a more streamlined accounts management system is used to see how much each program actually costs. This system also ensures consistent quality standards across the organisation; regardless of how the program is funded, expectations of quality standards stay the same. Although programs are funded discretely, participants noted that flexible funding from trusts and foundations is used to "plug some of the gaps". Capacity building funding is also used "right across" the organisation to enhance professional development, supervision and training.

Over time the organisation has built up a single client and contract management system. This has streamlined reporting, particularly when clients are engaged in multiple programs across the organisation's activities. Interview participants noted that implementing a single electronic web based client management system across the organisation has been an improvement and said that the system leads to greater integrated care and case coordination across services. Importantly for funding requirements, the system also produces reports for funders so "we're not double handling data". The system has been developed such that reports can be generated in different formats for different departments and funders. The management system also has a grants management component whereby all the deliverables of a funding contract are logged into the system

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[48] This risk is lessened if there is cooperation, joint planning and information sharing between the two levels of government and if the Commonwealth and state/territory funding rounds are synchronised (albeit this has its own problems).

so every time an acquittal report is due it can be managed and deliverables can be easily tracked. (Given that the organisation is applying to over 100 trusts and foundations every year, and having 20-40 of those requests successfully funded, it was noted that it was essential to have systems for managing all these funding contracts at different stages). In one participants' opinion, the system makes managing the multiple funding environment possible.

Despite the sophistication and integration of the system developed by the organisation, it was noted by several participants that it would be beneficial for government departments to streamline funding reports and systems across the whole of government because reporting against multiple contracts with multiple government departments becomes "a nightmare".

The Commonwealth funding allows the organisation to provide 'wrap-around' services which produces better treatment outcomes. Overall, the participants suggested that there is definitely a role for Commonwealth funding of the AOD treatment sector, and that AOD treatment funding is not just a state/territory issue. As one participant noted, "AOD is a health issue. It is clearly in the realm of Commonwealth responsibility, and it should be driven by evidence based policy and practice, and not moral debates." It was suggested that the Commonwealth funding provides checks and balances, in "big picture, gap-filling" ways. Commonwealth funding provides an extra level of protection for clients to ensure there are not significant gaps.

Organisation B
The organisation's programs are funded separately, by distinct pockets of money, and separate financial statements are produced for each funding agreement. Participants noted however that "While we don't cross over the funds, we certainly cross over the activities". To explain this, participants noted that clients participate across multiple programs within the organisation, although the client would not realise this due to the integrated approach of the organisation. The organisation also works in an integrated way with other organisations and agencies to care for clients: "we all have to work together". Clients are referred to the organisation's AOD counselling service from other agencies as well.

The organisation maintains discrete funding streams for its various programs. The counselling service (NGOTGP funded) dovetails and 'taps into' the housing services offered by the organisation. In this sense, the Commonwealth funded AOD treatment programs complement and enhance the programs funded by the state – the state funding and the Commonwealth funding dovetail, in that the clients cross over.

By maintaining discrete funding for individual programs, if one source of funding was to cease participants felt that this would not restrict the overall service greatly. Staff positions are funded separately from the different funding streams, with designated positions attached to each funded program. Participants said that staffing was easier to manage this way. Even though all the programs intermix, the funding for each program stands alone. However, it was noted that the loss of any one source of funding would lessen the integration for the client. Although the funding does not cross programs, the clients do. Clients get the benefit of multiple funding sources, even though in practice the funding streams are kept very separate within the financial arrangements of the organisation.

Other service provider key informants noted the complexities and challenges with co-funding (eg reporting arrangements) and the need to adopt and adapt systems to make it work, but on the whole there was strong support for co-funding. (This issue is also taken up in Chapter 6 and Chapter 14 where the option of transferring the funds to state/territory governments for single-funder purchasing is explored).

In summary there are both risks and benefits to the Commonwealth in co-funding organisations with states/territories; there are also risks and benefits associated with the Commonwealth being the sole funder. From an organisational financial viability and sector sustainability perspective, the benefits of co-funding appear to outweigh the risks.

The third issue is duplication. As we note elsewhere (Chapter 12), there are a number of definitions of duplication. Here we are concerned with funding duplication ('double dipping'). The distinction between an organisation and a project/service is critical here. The analyses that follow examine the number of organisations that are co-funded. The data available on individual projects are less robust (as will be seen later in this Chapter). Where both the Commonwealth and state/territory government purchase the same project/service, from the same organisation this could be interpreted as duplication. However, what becomes clear is that 'service' may mean "counselling services" or "residential rehabilitation" but the specific funds from the two levels of government make a separate and unique contribution to the whole (see later discussion about residential rehabilitation, and distinct components purchased by different funders). Additionally, assuming the absence of inappropriate use of funds by an organisation, it is difficult to see how 'duplication' can apply to AOD services given the significant unmet demand for treatment. Thus, the state/territory could fund the same organisation to provide the same services as funded by the Commonwealth and the organisation could as a result of the additional funds, expand the service through for example extending the opening hours; employing another staff member, creating new beds and so on. This is not duplication inasmuch as additional services, more episodes of care or greater service accessibility are achieved with the additional funds. (Clear delineation of the additional direct care provided as a result of the co-funding is essential). Thus, in summary co-funding is seen as positive for three reasons: it provides some assurances about organisational financial viability, it increases the amount or nature of the services that any one organisation can provide and it supports a sustainable specialist sector. There are nonetheless risks for the Commonwealth which can be mitigated by careful planning and co-operation between the funders.

We take as our starting point the Commonwealth data provided to the Review team regarding the organisations funded (by jurisdiction, and by NGOTGP, SMSDGF P1 and SMSDGF P2&3). That is, we know that there are many more organisations funded solely by the state/territory health departments. We do not consider these in the analysis as we have no data about the specific state/territory funding. Using the Commonwealth list of organisations, we examine whether we have a record of those organisations also receiving state/territory health funding. (These lists were given to us in August 2013 and so may be dated). We focus on 2012/2013 as the preferred year of the analysis.

Data sources: analysis of Commonwealth and state/territory co-funding

Table 5.6 shows the data sources available for these analyses. We could only look at state health funding (some organisations may also receive other government funding, e.g. Department of Social Services, Attorney-General's Department etc). In addition some organisations will also receive other non-government funding (e.g. client co-payments, philanthropy).

Table 5.6: Data sources for analysis of co-funding (Commonwealth and states/territories)

	Commonwealth grant data	State/territory data
NSW	Supplied by Commonwealth as at August 2013. Funded organisation, Fund (NGOTGP, P1, P2&3), and funding amount 2012/2013. STO descriptors of service types (where available)	List of funded NGOs from: NSW Health Annual Report 2012-13 Funding and Expenditure, page 43-51. Includes all Health funding (not limited to AOD).
ACT	As above	List of funded NGOs from RA data obtained from ACT Health. Includes only AOD funding.
SA	As above	List of funded NGOs from: Department of Health and Ageing South Australia, Annual Report 2012-13, page 173. Cross-checked against RA data (poor

		concordance). Not able to use funding data.
QLD	As above	List of funded NGOs from: Queensland Health Grant Funding Recipients 2012/13, Available at: http://www.health.qld.gov.au/ Cross-checked against RA data. Includes all Health funding (not limited to AOD).
VIC	As above	List of funded NGOs from: Victorian Health Policy and Funding Guidelines 2013-14. Part 2: Health Operations, State of Victoria, Department of Health, 2013. Includes all Health funding (not limited to AOD).
WA	As above	List of funded NGOs from RA data alone. No public domain data about funding amounts.
NT	As above	List of funded NGOs from: Department of Health, Northern Territory, Annual Report 2012-13. Cross-checked against RA data Includes all Health funding (not limited to AOD).
TAS	As above	List of funded NGOs from: Department of Health and Human Services, Tasmania. Annual Report 2012-2013 - Part 2 Regulatory Information, page 95. Includes only AOD funding.

We do not have data about state/territory service type purchasing from individual organisations (i.e. we cannot do specific analysis by service types). As seen in the above Table, state/territory health data came from either public domain records (for 2012/13, e.g. published lists of NGO treatment grants), or from our RA data interviews with state health departments. For this analysis, we ignored Commonwealth funding to state health departments (e.g. NT, NSW, SA, Tas, WA). (This means that the number of projects and unique organisations will not match those separately reported elsewhere in this Chapter). For this analysis, we also excluded national projects.

Proportions of organisations funded by the Commonwealth who were also funded by state/territory health departments (2012/2013)

All organisations in receipt of Commonwealth funds (NGOTGP, SMSDGF P1 and P2&3) were coded either 'yes' or 'no' in relation to whether they received state/territory health department funding. The data used to derive the yes/no combined public records of grants (for 2012/2013) with RA data. This was also supplemented with personal knowledge from the Review team. We suspect that these data are largely accurate, in that it is relatively clear whether an organisation receives funds or not.

Table 5.7 provides the results. Of the 228 unique organisations who received Commonwealth funds (NGOTGP and/or SMSDGF), 152 of them (that is 67%) were also in receipt of state/territory health department funding in 2012/13.

Table 5.7: Number of organisations funded by the Commonwealth (NGOTGP and SMSDGF) who are co-funded by state/territory health departments

Variable	# or %
# of Commonwealth projects	449
# of unique organisations	228
# of unique organisations NGOTGP	119
# of unique organisations Fund P1	108

# of unique organisations Fund 2&3	93
% co-funded by S/T - overall (of unique org's)	67% (152)
% co-funded by S/T for Fund 2&3 (of unique org's)	67% (62)
% co-funded by S/T for or NGOTGP (of unique org's)	70% (83)
% co-funded by S/T for SMSDGF P 1 (of unique orgs)	69% (74)

Note: this analysis is concerned with organisation co-funding between Commonwealth and states/territories. We note that the Commonwealth funds that same organisation for projects across NGOTGP and SMSDGF.

For the NGOTGP program, there were 119 organisations who received NGOTGP grants. Of these, 83 were also in receipt of state/territory health department funding (70%). The figure is similar for organisations who received SMSDGF P1 grants – of the 108 organisations who received SMSDGF P1 grants, 69% also were in receipt of state/territory health department funding.

For the Aboriginal and Torres Strait Islander services (SMSDGF P2&3) the figure is a little lower but similar. 67% of organisations who received SMSDGF P2&3 grants were also funded by the state/territory health departments in 2012/2013.

There are differences by jurisdiction (see Table 5.8 below). Some jurisdictions have all of the Commonwealth funded organisations also funded by state/territory (e.g. ACT), or close to all (NT). For the NGOTGP, ACT, Tas and WA have all or close to all funded; whereas in Victoria, only 59% of the Commonwealth funded NGOTGP organisations were also co-funded by the state health department in 2012/2013. Similarly there are variations for the SMSDGF P1: ACT and Tas have 100% co-funded, whereas Victoria has 57%, followed by SA at 63%. The greatest jurisdictional variation occurs for the Aboriginal and Torres Strait Islander services (SMSDGF P2&3). In Victoria only 29% of P2&3 services are co-funded by the state/territory; in Tasmania this was 33% and Queensland 39%. Thus in three jurisdictions, less than half of the Commonwealth funded P2&3 organisations were also funded by the state health departments. The analysis by jurisdiction thus moderates the overall national analysis.

Table 5.8: Jurisdictional analysis of co-funding, by fund type (NGOTGP, SMSDGF P1 and SMSDGF P2&3)

NSW			
	# of Commonwealth projects	124	
	# of unique organisations	65	
	# of unique organisations NGOTGP	28	
	# of unique organisations Fund P1	32	
	# of unique organisations Fund 2&3	30	
	% co-funded by S/T - overall (of unique org's)	45	69%
	% co-funded by S/T for Fund 2&3 (of unique org's)	24	80%
	% co-funded by S/T for or NGOTGP (of unique org's)	18	64%
	% co-funded by S/T for SMSDGF P 1 (of unique orgs)	21	66%
NT			
	# of Commonwealth projects	56	
	# of unique organisations	23	
	# of unique organisations NGOTGP	7	
	# of unique organisations Fund P1	5	
	# of unique organisations Fund 2&3	16	
	% co-funded by S/T - overall (of unique org's)	21	91%
	% co-funded by S/T for Fund 2&3 (of unique org's)	15	94%
	% co-funded by S/T for or NGOTGP (of unique org's)	6	86%

	% co-funded by S/T for SMSDGF P 1 (of unique orgs)	4	80%
QLD			
	# of Commonwealth projects	65	
	# of unique organisations	32	
	# of unique organisations NGOTGP	19	
	# of unique organisations Fund P1	12	
	# of unique organisations Fund 2&3	18	
	% co-funded by S/T - overall (of unique org's)	19	59%
	% co-funded by S/T for Fund 2&3 (of unique org's)	7	39%
	% co-funded by S/T for or NGOTGP (of unique org's)	13	68%
	% co-funded by S/T for SMSDGF P 1 (of unique orgs)	9	75%
ACT			
	# of Commonwealth projects	13	
	# of unique organisations	8	
	# of unique organisations NGOTGP	5	
	# of unique organisations Fund P1	6	
	# of unique organisations Fund 2&3	1	
	% co-funded by S/T - overall (of unique org's)	8	100%
	% co-funded by S/T for Fund 2&3 (of unique org's)	1	100%
	% co-funded by S/T for or NGOTGP (of unique org's)	5	100%
	% co-funded by S/T for SMSDGF P 1 (of unique orgs)	6	100%
SA			
	# of Commonwealth projects	34	
	# of unique organisations	18	
	# of unique organisations NGOTGP	13	
	# of unique organisations Fund P1	8	
	# of unique organisations Fund 2&3	5	
	% co-funded by S/T - overall (of unique org's)	11	61%
	% co-funded by S/T for Fund 2&3 (of unique org's)	4	80%
	% co-funded by S/T for or NGOTGP (of unique org's)	8	62%
	% co-funded by S/T for SMSDGF P 1 (of unique orgs)	5	63%
TAS			
	# of Commonwealth projects	14	
	# of unique organisations	9	
	# of unique organisations NGOTGP	5	
	# of unique organisations Fund P1	6	
	# of unique organisations Fund 2&3	3	
	% co-funded by S/T - overall (of unique org's)	7	78%
	% co-funded by S/T for Fund 2&3 (of unique org's)	1	33%
	% co-funded by S/T for or NGOTGP (of unique org's)	5	100%
	% co-funded by S/T for SMSDGF P 1 (of unique orgs)	6	100%
VIC			
	# of Commonwealth projects	87	
	# of unique organisations	50	
	# of unique organisations NGOTGP	32	
	# of unique organisations Fund P1	28	
	# of unique organisations Fund 2&3	7	
	% co-funded by S/T - overall (of unique org's)	27	54%
	% co-funded by S/T for Fund 2&3 (of unique org's)	2	29%
	% co-funded by S/T for or NGOTGP (of unique org's)	19	59%
	% co-funded by S/T for SMSDGF P 1 (of unique orgs)	16	57%
WA			
	# of Commonwealth projects	56	
	# of unique organisations	23	

	# of unique organisations NGOTGP	10	
	# of unique organisations Fund P1	11	
	# of unique organisations Fund 2&3	13	
	% co-funded by S/T - overall (of unique org's)	14	61%
	% co-funded by S/T for Fund 2&3 (of unique org's)	8	62%
	% co-funded by S/T for or NGOTGP (of unique org's)	9	90%
	% co-funded by S/T for SMSDGF P 1 (of unique orgs)	7	64%

When examined nationally, around two-thirds (67%) of organisations in receipt of Commonwealth funds are also funded by the state/territory health departments (they may also have other funding sources: client co-payments, philanthropy and government departments other than health). Arguably, this overall finding is good – the majority of the Commonwealth investment is in organisations which are co-funded, increasing the financial viability of the organisations in which the Commonwealth is investing. There does not appear to be any significant differences between the three funds at a national level – the proportion of organisations co-funded by states/territories is very similar for the NGOTGP scheme, for the P1 Fund and for the Aboriginal and Torres Strait Islander P2&3 Fund. However there are three jurisdictions (Vic, Tas and Qld) where two-thirds of the P2&3 organisations are sole funded by the Commonwealth. This suggests greater vulnerability for Aboriginal and Torres Strait Islander services (P2&3) in those jurisdictions.

This raises the question about whether one option for the future is to consider Commonwealth investment limited to those organisations that also have state/territory funding support. The rationale for this would be to ensure that the Commonwealth investment leverages off state/territory investment; that organisations are sustainable and financially viable. If states/territories and the Commonwealth are 'on the same page' with what is 'good' treatment, this should forestall states/territories going off on a different path. However, requiring that an organisation has other funding may limit the potential pool of organisations. Consideration may need to be given to exceptions, especially for unique or gap-filling services. More important is the question of whether co-funding is a reasonable metric of sustainability. Some organisations may be sole funded but at a level which ensures financial sustainability; likewise others which are co-funded may be co-funded at a level which does not support sustainability. We turn to this next.

As implied in the above paragraph, analysis of simply whether an organisation receives funds from more than one source is limited because it only examines whether an organisation receives *any* funding from state/territory health departments (yes/no). It does not take into account the quantum of those funds, which may be important in an analysis of financial viability. By way of example, the Lyndon Community, in NSW, received $3,595,760 from the Commonwealth in 2012/2013, and according to the NSW Ministry of Health Annual Report 2012/13 it received $10,075 from NSW Health. This represents less than 1% of the total budget for the organisation. Thus we need to examine the quantum of funds.

Quantum of funds: Commonwealth and state/territory health departments (2012/2013)

This analysis is difficult because there are no solid data on the amount of funds to each organisation (see Table 5.6 data sources). To take the Lyndon Community example, while the $10,075 is on the public record, it is entirely possible that they receive other funds from state health department (or also equally possible that they do not. There is no way of knowing from the data available).

The data we could obtain from each jurisdiction in some cases refers to any health department funding, and in other cases specifically AOD funding. Those that include all health funding (NSW, Qld, Vic, NT) will make a big difference to the percentages. For example one organisation in Tasmania,

received $641,633 for alcohol and drug services from the state but they also received $3,450,171 for Children and Youth Services from the state. Thus the percentage Commonwealth contribution would be 37% if only the state AOD funding was included, and 9% if all state health funding was included. This demonstrates the vagaries of this exercise.

There are other reasons why the data are unreliable. In the published annual reports the grants reported generally refer to established grants programs and do not include individually negotiated block grants. In some instances we were aware of an organisation receiving funds but they were not listed in the data we could obtain. For one jurisdiction – South Australia – we judged that the data that we had available was unreliable. For another jurisdiction – Western Australia – the data were not in the public domain. Thus both SA and WA were excluded from this analysis. Hence, these data can only begin to draw a picture of the amount of funds, and may misrepresent the true situation. We note that we are not alone in trying to establish the amount of state/territory funds provided to NGOs – the Mental Health Commission review is having very similar challenges (and with fewer organisations). It would be very useful for the Intergovernmental Committee on Drugs (IGCD) to conduct some work in this area. It is in the interests of all funding bodies to know the relative investment in different organisations and would facilitate better decision-making on behalf of both federal and state/territory governments.

We could not do this analysis by fund type (P1, NGOTGP SMSDGF) because we don't know what they receive the state funds for. For example, Ngaimbe Aboriginal Corporation receives both NGOTGP and SMSDGF P2&3 funds – they also receive a grant from the state health department, but we do not know if it aligns with the P2&3 residential rehabilitation (The Glen) or if it is given to the organisation for other services.

In those NGOs where there is either Commonwealth or state/territory funding (either together or singly funded), the total amount of funds by jurisdictions from each of the two funders is given in Table 5.9. For each jurisdiction, the proportion of Commonwealth funds relative to state funds for the NGOs which the Commonwealth funds (and for which we had data) are provided. Note: unable to report data for SA and WA; some NGOs funded by Commonwealth and state are missing in each jurisdiction.

Table 5.9: For NGOs funded by the Commonwealth the contribution of state/territory health departments to those NGOs

	Commonwealth	State	TOTAL:	% Commonwealth
NSW	$31,872,958	$36,193,523	$68,066,481	47%
NT	$14,070,226	$31,475,598	$45,545,824	31%
QLD	$24,503,105	$24,890,658	$49,393,763	50%
ACT	$3,354,158	$8,641,705	$11,995,863	28%
SA	na	na	na	-
TAS	$4,506,447	$2,544,587	$7,051,034	64%
VIC	$18,444,617	$70,863,000	$89,307,617	21%
WA	na	na	na	-
TOTAL				36%

Note: for NSW, Vic, NT, Qld all health funding is included from the Annual Reports, whereas for Act and Tas only AOD funding is included.

Given the problems with the data, little of detail can be said except that it does show that states must be investing in organisations that the Commonwealth does not invest in, given that in the budget analysis (Chapter 4), the states/territories contribute 79% to specialist, whereas here it is approximately 64% (however arguably a not dissimilar figure). There are variations by state/territory – the ones that have the highest Commonwealth investment are Tas, Qld and NSW (that is in amount only, for those agencies where we have Commonwealth amounts and state amounts to those agencies).

More details about the amount of funds by jurisdiction is given in Table 5.10, below. Here for each jurisdiction, we show the range of Commonwealth funding (maximum, minimum, mean and the number of organisations in each jurisdiction where the Commonwealth funding represents 70% or more of an organisation's funding. We chose 70% as the cut-off based on the Productivity Commission (2010) report that three-quarters of the departments and agencies responding to the Commission's survey indicated that they contribute to costs (not fully fund) (p. 280) and that the contribution was approximated to be 70%, with the remaining made up from fees and charges (client co-payments).

Table 5.10: Range of funding amounts: Commonwealth proportion of state/territory health investment

	Number of agencies in the analysis	Range of Commonwealth funding as a percentage of total funding	% where Commonwealth funds are more than 70% of total funding (CW and S/T)
NSW	61	Maximum 100% minimum 2% mean 66% median 80%	37 out of 61 (60.6%)
ACT	8	maximum 64% minimum 16% mean 33% median 28%	0 out of 8 (0%)
SA		Data not available	
QLD	32	maximum 100%	20 out of 32 (62.5%)

		minimum 7% mean 73% median 78%	
VIC	47	maximum 100% minimum 3% mean 58% median 55%	22 out of 47 (47%),
WA	20	Data not available	
NT	23	maximum 100% minimum 4% mean 42% median 32%	5 out of 23 (22%)
TAS	9	maximum 100% minimum 27% mean 63% median 61%	2 out of 9 (22%)

As can be seen, there is a range within each jurisdiction of the proportion of Commonwealth funds of the total organisation funds (ranging from 100% i.e. all Commonwealth, to 2% of the funds being Commonwealth) by individual organisation.

NSW, Qld and Victoria stand out – around half or more of the Commonwealth funded services are funded at 70% or greater by the Commonwealth. So even though the yes/no analysis did not look too bad, this more detailed (but still fraught data) analysis, suggests that there are a significant number of organisations in NSW, Queensland and Victoria that are reliant on Commonwealth funding (they receive 70% or greater of their total funds from the Commonwealth). For the record, the number of agencies (remembering that this analysis did not include every organisation) is:

      NSW: 37 agencies

      Vic: 22 agencies

      Qld: 20 agencies

As compared to those jurisdictions where the investment mix is more balanced between state and Commonwealth at the individual organisational level:

      ACT: 0 agencies

      NT: 5 agencies

      Tas: 2 agencies

At a minimum, this would suggest that the Commonwealth be aware of/alert to re-commissioning activities in these jurisdictions.

What is purchased: description of treatment and capacity building

The Commonwealth purchases both direct care (specialist treatment and supporting treatment functions) through the NGOTGP and the SMSDGF, as well as what is termed 'capacity building' projects. Before describing the amounts of funding to treatment and capacity building, we provide an outline of both of these activities.

Direct care (specialist treatment services and supporting treatment functions)

Specialist services are synonymous with what are regarded by many key informants to the Review as "core" AOD services. We use the term 'core AOD treatment' to refer to these elements, which are evidence-based and make up the essential parts of an AOD treatment pathway. The service types are: withdrawal, rehabilitation, psycho-social therapy (counselling), and maintenance pharmacotherapy. Withdrawal management (detoxification) involves either medicated or non-

medicated supervised treatment to help a client cease or reduce drug use by removing drugs from the body, stabilising a client, and helping to manage withdrawal symptoms after a long (or heavy) period of drug use. Withdrawal should not be offered in isolation of a longer-term treatment option as its primary focus is neuro-adaptation reversal (i.e. not addressing broader concerns associated with AOD dependence). Rehabilitation may follow a withdrawal treatment episode, and helps clients to address the psycho-social factors which may have contributed to their drug use and help prevent future relapse. Rehabilitation may be delivered in a residential setting, or via therapeutic communities and community-based rehabilitation services. Psycho-social therapy (primarily counselling) encompasses a range of approaches including psychotherapy, cognitive behavioural therapy, relapse prevention and motivational interviewing. Counselling may be delivered individually or in group sessions, and may also include family members. Maintenance pharmacotherapy treatment supports clients to reduce or cease drug use through the prescription of medication which delivers a stabilising dose to prevent withdrawal and craving symptoms, thus helping to reduce the harms associated with drug use (including treatments such as buprenorphine and methadone maintenance).

The list of core AOD treatment purchased across Australia, using the AODTS-NMDS consists of the following service types:
- Assessment only
- Withdrawal management
- Counselling
- Rehabilitation
- Support and case management only
- Information and education only
- Pharmacotherapy maintenance
- Other

These largely accord with the elements within DA-CCP:
- Assessment
- Withdrawal management
- Individual – Psychosocial interventions
- Group – Psychosocial interventions
- Outreach Case management and support
- Non-residential rehabilitation – day program
- Residential rehabilitation
- Pharmacotherapies
- Assertive Follow-up

Given the extensive body of knowledge around the above service types, and their associated efficacy, effectiveness and cost-effectiveness, for now it is sufficient to note that the Commonwealth is currently purchasing from across the array of known effective interventions. (We examine later the balance between these service types across the NGOTGP and SMSGDF Priority 1).

Two of the case examples undertaken as part of the Review (see Chapter 17) were with non-government organisations (Organisation A and Organisation B) both of whom are contracted to provide core AOD treatment services funded under the NGOTGP and SMSDGF. Organisation A is a specialist AOD treatment provider.

Case example: Organisation A – a specialist AOD treatment service
(The full case example can be found in Chapter 17)

The organisation has a long history of residential rehabilitation service delivery (particularly within the therapeutic community model) and is a large, well established, specialist AOD treatment provider within its jurisdiction. Since its initial establishment as a residential rehabilitation treatment service, the organisation has expanded its service delivery purview and aims to "provide a comprehensive range of community-based treatment and support services to address alcohol and other drug problems, along with any associated mental health, vocational, health, relationship and family issues".

It was estimated that 55% of the organisation's activities are state funded (primarily through the state Department of Health, but sometimes also Department of Education and Justice etc.); around 25% of activities are Commonwealth funded (historically and variously through the Department of Health and Ageing, FACSIA, and AGs proceeds of crime funding); 10% of activities are funded through fee for service (primarily through clients' Centrelink contribution to treatment in residential programs, as well as fee for service for training programs which are nonetheless heavily subsidised); and 8-9% of activities are funded through donations, trusts and foundations, philanthropic/corporate support. Participants noted that this final category of funds "fills gaps" and is used to supplement programs and resource capital works, as well as fund discrete programs and innovations (e.g. employment programs; financial counselling; community school programs).

The organisation is in receipt of both NGOTGP and SMSDGF funding. The NGOTGP funds equate to approximately $1.1 million a year which fully funds a 15 bed residential rehabilitation program (in a country area, which has approximately 20% Aboriginal and Torres Strait Islander clients). The funding available to the organisation through the NGOTGP has grown over time through the various funding rounds, as the identified need within the community was recognised.

Participants in this case example suggested that the strength of the Commonwealth funding has always been that regardless of whatever strategy a particular state/territory government may be emphasising, the Commonwealth funding "fills in the gaps and some of the fallout". This could apply geographically, or in terms of particular populations, especially those difficult to reach (e.g. Aboriginal and Torres Strait Islander, CALD), or may encourage the development of niche projects that the state government may not want to take up (for this organisation, this included child and family programs, and residential programs in a state with a low number of beds per capita).

Supporting treatment functions are also an important part of the overall treatment system. The Commonwealth purchase supporting treatment functions from a number of organisations. Supporting treatment includes generating entry points into treatment, supporting client retention in treatment through wrap-around services, negotiating barriers to treatment, and providing adjunctive welfare and support services. These supporting treatment functions are essential, especially considering the nature of AOD dependence as a chronic, relapsing condition, and the marginalisation of AOD treatment clients (and would be clients).

Organisation B is a generalist welfare service that also provides AOD treatment in the context of holistic care. It is illustrative of the supporting treatment functions and wrap around care that is funded by the Commonwealth.

Case example: Organisation B - a generalist welfare service
(The full case example can be found in Chapter 17)

The organisation is located in an inner city area in one Australian capital city. The organisation provides primary health care and welfare services to marginalised inner city populations including homeless and disadvantaged men and women, many of whom have comorbid mental health and AOD issues. The participants consulted described the service as 'medium sized', and as engaging in health promotion, harm reduction and health education activities.

Within the broader activities of the organisation (which include accommodation services and holistic care and case management) the organisation runs two specific AOD treatment activities: an AOD counselling service (run by a clinical psychologist), and a capacity building program to enhance the capacity of staff and managers to more effectively work with clients who have comorbid AOD and mental health issues. This program includes training, training audits, and evaluation. Although these two services were described by participants as AOD treatment specific services, they noted the holistic nature of their services and that AOD treatment and harm minimisation are integrated across all of the organisation's activities (for example, through the case management model used within a crisis centre for clients with complex needs which operates using a harm minimisation model, and the organisation's AOD/HIV integrated care program).

The organisation receives funding from multiple government departments including the state Department of Family and Community Services (for homeless service), the state Health Department (e.g. for rehab service), and the Commonwealth Medicare branch (for medical clinic for homeless people). The two specific AOD treatment services are both fully funded by the Commonwealth; the counselling service by the NGOTGP and the capacity building program by the SMSDGF (both relatively small grants, each funded over three years). The organisation also receives income through client fees for other programs, and occasional donations corporate donations (but does not have any fee for service programs).

Participants said that the counselling service funded through the NGOTGP had been an excellent program (although noting that it would be good to build a psychiatrist into this). The counselling service has intersected well with the organisation's medical clinic, as the organisation has been able to give clients mental health support through this program. The counselling service dovetails and 'taps into' the housing services offered by the organisation. Participants suggested that these services stop 'clogging up' of hospital outpatient services, and give clients timely support rather than 'waiting' in health services. These support services within NGOs are essential for supporting vulnerable clients.

Other supporting treatment functions are undertaken by consumers and peers, including those working with consumers of AOD treatment, and those working with people who use drugs. Another case example undertaken for the Review examined the role played by peer-based drug user organisations that work with and for marginalised populations of people who inject drugs. The focus of the case example is on how peer-based drug user organisations support AOD treatment in Australia. Australia's drug user organisations are funded by the Commonwealth, as well as state and territory governments. AIVL is a recipient of both SMSGDF and NGOTGP funding. Additionally, three of the state and territory drug user organisations consulted for this case study receive NGOTGP funds, and one organisation receives funding from the SMSDGF.

Case example: Supporting treatment functions performed by Australia's Drug User Organisations
(The full case example is provided in Chapter 17)

Through consultation with eight drug user organisations across Australia[49], we identified four[50] roles/activities that drug user organisations undertake in supporting treatment (noting that some functions overlap):
Creating treatment access and entry points
Client complaints services
Provision of peer-based treatment interventions
Advocating for better treatment policies

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[49] The drug user organisations consulted for this case study were representatives from: AIVL, CAHMA, SAIN, WASUA, NTAHC, QuIHN, QuIVAA and NUAA. Not all of these organisations receive Commonwealth and/or state/territory funding. HRV was not able to attend.
[50] There is a fifth role – workforce development, which we cover under the capacity building section later in this chapter.

> The aims, objectives and functions of drug user organisations include: addressing and representing the health needs of people who use illicit drugs and people on opioid pharmacotherapies through a health promotion and disease prevention approach; preventing the transmission of blood borne communicable diseases such as HIV/AIDS and hepatitis C among people who inject illicit drugs; promoting the provision of high quality, accessible and relevant services to people who use illicit drugs and people on opioid pharmacotherapies throughout Australia; as well as promoting and protecting the health and human rights of people who use illicit drugs and people on opioid pharmacotherapies (for full list of aims see Australian Injecting and Illicit Drug Users League, 2012, p. 3).

Having discussed the provision of direct care (core AOD treatment) and supporting treatment functions, we now turn to the second category of funding for the Commonwealth, capacity building.

Capacity building

Unlike AOD treatment, there is not an agreed definition or clear conceptualisation of capacity building, despite it being regarded as essential for ensuring a strong and responsive AOD sector into the future. There are diverse definitions of capacity building, reflecting in part the use of the term in varying fields such as international development, education and health (Crisp, Swerissen, & Duckett, 2000). Indeed, the term 'capacity building' has been criticised as being so broad it has become meaningless, or alternatively as being a euphemism for training (Potter & Brough, 2004). It is important to be alert to different interpretations of the term (Crisp et al., 2000). Over time, capacity building has evolved as a concept and now encompasses such notions as developing high-performing organisations (McKinsey & Company, 2001); building infrastructure, partnerships, organisational environments, and problem solving capacity (Hawe, King, Noort, Jordens, & Lloyd, 2000); partnership and community-based approaches Crisp et al. (2000); workforce development, organisational development, and leadership NSW Health (2001).

Various United Nations agencies have emphasised the ways in which capacity building is a *process*, linked to long term strategic planning and the capability to adapt to system-wide changes. The United Nations Development Program provides a brief, high level definition of 'capacity development' (which is taken here to equate to capacity building) "as the process through which individuals, organisations and societies obtain, strengthen and maintain the capabilities to set and achieve their own developmental objectives over time" (United Nations Development Programme, 2008). In this way, over time capacity building has been understood as constituting more than mere training programs but rather as an integral process for the development of institutions, so that they may better "perform core functions, solve problems, define and achieve objectives, and understand and deal with development needs" (United Nations Educational Scientific and Cultural Organization, 2006, p. 3).

Despite the multiplicity of uses and meanings of 'capacity building', some core concepts emerge across the literature:
- An emphasis not on service delivery per se, but on building the underlying capacity of organisations or systems (or in some cases communities or societies) to achieve their goals (Crisp et al., 2000; LaFond, Brown, & Macintyre, 2002; McKinsey & Company, 2001; National Centre for Education and Training on Addiction, No date; United Nations Development Programme, 2008);
- An approach which goes beyond a sole focus on the skills of individual staff, to address organisational and systems issues e.g. policies, procedures, missions and values (Crisp et al.,

> 2000; Kaplan, 2000; Loureiro, 2011; National Centre for Education and Training on Addiction, No date; Potter & Brough, 2004; World Health Organization, No date);

- A focus on achieving long-term outcomes, sustainability, and enhanced abilities to problem-solve and adapt to change (Crisp et al., 2000; Hawe et al., 2000; LaFond et al., 2002; Loureiro, 2011; Substance Abuse and Mental Health Services Administration, No date; United Nations Economic and Social Council, 2006; United Nations Educational Scientific and Cultural Organization, 2006);

- An emphasis on partnership and collaboration between services, organisations and systems (Crisp et al., 2000; Department of Health and Ageing, 2011; Hawe et al., 2000; National Improved Services Initiative Forum, 2010; NSW Health, 2001; Substance Abuse and Mental Health Services Administration, No date);

- An emphasis on stakeholder and community engagement (Crisp et al., 2000; LaFond et al., 2002; Loureiro, 2011; McDonald, Schultz, & Chang, 2013; Substance Abuse and Mental Health Services Administration, No date; United Nations Development Programme, 2008; United Nations Economic and Social Council, 2006);

- A conceptualisation of the role of institutional funders as enablers of change, by empowering and strengthening the capabilities of organisations and communities to respond effectively to new challenges (Crisp et al., 2000; Loureiro, 2011; United Nations Development Programme, 2008).

The way that the Commonwealth Department of Health has historically understood the concept of capacity building in the context of the AOD sector can be ascertained through its development of the Improved Services Initiative (ISI). The ISI aimed to build capacity to effectively identify and treat coinciding mental illness and substance abuse ('comorbidity'). This initiative formed part of the Commonwealth's component of the Council of Australian Governments' (COAG) National Action Plan on Mental Health 2006 - 2011. Non-government alcohol and other drug treatment services across Australia were funded through competitive grants processes to undertake a range of capacity building activities, and the state and territory peaks were funded to support these activities and enhance cross-sectoral support and strategic partnerships.

The ISI Capacity Building Grants program guidelines noted that the 'Improved Services for People with Drug and Alcohol Problems and Mental Illness Measure'(Department of Health and Ageing, 2007) was being rolled out with two components: firstly to "*build the capacity* of AOD NGO treatment services to better identify and effectively treat people with coinciding mental illness and substance abuse in the Australian community"; and secondly to "facilitate further support to AOD NGO treatment services through the *development of stronger partnerships* with the broader health network" (emphasis added). As such, the two components recognised two different but interlinked aspects of capacity building, that is:

   1. the development of capabilities, knowledge and skills within organisations, and
   2. the development of cross-sector partnerships and networks.

The ISI is now part of the SMSDGF and forms Priority 1 (along with direct treatment services) under that fund. While capacity building funded under the ISI had an explicit focus on comorbidity, in the SMSDGF this has been broadened to cover complex needs and comorbidity, and for people from culturally and linguistically diverse (CALD) backgrounds. (See above for details of the Fund guidelines and priorities).

We sought in the Review to establish some conceptual clarity about capacity building, and to provide a framework for future consideration of capacity building under the SMDGF. We define the concept of 'capacity building' as relating to activities which aim to improve health outcomes by strengthening and maintaining the competencies, skills, knowledge and values of individual workers, organisations

and the sector. We conceptualise capacity building as operating through three separate but related process streams:

1. Priority topic or client target population
2. Organisational or institutional capacity building
3. Intra- and inter-sectoral systems of care.

The first stream relates to capacity building regarding a particular *priority topic* or *client target population*. This could include a focus on building workers' knowledge and competencies in relation to comorbidity, family-sensitive practice, or adapting practice models to be responsive to culturally and linguistically diverse (CALD) populations (for example). Activities could include seminars, placements, mentoring programs, secondary consultations, and implementing new practice guidelines.

The second stream relates to *organisational* or *institutional* capacity building. This includes activities which aim to improve governance structures of agencies (for example ensuring a properly constituted board), implementing consumer engagement programs, developing a quality framework and integrating this across the organisation's procedures, and infrastructure development (e.g. electronic case management systems). The activities in this second stream could be applied broadly or could also be applied to a targeted priority issue, as in Stream 1.

The third stream includes capacity building activities which aim to improve *systems of care within and between the treatment sector*. This includes building sustainable services through building sector workforce standards, implementing data collection systems, facilitating inter-sectoral cooperation to strengthen linkages with the wider health, social and community service network, as well as strengthening intra-sectoral linkages and networks. The activities in this third stream could be applied broadly or could also be applied to a targeted priority issue, as in Stream 1.

Although the three streams are conceptualised separately here, they work synergistically and interrelate depending upon priority topics and needs.

Both Organisation A and Organisation B had received Commonwealth grants for capacity building under the SMSDGF.

Case example: Organisation A and Organisation B - capacity building projects

Organisation A:
Organisation A is in receipt of capacity building funding through the SMSDGF. The organisation has used this funding to build on earlier dual-diagnosis (comorbidity) work that had been unfunded at a state level, but which had been initially developed through philanthropic funds. This was a perceived need as 80-90% of the organisation's clients have a dual diagnosis. One participant noted that the first round of SMSDGF capacity building funding "really helped us set a bench mark" and "lift the bar". The second round of funding has since extended the initiative into GLBTQI, CALD and Aboriginal and Torres Strait Islander capacity building initiatives. This has included, for example, supporting the activities of an Aboriginal Advisory Group, employing an Aboriginal Consultant who works part time to improve links at a systems level, as well as employing a young Aboriginal woman to give her work experience in this area. These activities were undertaken so as to extend capacity building beyond mental health and into areas where there was need for staff development. It was said that this capacity building funding had been "fantastic and critical" for the organisation – because state funding is so limited, this capacity building funding as well as trust and foundation money supplement staff development and supervision across the organisation (which should be basic requirements).

Organisation B:
Organisation B has implemented a capacity building program to enhance the capacity of staff and managers to more effectively work with clients who have comorbid AOD and mental health issues. This program includes training, training audits, and evaluation. Participants said that the capacity building program which had been

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funded through the SMSDGF had been "amazing" for their organisation. They noted that up-skilling staff and evaluating programs has been incredibly valuable.

Aside from individual service providers conducting capacity building projects, the AOD state/territory peak bodies have also received funds to engage in capacity building activities. A case example for the Review was the role that the state/territory peak bodies play in relation to capacity building.

In the case example below, we have categorised responses using the 'three streams' of capacity building.

Case example: The role of the state and territory AOD peak bodies in capacity building
(The full details of the case example can be found in Chapter 17)

1. Capacity building regarding a particular priority topic or client target population

The peaks articulated a particular role in workforce development, training, and education. Peaks are well placed to provide support to the specialist treatment sector to deliver services which are evidence informed and reflective of good practice. The role of the peaks in knowledge dissemination and knowledge transfer was highlighted. This is significant for building workers' knowledge and competencies in relation to particular priority topics or target client populations.

One example is the regular *Infosessions* held by the Alcohol, Tobacco and other Drugs Council of Tasmania (ATDC). Every six to eight weeks, ATDC hosts a 60 – 90 minute session for sector workers on priority AOD topics, presented by specialists working in Tasmania. Topics are determined by feedback from the sector on what they require (e.g. understanding pharmacotherapy: how opiate substitutes work on the body, how they interact with other drugs, physical and mental side effects and issues for collaborative care). Question and answer time, as well as coffee/tea after each session also provides informal networking for sector workers, which have been shown over time (through event evaluations) to increase communication between agencies.

In the consultation, the peak bodies also identified a number of activities, functions and roles that peaks can play in relation to supporting government agendas in relation to identified priority topics. For example, the Alcohol, Tobacco and other Drugs Association ACT (ATODA) has been a key support to the ACT and Federal Governments regarding tobacco reform. This has included the establishment of the Under 10% Project (www.under10percent.org.au) that aims to improve the health and wellbeing of the Canberra community by strengthening tobacco management practices in health and community sector workplaces that support disadvantaged people. The program (which is early in its development) has supported over 10 health and community services to develop and implement tobacco management policies and practices.

2. Organisational or institutional capacity building

Peaks act as conduits to define what is meant by 'good quality' in the AOD treatment system and contribute to improved quality of AOD treatment through developing capabilities at an institutional or organisational level. This in turn produces better health outcomes for clients.

For example, the Western Australian Network of Alcohol and other Drug Agencies (WANADA) was instrumental in developing the first internationally recognised set of standards specific to the AOD sector, the Standard on Culturally Secure Practice. This Standard is the culmination of 12 years of sector development work, which commenced with consultation with sector workers, managers, service participants and government to develop a quality framework. The implementation of the framework was supported by WANADA across the sector (including AOD programs funded by OATSIH and the state Office of Aboriginal Health). In 2010, the framework was reviewed and updated with a particular additional focus on cultural security and is now a registered accreditation standard with the Joint Accreditation System of Australia and New Zealand. In addition, there is now recognition of the value of continuous quality improvement across all AOD services in WA, including 'industry specific' application of evidence based practice. Services in the NT, Qld and SA are currently working with the Standard to shape their service delivery.

The SA Network of Drug and Alcohol Services (SANDAS) provides support to its members in adopting and implementing quality improvement approaches, frameworks and standards relevant to organisational strengthening and the services they provide. In 2013 SANDAS partnered with SACOSS to establish the NGO finance and quality improvement officer network. This network plays a role in systems and contractual aspects of capacity building and provides a forum for both state and Commonwealth funding bodies to more effectively and efficiently communicate and implement changes and seek feedback for their own quality improvement needs.

3. Improving intra- and inter-sectoral systems of care

The peaks identified the importance of effective and efficient sector coordination and networking to maximise clinical learning, to ensure consistent and reliably high quality service delivery which is informed by an understanding of what constitutes good practice, as well as clarity around how each service fits within and contributes to the larger AOD and health and welfare systems.

Networking was considered as essential for the AOD sector because treatment crosses over with a number of service areas, such as mental health, homelessness, child welfare etc. As such, the peaks afford the opportunity for the specialist AOD agencies to be better networked with other agencies working with the same client group. One example here is the Community Mental Health and Drug and Alcohol Research Network (CMHDARN), established by the Network of Alcohol and other Drugs (NADA) and the Mental Health Coordinating Council in NSW, which aims to build the capacity of services to engage in research and develop more strategic and long term relationships with researchers. In 2012/13, CMHDARN facilitated four research forums and two reflective practice webinars, provided 16 research seed grants, distributed two CMHDARN Yarn newsletters, and had 951 individuals accessing the CMHDARN website (www.cmhdaresearchnetwork.com.au).

An important feature of the peaks raised in our consultation is that they are a collaborative group and networked themselves across Australia, thus facilitating national learning. A good example of this is the work the peaks have undertaken to support the national projects currently being undertaken on behalf of Commonwealth. Each peak has facilitated the Rapid Assessment process for this Review project in their jurisdiction, which included arranging for the Review team to meet with AOD agencies. In addition, the peaks have been able to provide important advice to the team developing the Quality Framework for Commonwealth funded AOD agencies, including current levels of engagement with quality standards in the sector, the appropriateness (or otherwise) of specific practice guidelines, practical issues around implementation (which vary across jurisdictions).

The examples given have been provided by the peaks.

The investment mix by the Commonwealth (NGOTGP and SMSDGF combined) in direct care and capacity building

In an ideal world this section of the Review would now describe the investment by the Commonwealth, broken down into:
- AOD treatment
  - Direct care services
    - Assessment only
    - Withdrawal management
    - Counselling
    - Rehabilitation
    - Support and case management only
    - Information and education only
    - Pharmacotherapy maintenance
    - Other
  - Supporting treatment functions
- Capacity building

- o   Priority topic or client target population (Stream 1)
- o   Organisational or institutional capacity building (Stream 2)
- o   Intra- and inter-sectoral systems of care (Stream 3)

Unfortunately, the available data did not conform to those neat headings.

We sought data regarding the service types delivered from the state/territory Commonwealth offices (STOs). In some cases summary descriptions were given in spreadsheets; in other cases coding systems were used. In some cases data were missing. STOs took different approaches to the exercise, so the data sources are not clear: in some cases it may have been the individual contracts, in others the progress reports but in most cases, the knowledge of the STO officer about the service. Data were obtained for the NGOTGP funded projects and the Priority 1 SMSDGF funded projects (data were not collected on the SMSDGF Priority 2&3 projects).

As data were incomplete in some instances, we used a simple coding system that involved the following service types/activities: counselling; residential rehabilitation; detoxification; comorbidity treatment; capacity building; outreach; and other. Counselling included all forms of outpatient support, counselling, case management, aftercare and frequently included also outreach. The 'other' category included NSP, education and information, supported accommodation alone, and pharmacotherapy support. Each funded project was coded only once, endeavouring to capture the main service type being funded. However, many projects included counselling, outreach, case management, home-based withdrawal and so on. Hence this coding should be regarded as indicative only. (It was not possible to code by drug type).

The table below summarises the results for the NGOTGP. As can be seen, the majority of projects and the majority of funds as at 2012/13 are in relation to counselling (outpatient) services.

Table 5.11: Service types funded under the NGOTGP (2012/2013)

	# of projects	% of projects	AUD (Approx amount)	% of overall funding
Counselling	82	49%	19,000,000	40%
Residential rehabilitation	46	27%	18,000,000	37%
Detoxification	7	4%	4,000,000	8%
Comorbidity treatment	2	1%	700,000	2%
Capacity building	4	2%	1,300,000	3%
Outreach	15	9%	3,000,000	6%
Other	12	7%	2,000,000	4%

Notes:
Dollars amounts have been rounded, because of lack of precision in the data.
Source: Rapid assessment data: the STOs provided notes about the services provided by each organisation.
The total # of projects for which coding could occur was 168 (out of 171 NGOTGP projects).

Examination of the treatment service types for Priority 1 only followed the same process as for the NGOTGP. Information was obtained from the State/Territory Commonwealth offices in relation to the types of services funded under Priority 1 of the SMSDGF (Priority 2 and 3 were all Aboriginal and Torres Strait Islander services). As data were incomplete in some instances, a simple coding system was used. The following service types/activities were coded: counselling; residential rehabilitation; detoxification; comorbidity treatment; capacity building; outreach; and other. Capacity building was used where it was clear that no direct treatment regarding comorbidity was being provided, whereas the comorbidity code was used where the predominant focus was on treatment provision per se. In reality however, much comorbidity capacity building is also treatment, and comorbid

treatment is also capacity building. Each funded project has been coded only once, endeavouring to capture the main service type being funded. Hence this coding should be regarded as indicative only.

Table 5.12: Services types funded under SMSDGF Priority 1 (supporting AOD treatment) 2012/2013

Service types (Priority 1)	# of projects	% of projects	AUD (Approx amount)	% of total funding
Capacity building	55	45%	9,600,000	43%
Comorbidity treatment	15	12%	2,200,000	10%
Counselling	36	29%	7,000,000	32%
Residential rehabilitation	10	8%	1,500,000	7%
Outreach	5	4%	1,600,000	7%
Detoxification	1	1%	180,000	1%
Other	1	1%	100,000	<1%
		100%		100%

Notes:
Not every project is included in this analysis due to missing data: data were available on 123 out of 127 Priority 1 projects.
Dollars amounts have been rounded, because of lack of precision in the data.
Source: Rapid assessment data: the STOs provided notes about the services provided by each organisation.

Pooling the information across the NGOTGP and the SMSDGF (excluding the P2&3 Aboriginal and Torres Strait Islander services) reveals the results, as given in Table 5.13.

Table 5.13: Summary: services types funded under NGOTGP and SMSDGF Priority 1 2012/2013

		# of projects	% of projects	AUD (Approx amount)	% of overall funding
Counselling	NGOTGP	82	41%	19,000,000	37%
	SMSDGF	36		7,000,000	
Residential rehabilitation	NGOTGP	46	19%	18,000,000	28%
	SMSDGF	10		1,500,000	
Detoxification	NGOTGP	7	3%	4,000,000	6%
	SMSDGF	1		180,000	
Comorbidity treatment	NGOTGP	2	6%	700,000	4%
	SMSDGF	15		2,200,000	
Capacity building	NGOTGP	4	20%	1,300,000	16%
	SMSDGF	55		9,600,000	
Outreach	NGOTGP	15	7%	3,000,000	7%
	SMSDGF	5		1,600,000	
Other	NGOTGP	12	4%	2,000,000	3%
	SMSDGF	1		100,000	
TOTAL		291	100%	70,180,000	100%

The greatest proportion of projects is directed towards counselling (41%) which similarly is the highest proportion of the Commonwealth grant funds (37%). This is followed by residential rehabilitation (at 19% of the projects) and 28% of the funding. Capacity building represents 20% of all the projects and 16% of the Commonwealth funding.

The relative investment in direct treatment compared to capacity building is useful to understand. The table below summarises the investment mix for the Commonwealth (across NGOTGP and SMSDGF, excluding Aboriginal and Torres Strait Islander services, that is Priority 2 and 3 from the SMSDGF).

Table 5.14: Relative investment in treatment and capacity building

	# of projects	% of projects	AUD	% of funding
Direct treatment	232	80%	59,280,000	84%
Capacity building	59	20%	10,900,000	16%
	291		70,180,000	

In terms of the total funds to Aboriginal and Torres Strait Islander AOD services, as noted earlier the SMSDGF allocated $56,312,052 under Priorities 2 & 3 for the year 2012/2013 (see Table 5.4). The funds within the NGOTGP that went to Aboriginal and Torres Strait Islander AOD services amounted to $6,564,532. This means that of the total $130 million in NGOTGP and SMSDGF for the year 2012/2013, 48% was allocated to Aboriginal and Torres Strait Islander AOD services.

Relationship between the Commonwealth AOD treatment (direct care) funding and state/territory treatment funding

This section aims to examine the degree of concordance between the Commonwealth's investment in direct care and the state/territory investment in direct care.

The greatest proportion of Commonwealth projects is directed towards counselling (41% of the projects and 37% of the funds). This is consistent with the data on what service types clients received (AODTS-NMDS), where counselling forms the highest proportion of all episodes of care (see Chapter 7). Thus, there appears to be concordance between the state/territory investment and the Commonwealth investment inasmuch as the AODTS-NMDS shows the significant focus on counselling services.

The state/territory health departments did not provide specific data by organisation; however we do know broadly the types of services that they purchase for their jurisdiction from the RA data and from Patient Pathways project. These are summarised in Table 6.

We use a simplified coding system: withdrawal, counselling, residential rehabilitation, and telephone information, assessment and referral services. Withdrawal includes hospital-based and community residential withdrawal as well as outpatient or home-based withdrawal. Counselling is taken to include non-residential psycho-social support programs, group-based programs, day programs and individual counselling. In all jurisdictions, the state/territory health departments fund assessment, case management and support, and information & education. These have not been listed.

Table 5.15: State/territory service types; Commonwealth service types for NGOTGP and SMSDGF

	Service types being purchased by S/T2	Service types being purchased by Commonwealth in that jurisdiction (NGOTGP)	Service types being purchased by Commonwealth in that jurisdiction (SMSDGF P1)1
NSW	• Withdrawal • Counselling	• Counselling • Withdrawal	• Counselling • Residential rehabilitation

	Service types being purchased by S/T2	Service types being purchased by Commonwealth in that jurisdiction (NGOTGP)	Service types being purchased by Commonwealth in that jurisdiction (SMSDGF P1)1
	• Residential Rehabilitation • Consultation/liaison • Opioid pharmacotherapy maintenance • Telephone information, assessment and referral services	• Residential rehabilitation	
ACT	• Withdrawal • Counselling • Opioid pharmacotherapy maintenance • Support and case management • Residential rehabilitation • Telephone information, assessment and referral services	• Counselling • Residential rehabilitation	• Residential rehabilitation
SA	• Withdrawal • Counselling • Opioid pharmacotherapy maintenance • Residential rehabilitation • Telephone information, assessment and referral services	• Counselling • Withdrawal • Residential rehabilitation	• Counselling
QLD	• Withdrawal • Counselling • Residential rehabilitation • Opioid pharmacotherapy maintenance • Telephone information, assessment and referral services	• Counselling • Withdrawal • Residential rehabilitation	• Counselling • Residential rehabilitation
VIC	• Withdrawal • Counselling/care and recovery • Opioid pharmacotherapy maintenance • Residential rehabilitation • Supported accommodation • Telephone information, assessment and referral services	• Counselling • Withdrawal • Residential rehabilitation	• Counselling
WA	• Withdrawal • Counselling • Opioid pharmacotherapy maintenance • Residential rehabilitation • Consultation/liaison • Telephone information,	• Counselling • Residential rehabilitation	• Counselling • Residential rehabilitation

	Service types being purchased by S/T2	Service types being purchased by Commonwealth in that jurisdiction (NGOTGP)	Service types being purchased by Commonwealth in that jurisdiction (SMSDGF P1)1
	assessment and referral services		
NT	• Withdrawal • Counselling opioid pharmacotherapy maintenance • Residential rehabilitation • Telephone information, assessment and referral services	• Counselling • Residential rehabilitation	• Counselling
TAS	• Withdrawal • Counselling • Opioid pharmacotherapy maintenance • Residential rehabilitation • Consultation/liaison • Telephone information, assessment and referral services	• Counselling • Residential rehabilitation	• None (all capacity building projects)

Note:
1. The Commonwealth purchases capacity building projects in each of the jurisdictions listed above (as part of SMSDGF), but these have been excluded because we are focussed on direct service delivery for this analysis.
2. The descriptions here are taken from the Pathways Project, system descriptions. While each jurisdiction has slightly different terms, we have standardised the terms for ease of reference.

In summary, every state/territory health department funds withdrawal services, counselling services, and residential rehabilitation. In addition, in every jurisdiction, opioid pharmacotherapy maintenance programs are funded by state/territory health departments (and co-funded by the Commonwealth through Medicare and PBS). It should also be noted that states/territories fund capacity building.

What is apparent is that the Commonwealth purchasing – concentrated as it is in counselling and residential rehabilitation - is not necessarily out of step with state/territory health department purchasing. What we do not know is the relative investment in the different treatment types at the state/territory level. Again, this would be valuable information for service planning and an analysis which the IGCD could undertake.

Residential rehabilitation analyses

We undertook a more detailed analysis of residential rehabilitation, as this represents 28% of the Commonwealth direct treatment investment and is the most expensive service type per se. (See Table 5.13; excluding SMSDGF P2 & 3 Aboriginal and Torres Strait Islander services – these require a separate analysis, unable to be undertaken as part of the review).

Commonwealth funded residential rehabilitation services, as classified from STO data (limited in some cases, so may not be 100% accurate), are given in Table 5.16.

In some instances it is clear that the Commonwealth is purchasing either additional beds or a new program within the residential rehabilitation. For example in one residential service, the

Commonwealth funds are for a pilot day program; in another it is for an opioid pharmacotherapy maintenance in the residential service; in another it is funds to support families with their children. In other instances, the data simply indicate that it is a residential rehabilitation service, with no clear delineation of whether the Commonwealth funds are being used for a specific component, or whether it is contributing to the overall service delivery.

There were 41 residential rehabilitation services receiving Commonwealth funds from the NGOTGP and the SMSDGF P1 in 2012/2013. These were services in NSW (n= 20), the ACT (n= 3), the NT (n=1), Qld (n=8), SA (n=2), Tas (n=2), Vic (n=3) and WA (n=2). That is, there is at least one residential rehabilitation service in each jurisdiction receiving Commonwealth funds.

In terms of the proportions of those 41 that were also funded by the state/territory health departments, this was the case for 32 services (that is 78%). The majority of the Commonwealth's investment in residential rehabilitation is therefore also supported by state/territory investment.

Table 5.16: Residential rehabilitation services receiving Commonwealth funding (NGOTGP and SMSDGF P1) and whether state/territory also funded the service

	# of Commonwealth funded services	# co-funded by state/territory
NSW	20	14 (70%)
ACT	3	3 (100%)
SA	2	2 (100%)
QLD	8	5 (62%)
VIC	3	3 (100%)
WA	2	2 (100%)
NT	1	1 (100%)
TAS	2	2 (100%)

Indeed, only NSW and QLD state health departments do not contribute funds to all the residential rehabilitation services funded by the Commonwealth in their jurisdictions.

Discussion

This Chapter has described the funding rounds associated with the NGOTGP and SMSDGF at a point in time, with fund amounts reflecting the 2012/2013 year. There are a number of simple procedural details associated with the open competitive rounds for the NGOTGP and SMSDGF that could be improved. The importance of clear and concise documentation (in both the Guidelines and the Intention to Apply) should reduce confusion in the sector. The inclusion of content experts in the assessment panels seems a useful future initiative. Overall, however, the analyses reinforce the importance of a mutually co-operative relationship between the two primary funders: the Commonwealth and the states/territories. It behoves the states/territories to consult with and engage the Commonwealth in their purchasing processes to the same extent as it behoves the Commonwealth to engage in collaborative processes with the states/territories.

This Chapter also reinforces the importance of accurate and detailed data. This includes both Commonwealth and state/territory funding data. In order to accurately assess investment mix for any one funder, let alone investment mix across multiple funders, better data are needed. These analyses are important because they speak to the potential for duplication, and opportunities for better planning. The kinds of data that would be required to conduct these analyses fully include:
- The total amount of funding from the Commonwealth to each organisation

- The total amount of funding from the state/territory health department to each organisation
- Other funding amounts by organisation (client co-payments, philanthropy)
- The services/projects purchased by the state/territory from each organisation (including the type and amount of care as measured by bed days, number of clients, number of episodes of care and associated outcomes)
- The services/projects purchased by the Commonwealth from each organisation (including the type and amount of care as measured by bed days, number of clients, number of episodes of care and associated outcomes).

This would require data collection by government funders (both state/territory and Commonwealth) as well as by individual agencies. Standardised templates for the data (notably the service types and the associated type and quantity of care) would be useful. Some data may be sensitive and subject to confidentiality provisions.

If this kind of information is important for future planning and purchasing (and we believe it is), then considerable effort needs to be made to accurately collect, collate and analyse the data. This can only be done as a co-operative venture between the states/territories and the Commonwealth and is best lead by the IGCD.

The AOD field is not alone in relation to the paucity of good data to understand funding amounts, specific services to be delivered and so on. We note that the Mental Health Commission is having similar challenges with its review of the NGO Mental Health services funding arrangements (Senate Estimates 2nd June, 2014[51]); the NSW government's review of NGO funding in that state was also unable to ascertain the amounts of funds being provided (GMIT report, Nov 2012). Not only is the information regarded by some as 'commercial in confidence', the public domain sources (e.g. government annual reports where grants are required to be reported) present only part of the picture. There is a more complicated side to this as well – despite the obvious need for both levels of government to work together when they are co-funding (to avoid funding omissions, duplications, gaps), the processes for funding rounds (governance, timing and probity issues) can at times override co-operation.

To return to the issues identified earlier (financial viability of individual agencies; 'duplication' of funding; and sector sustainability), there does appear to be substantial concordance between the agencies chosen to receive Commonwealth funds and those also funded by state/territory health departments. Overall 67% of the agencies that the Commonwealth funds are also in receipt of state/territory health funds. This suggests a successful leverage of combined funding at an organisation financial viability level. This also augurs well for sector sustainability. For those jurisdictions where there is a lower percentage of co-funded services (less than 65%: QLD, SA, VIC and WA) further examination of the individual agencies appears warranted. There does not appear to be any systematic difference in the rate of co-funding for the three fund categories: NGOTGP,

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[51] When asked about the Mental Health Commission Review, which includes intended analysis of Commonwealth and "the NGO sectors, the states, the private sector, trying to find out what expenditure is occurring and, obviously, relating back to our terms of reference about things such as effectiveness, efficiency, duplication, red tape, gaps in services, ways of doing things", and noting the complexity of understanding all expenditure ("It is obviously an extraordinarily complex area in relation to the mental health system across Australia and looking at Commonwealth and state programs, non-government organisations, the private sector and the roles of consumers and carers and the like") Mr Butt noted that for Commonwealth data "there are various things in it that we are still working our way through or we went back and asked for further information". For NGO data "We have subsequently gone out to 310 NGOs asking them for further detail on their expenditure", and for states/territories, two have not responded and there are concerns about "contracts that they have entered into which are commercial in confidence". The clear impression form the Senate Estimates Transcript (2nd June, 2014) is that there are significant challenges with collating mental health expenditure data.

SMSDGF P1 and SMSDGF P2&3. The jurisdictions where the Commonwealth investment represents 70% or more for a number of individual agencies is in NSW, Vic and Qld (see Table 4).

The state/territory health departments in every instance invest in the full array of AOD treatment services (see Table 5.15). There is no evidence that the Commonwealth's investment is out of step with the states/territories. The service types supported by Commonwealth funds (largely counselling and residential rehabilitation) are also supported by state/territory funds (although the quantum is unknown). The vast majority of residential rehabilitation services are co-funded by both levels of government (see Table 5.16). In only two jurisdictions (NSW and QLD) are there residential rehabilitation agencies not in receipt of state funds.

We reinforce that the data on the investment mix are preliminary only, and it requires a co-operative effort by both levels of government to ascertain the true investment mix in each organisation, the mix of service types at a state or national level, and the mix of activities (episodes of care, bed days, and client outcomes).

As this analysis demonstrates, the Commonwealth plays an essential role in purchasing core AOD treatment. But the investment goes beyond this; the Commonwealth also has a vital role to play in ensuring a sustainable sector, generating better outcomes for treatment through direct support for treatment functions and targeted initiatives to build sector capacity.

Conclusions

- Through the NGOTGP, in 2012/13 the Commonwealth's total funding amount was approximately $49 million for that year.
- NGOTGP grants were spread across all Australian jurisdictions. All grants were competitively tendered. There was no change to the priority areas for the NGOTGP in the 2012 round relative to earlier rounds.
- As a flexible fund, the SMSDGF can use multiple mechanisms for purchasing: open competitive grant rounds, targeted grant rounds, one-off funding, and procurement. The SMSDGF has six priority areas, of which four directly relate to alcohol and other drug treatment.
- In 2012/13, the SMSDGF had grants totalling about $80 million for that year.
- Approximately 70% of the SMSDGF funds were for Aboriginal and Torres Strait Islander services in 2012/2013. The remaining 30%, which were subject to competitive tendering, were largely capacity building projects and counselling services in the 2012 round. All jurisdictions received SMSDGF grants in 2012/13.
- The Commonwealth purchases core AOD treatment services and capacity building with the NGOTGP and SMSDGF grants schemes.
- Within 'treatment' we identified 'core AOD treatment': withdrawal, residential rehabilitation, psycho-social therapy (counselling), and maintenance pharmacotherapy; and supporting treatment functions
- Within 'capacity building', we proposed three streams:
  - Client/priority topic
  - Organisational / institutional
  - Intra- and inter-sectoral systems of care.
- The current Commonwealth investment is 84% in treatment and 16% in capacity building (when the quantum of funds is used as the metric).
- When the NGOTGP and SMSDGF funds are considered together (and excluding Priority 2 & 3), the Commonwealth invests predominantly in counselling (37% of funds), followed by residential rehabilitation (28% of funds).

- This investment is not inconsistent with states/territories investment. While we do not know the quantum of funds, the most common service type is counselling.
- The Commonwealth purchases core service types that align with the states/territories purchasing.
- Based on the data available, there is no evidence of 'duplication' to the extent that unmet demand is high, and organisations use Commonwealth funds to deliver more or better care.
- In terms of the total funds to Aboriginal and Torres Strait Islander AOD services, the SMSDGF allocated $56,312,052 under Priorities 2 & 3 for the year 2012/2013. The funds within the NGOTGP that went to Aboriginal and Torres Strait Islander AOD services amounted to $6,564,532. This means that of the total $130 million in NGOTGP and SMSDGF for the year 2012/2013, 48% was allocated to Aboriginal and Torres Strait Islander AOD services.

Chapter 6: Existing purchasing mechanisms

Thus far we have considered the funding sources and flows (Chapter 3) and the amounts of funding (Chapter 4), and the details regarding the NGOTGP and SMSDGF processes in 2012/2013 (Chapter 5). Here we consider the detailed purchasing mechanisms for AOD treatment.

In summary, the Commonwealth and state/territory governments currently purchase AOD treatment through a number of different mechanisms:
- Competitive selection processes (grants schemes)
- Fee-for-service (Medicare)
- Activity-based funding (hospitals)
- Block grants, historically driven or individually negotiated
- Transfer of funds to state/territory governments (special purpose payments to states/territories).

In addition, there are two other funding mechanisms, which are not fully implemented at present in Australian AOD treatment purchasing:
- Capitation
- Payment for outcomes.

Working Paper # 10 provided a review of these various approaches, and also provided a conceptual schema to think about the different mechanisms. Here we have refined and simplified our thinking down to two critical components:
1. Choosing a provider
2. Choosing a payment mechanism.

At present, there are four ways in which the Commonwealth and state/territory governments select AOD treatment providers:
1. Through competitive selection processes
2. Through individually negotiated arrangements (often based on historical agreements)
3. Through delegation to another level of government (transfer to states/territories)
4. Through an accreditation and/or registration process.

At present there are also four ways in which the Commonwealth and state/territory governments could provide the funds:
1. Through a block grant (lump sum)
2. Through a price per unit of activity
3. Through a capitation model
4. Through payment for outcomes.

This chapter reviews these two parts to purchasing mechanisms (choice of provider; choice of payment mechanism). The chapter uses both literature and key informant data (see Working Paper # 10) to describe the strengths and challenges associated with the different mechanisms. The chapter also provides a summary of Commonwealth, state and territory AOD treatment purchasing mechanisms.

Choice of provider

Competitive selection processes (open, targeted, preferred-provider panel, consortia)
For government purchasers in Australia, competition is now a common way of selecting providers. The *Commonwealth Government Grant Guidelines* require that, unless specifically agreed otherwise (by the Minister, Chief Executive or delegate), competitive merit-based processes be used to allocate

grants (Department of Finance and Deregulation, 2013). There are a range of options for competitive selection: open, targeted, and preferred-provider panels. In addition, consortia arrangements can be competitively selected. The key informants, both purchasers and providers of AOD treatment across Australia were very familiar with and had extensive experience of competitive funding processes as they have occurred through the Commonwealth grants schemes and through state/territory processes.

From the purchaser perspective an open competitive selection process is usually considered most appropriate for a higher value or higher risk project (The Chartered Institute of Purchasing and Supply), although how this is defined will differ depending on the sector. Open competition means that new players are free to enter the market (Australian National Audit Office, 2013). From a purchaser perspective open competitive selection processes are therefore well suited to markets with multiple potential providers (Jensen & Stonecash, 2005), as the selection process may result in competition (The Chartered Institute of Purchasing and Supply). Speaking to the advantages of competitive processes from the purchaser's point of view, one key informant noted that "the reform process involves opening up the market to both NGO and private providers in [state] and interstate. Contestability will be tested within an open market, as a driver of service quality". The literature notes not only service quality but potentially reduced costs to the purchaser where there is a genuine level of competition (Bajari, McMillan, & Tadelis, 2009; Jensen & Stonecash, 2005; Rimmer, 1991).

Another advantage of competitive process, and particularly open competition, is the transparency and accountability of the selection process (ICAC, 2012; Productivity Commission, 2010; The Chartered Institute of Purchasing and Supply). Open competitive processes are likely to minimise allegations of unfairness or bias against the purchaser, and provide a clear paper trail. Key informants noted this advantage of competitive processes - they are seen to hold a level of transparency and fairness. Procedurally, open competitive funding rounds allow the purchaser to consider many applications at one time, which is administratively efficient. (The Chartered Institute of Purchasing and Supply). From the purchaser perspective applications can more easily be judged directly against each other when they are received together (Australian National Audit Office, 2013). The uniform application process arguably provides a 'level playing field', with all services facing the same application rules (Australian National Audit Office, 2013). Despite the apparent logic of 'level playing field' notion, our key informants (both purchasers and providers) were aware that this may not always be the case. Equity and fairness in competitive processes may not occur because agencies have different level of resources they can bring to the competition. Smaller agencies need more support: "it is not a level playing field, but under the current system it looks like we assume that it is".

The vast majority of key informants (both purchasers and providers) acknowledged the role of competitive processes for AOD service provision, where these processes were well implemented. A careful and comprehensive approach to market, with well-specified conditions, and where the purchaser clearly specifies what it wants, can work. The importance of good processes was emphasised by key informants. For example, well-constituted and qualified assessment panels, clear documentation for tendering, time spent developing the RFT and ITA materials, and the use of assessment criteria (including weighted criteria) were all important. Key informants argued that the purchaser needs to put substantial work and time into policy formulation and preparation before going out to market. Managing expectations is another important part of the processes for competitive grant processes that was noted by key informants. The recent experiences have not been well regarded because of implementation issues.

According to key informants, competitive processes can encourage innovation and new ways of practice to be tested. One key informant commented that, "there does come a time when you need a shake-up"; want to "freshen it up" and so retaining an open competitive process is useful in that circumstance (although this person, a provider, went on to say that for base or core services, it was not the appropriate funding model). It was also noted that competitive processes work well when there are highly specific criteria regarding exactly what would be purchased (and this is based on identified gaps).

Case example: Organisation A and Organisation B: competitive tendering
(For full details, see Chapter 17)

Organisation A
The organisation actively seeks opportunities to tender from multiple government departments and philanthropic agencies. One participant noted that when preparing tender applications, the organisation generally already has "a good feel" for what the government will fund based on past experience.

Tendering timelines were regarded as manageable, and participants were confident that the organisation had the skills and capabilities to prepare tenders and grant applications in a timely way. The organisation is focussed on a particular vision of holistic care provision, and as such chooses to tender only for funding which would enhance the core business of the organisation, including funding which broadens the availability of wrap-around services which support treatment for clients.

Tender and grant writing was regarded as "a skill". Writing applications is regarded as part of the ordinary activity of teams: "it is a mindset within the teams". It was also noted that the organisation invested significant time and energy into generating new ideas and innovations for trust and foundations' funding rounds.

It was suggested that going through a complete re-tendering process every 3 years, as is necessary with the Commonwealth funds, seemed "a bit unusual and over the top". Re-tendering was regarded as appropriate where it is "new money" or for new treatment programs, but if it is the Commonwealth's intention to continue the funding source and sustain organisations that are achieving well then re-tendering should not be necessary.

Organisation B
The organisation is often invited to tender, or may see open tendering opportunities through government websites and list servers. Participants noted that they look for funding opportunities which specifically fit the organisation's mission. Usually the CEO would write tenders (with input from staff), or sometimes a consultant will be engaged to write the tender (depending how big the application is and where expertise lies). Up until recently, the CEO was responsible for writing all the tenders and the reports.

Participants noted that competitive tendering processes generated "stress" and were "time consuming". The tendering process becomes the whole focus of CEO's work for that period, which takes the CEO away from other activities. Participants noted that timeframes for tenders are often short. They suggested that organisations should have at least 8 weeks to prepare a tender, and sometimes this is not the case.

Overall, participants said that the information provided by government in tendering processes is "usually ok" especially if a FAQ is provided on the website.

Participants expressed some concerns about how services are purchased by government through tendering processes – i.e. what's the basis of their decisions? There was a perception that tendering processes are now vastly different to how they have worked in the past, with the expectation that services produce "more outcomes for less money". In the past, when tendering for funding, the organisation would have considered "What's our capacity? What is our expertise?", but now the organisation has additional concerns: "Is there enough money in this tender to do what the government is asking us to do?"

Competitive selection processes have some disadvantages. There is debate about whether competitive processes produce efficiencies (cost savings in service delivery). According to the Australian Productivity Commission competitive grants processes have been shown to increase economic efficiency (Productivity Commission, 2010). However, it is important to note that much of the research on the cost benefits of competitive application processes has been in areas such as waste collection and transport or road maintenance, rather than social services (Jensen & Stonecash, 2005; McDonald, 2002). It has been argued that there is little evidence that competitive processes improving efficiency and effectiveness in the social services context (McDonald, 2002). Economic and public administration research literature indicates that the success of any particular competitive funding process in making savings for the purchaser will depend on the level of genuine competition between service providers (Bajari et al., 2009; Jensen & Stonecash, 2005; Rimmer, 1991). Other important factors influencing the extent of potential savings will be the extent of existing inefficiency in service provision and the ability of agency management to innovate and/or change service delivery; as well as purchaser's control over contracts and evaluation (Rimmer, 1991).

The concern has been raised by a reviewer of health sector purchasing that many successful bids in competitive processes may be unreasonably low, even below cost – particularly if there are a large number of applicants (Duran, Sheiman, Scheider, & Ovretveit, 2005). This may be partly because administrative and overhead costs may be underestimated by NGO services applying in competitive public funding processes – leading to longer term lack of sustainability (Housego & O'Brien, 2012). An additional concern is that in labour intensive industries (such as the alcohol and drug sector) there is a temptation in public sector contracting processes to economise on staff costs – for example fewer staff, less qualified workers, greater work intensity, erosion of pay / conditions (Jensen & Stonecash, 2005). There is some evidence from the health sector that links competitive processes with reduced salaries for the lowest paid workers and increased salaries for senior managers (Adams & Hess, 2000). Concerns have also been raised that uncertainty brought about through competitive selection processes may lead to loss of qualified staff leading up to and during the application period, and reduced motivation of workers (Adams & Hess, 2000). Key informants also noted that experienced personnel leave the sector as a result of the uncertainty created by the competitive processes, yet a stable workforce equates to better AOD treatment outcomes.

Competitive tendering has the potential to reduce service quality if the main emphasis is on cost reduction, eg selection of lowest cost tender (Duran et al., 2005; Jensen & Stonecash, 2005). Such risks of open competitive processes may be amplified if public officials are inexperienced in market approaches (Adams & Hess, 2000). However, having said this, the purchaser does not need to select the lowest cost provider. Australian Government guidance supports the concept of value-for-money purchasing, with the concept of value-for-money including both cost and quality (Commonwealth Grant Guidelines, 2013). However, the success of the value-for-money concept will depend on accurately identifying quality and weighing this appropriately against cost during the selection process. There has been little research on how AOD treatment grants are allocated. However, a UK study of allocation of funding highlighted the need for agreed standards and staff training when allocating funding at local level (Foster, Peters, & Marshall, 2001). In this instance responsibility for residential alcohol treatment services had been allocated to social services, but there was little agreement amongst social service staff on the priorities for making funding decisions.

Another area of concern for open competitive processes is that they can impose a high potential administrative burden, particularly for service providers, but also sometimes for purchasers (Bredgaard & Larsen, 2008; Productivity Commission, 2010). However, administrative processes may not be problematic, or may be amendable to process improvements (Bredgaard & Larsen, 2008). A resource-intensive application process may particularly be a barrier to small- to medium-sized enterprises with limited capacity to respond to the tender (The Chartered Institute of Purchasing

and Supply), and some appropriate services may be deterred from applying (Butcher, nd; McDonald, 2002). From the provider key informants this was reinforced: a commonly raised concern was the amount of time and resources these processes consumed. This was-particularly noted for smaller NGO services, which may be disadvantaged through having fewer resources to draw on in the process.

Australian government and other documents draw attention to the principle of proportionality, and recommend potentially using other contracting processes for services with specialised requirements, where there is a limited applicant pool or for relatively small value / low risk projects (Adams & Hess, 2000; Australian National Audit Office, 2013; The Chartered Institute of Purchasing and Supply). A further concern by key informants is how to think about Big International NGOs in the context of competitive processes. Key informants worry that competitive processes tend to favour larger providers and big international NGOs, which then has the potential to reduce diversity, remove smaller organisations, and reduce the AOD service connectedness to local community ("not another Woolworths").

Competition can adversely impact on collaboration, and promote division in the sector, according to an Australian researcher on NGO social service provision (McDonald, 2002). Key informants noted that competitive processes can have a negative impact on the cohesion of the sector, while this is a fundamental requirement for continuity of care. A number of key informants (providers) expressed strong views about the negative sector consequences of competitive processes: "tendering divides the field, prevents cooperation"; "the competitive tendering process frays relationships"; it "decimates the capacity" of the sector. Some key informants noted the complexity of relationships between providers — the importance of partnerships and collaboration yet the requirement to compete at various times. In this sense, competitive processes can undo partnerships and threaten collaborative working relationships. This was noted especially in rural/remote areas, where collaboration between agencies is vitally important. Competitive funding processes can also be challenging in smaller jurisdictions or regions, where the array of ongoing base services is important for the sustainability of the sector: "Putting contestability forward and expecting collaboration is ridiculous. This is so fragmenting for services. It brings out the worst in all of us" (provider).

Key informants also reinforced that competitive processes should not be a way of managing performance problems. There was a sense that this may have occurred. As one key informant argued, "defunding needs to be done in a different way, through performance management (quality, outcomes etc) not through a funding process" (purchaser).

Key informants noted that there are potential risks for the purchaser. Existing infrastructure and previous investment may be put at risk under competitive processes. While competitive tendering opens the market, it also represents a risk to the purchaser, as the benefits arising from previous investment may be lost. Examples were given where the funder has worked closely with an agency, built a facility and committed to future capacity; going out to tender subsequently places that investment at risk. Another difficulty for the purchaser is where no-one submits an application. The purchaser is relying on an assumption that there is a market of providers, but this is not always the case (we were provided with a specific example). A preferred model in this situation may be targeted competition, where organisations are specifically approached to work with the purchaser (see below for discussion of this option).

Situating competitive processes most appropriately within the context of what is being purchased (core ongoing AOD treatment services, or pilots and innovations) and whether the grant schemes represent new or growth money seems important. Some key informants argued that competitive tendering works well where there is new money, or growth funds, or a new service type being

purchased. At present, competitive processes are used to purchase standard AOD treatment that has been provided by the same agencies for many years. Some key informants wondered whether a better model would be to use a different funding approach for base services and reserve competitive processes for innovations, pilot programs and where additional or new funds are being provided. As noted by one, "everything up for grabs every three years is farcical" (purchaser), and another "why do we have to go through this every time?" (provider).

Competitive approaches assume that the purchaser wants changes to the pool of providers (this key informant view is linked to the public sector contracting literature's discussion of open markets). Key informants questioned whether the purchaser always wants to change the market. This links to how people think about the AOD treatment "market". Key informants to this Review argued that it was important for the purchasing mechanisms to enable retention of a specialist sector (however as noted elsewhere in this report the distinction between the generalist and specialist AOD treatment sector is blurred). We noted the tension between allowing new providers into the sector versus retaining a specialist sector[52]. Effectively, an open competitive grants process was perceived by key informants to allow and even encourage non-specialist services to submit applications ("who may produce high quality tenders despite lack of staff and organisational expertise"). A number of key informants reinforced the importance of investment in the specialist sector ("this is your treatment sector," "invest in this"). In understanding this, key informants appreciated that all sectors were under strain and hence scope creep was an issue more generally; both for existing specialist AOD services (getting into non-core areas of business because of "chasing" funding) and for non-specialist AOD getting into the AOD space; given competition and the need to "play every card".

In sum, key informants argued that open competitive processes do not support a sustained, specialist sector. An alternate model is a preferred-provider process – where only preferred providers are eligible to compete for funding. This issue along with some of the other challenges raised above regarding fully open competitive processes leads to consideration of alternate competitive processes – targeted or preferred-provider panels.

Targeted competition and preferred-provider panels

The Australian National Audit Office notes that preferred-provider panels and targeted competitive approaches can be used to ameliorate some of the issues associated with open competitive processes (Australian National Audit Office, 2013). Targeted or restricted competitive processes are open to a small number of potential grant recipients based on the specialised requirements of the granting activity or project under consideration (Commonwealth Grant Guidelines, Department of Finance and Deregulation, 2013). The purchaser approaches services to ask them to apply. The general literature identifies targeted competitive process as appropriate where only a small number of organisations are capable of delivering the service (Kramer & Grossman, 1987). For example, funders may be looking to buy services in a specific geographical location or in a remote region, or to purchase highly specialised services might only be deliverable by a limited number of organisations. Targeted approaches require justification as there is a presumption for open competitive approaches under government grant guidelines (Australian National Audit Office, 2013). Targeted approaches reduce the amount of administrative work required for the purchaser. They can also ensure continuity for agencies and clients (Kramer & Grossman, 1987). Arguably therefore, targeted approaches may cost less for the purchaser and the potential provider (Kramer & Grossman, 1987). However, targeted approaches suffer the disadvantage of reducing the transparency and the perceived fairness of the application process (Australian National Audit Office, 2013), particularly for services not selected for consideration. Another disadvantage is that when applications are assessed

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[52] Note: it is not necessarily the case that all specialist services are currently receiving Commonwealth funds. The sector could expand through introduction of specialist providers previously not funded by the Commonwealth.

in isolation it can be more difficult for purchasers to assess them consistently against other applications (Australian National Audit Office, 2013).

Preferred-provider panels are a variant of the competitive approach. Provider panels involve the pre-selection of accredited or preferred providers, who are then the only ones eligible to compete in later funding rounds. The relative advantages and disadvantages described above in relation to targeted competitive processes, apply equally here. The main benefit is likely to be a reduction in the administrative burden of the application process compared to a completely open application process (The Chartered Institute of Purchasing and Supply). The main drawbacks are that this process does not facilitate the entry of new providers into the market (once the pre-qualification round is done) until the next pre-qualification round. There may also be a reduction in the perceived fairness and transparency of the process. Preferred-provider panels, once established can then be subject to competitive processes for individual grants or contracts, or as a result of entry into a preferred-provider panel, can then become by default the service providers (who are thus accredited and paid through fee-for-service). The Department of Veteran's Affairs is currently exploring the options of establishing a preferred-provider panel for the provision of AOD treatment. We provide this as a case example.

Department of Veterans' Affairs Case example: preferred-provider and fixed fee schedule model
(The full case example can be found in Chapter 17).

Context
DVA currently provides a range of healthcare services to veterans and others entitled to treatment under three main pieces of legislation: the *Veterans' Entitlements Act 1986*, the *Safety Rehabilitation and Compensation Act 1988* and the *Military Rehabilitation and Compensation Act 2004*.

In general, two pathways under which an entitled person may receive access to healthcare are:
1. Liability Pathway (where the Commonwealth has accepted liability for a condition(s) caused by service) which covers a range of healthcare needs; and
2. Non-Liability Pathway (including for those who have served on operations and some peace time service categories) for specific disorders: e.g. cancer, tuberculosis, PTSD, anxiety, depression. These conditions do not need to have service-causation established to access appropriate healthcare.
Help is also available through the Veterans and Veterans Families Counselling Service to a range of eligible current and ex-serving Defence members and their families.

The Veteran Mental Health Strategy was released on 27 May 2013 (see Department of Veterans' Affairs, 2013) and provides a ten-year framework for mental health care provision for current and future veterans and their families. The Strategy's stated purpose is to:
"Set the context for the provision of mental health services in the veteran and ex-service community and for addressing mental health needs;
Identify strategic objectives and priority actions to guide mental health policy and programs; and ensure the best possible outcomes for individual mental health and wellbeing."

The strategy underpins a commitment of $26.4 million dollars over four years (in addition to existing funding of $166 million per year) to expand the provision of mental health services to veterans. Under the budget measure there a range of new initiatives commencing in 2014, including an extension of the non-liability healthcare beyond the existing conditions to now include alcohol and other drug issues. The eligibility criteria will also be further extended to include more peace-time service categories. The new strategy recognises that alcohol and other drug issues may have an impact on the health and wellbeing of veterans and their families. From July 2014 eligible clients will be able to access free treatment for diagnosed alcohol and substance use disorders, without the need to lodge a compensation claim (Department of Veterans' Affairs, 2013, p. 17). In addition to these changes to access to treatment, DVA continues to examine existing purchasing arrangements to ensure clients are provided treatment that meets their needs, including considerations of access, service settings, evidence-based treatments, safety and quality assurance.

Current approach
DVA has a long established, standard system for how it pays for healthcare for veterans, through procurement arrangements (via tender) and agreements with providers. For example, DVA has entered into Hospital Services Agreements with private hospitals throughout Australia. DVA is billed by the private hospital for each individual patient, generally at fixed, agreed costs (see fee schedules: http://www.dva.gov.au/service_providers/Fee_schedules/Pages/index.aspx). Where a healthcare provider accepts a DVA repatriation health card (Gold or White) for payment for treatment, the provider agrees to accept DVA fees and conditions for the services provided. This process is managed within DVA by the 'hospital contracting area'. DVA has also entered into agreements to provide mental health services through private hospitals.

In November 2010, a simplified process for registration of allied mental health providers was introduced. Under this system of statutory registration, clinical psychologists, psychologists, social workers and occupational therapists who were registered with Medicare Australia to provide mental health services would automatically be able to provide allied mental health services to repatriation health card holders. This meant that DVA was no longer required to approve individual service providers as long as the service met Medicare registration requirements.

Extension of service providers
DVA is currently examining purchasing arrangements for AOD treatment. An option is a panel of providers to deliver AOD treatments, which are required to meet quality and accreditation standards, for instance Core Service Standards recently developed. Providers might be drawn from the government, NGO and/or private sectors, thereby enhancing access to services outside of hospital settings. A greater number of providers may offer increased accessibility for clients, and a good geographic spread of services is important. A panel arrangement would require consideration of fees, charges and quality standards[53].

A system for accrediting AOD services (in order to join the preferred-provider panel) is a key factor. AOD treatment providers may not necessarily be registered with Medicare, particularly services provided through the NGO sector. The challenge is how to select a panel of AOD treatment providers in the absence (at present) of a national accreditation system, and how to ensure the ongoing provision of quality services for clients. To inform its thinking, DVA will engage AOD treatment clinical consultants to provide advice on a set of 'Core Service Standards for Alcohol and Other Substance Use Disorder treatment service quality' which have recently been developed (see the full case in Chapter 17) and advice on the development of a model for using the standards to assess treatment providers.

Reflections and implications for AOD treatment funding
A 'panel of providers' model for AOD services is akin to the notion of 'preferred-provider panel'. The notion of 'preferred provider' has yet to be applied to the AOD NGO sector and is worthy of consideration for AOD treatment funding more broadly. A panel of providers could be used across multiple government departments seeking treatment services (notwithstanding the question of which agency may be best placed to assess and accredit quality treatment providers).

The length of contracts with the accredited 'panel of providers' may be a critical issue for sustainability, both in terms of continuity of service provision and for the organisations themselves. It is unclear how often new providers for panels would be sought (regularly or as a one-off expression of interest).Another challenge within a preferred-provider model is how to monitor standards, accreditation and quality over time.

There was significant discussion in some of the consultations about the notion of a preferred-provider panel (one purchaser group; and six provider groups). Key informants who discussed preferred providers as a possible funding approach argued that a pre-approval process, showing that

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[53] As a guide, fee schedules for other current services are available on DVA's website:
http://www.dva.gov.au/service_providers/Fee_schedules/Pages/index.aspx;
http://www.dva.gov.au/service_providers/Fee_schedules/Pages/Dental_and_Allied_Health.aspx

an organisation met quality standards, accreditation, and so on, could be applied to the Commonwealth grants, such that only organisations on the preferred-provider panel would be eligible to apply for funding. Furthermore, these key informants argued that all existing funded agencies could become the 'preferred-provider panel'. They argued that the market has already been tested (through previous NGOTGP and SMSDGF competitive grant rounds). Further, the investments already made in infrastructure would be preserved under this approach.

A preferred provider approach would reduce the 'red tape' and administrative burden in competitive processes, because the establishment of a preferred-provider panel would include establishing the credentials, qualifications and agency administrative systems (accreditation, QA frameworks, standards etc), such that competitive grant rounds could concentrate on the specifics of the AOD service delivery. Specifically, the providers that can compete are those who have already passed through a level of scrutiny, quality assessment and so on by being part of the preferred-provider panel. As one key informant noted, the AOD sector is a "well-established market" (provider), having been co-funded by Commonwealth and state/territory governments for many years. In this sense, the key informants arguing for this model felt that governments had created a 'preferred provider' status for agencies given that many had been continuously funded and expect to be supported into the future. Preferred provider status provides longer-term security for base funding (but remains consistent with a competitive process).

The notion of a preferred-provider panel is also consistent with the key informants' strong views about preserving a specialist AOD sector, when it is assumed that preferred providers would only be specialist services. Most key informants argued that funding approaches needed to consider the specialist nature of the work and aim to sustain a specialist sector, rather than disperse funding across providers who may or may not be specialist AOD providers. In this view, the preferred-provider panel effectively operates a gate-keeping function, allowing only specialist services to participate.

Key informants who discussed this option acknowledged that with the preferred-provider panel a system would be required to enable new players to enter the market; or existing players to expand. None of the discussion about preferred-provider panels obviated the need for strong accountability and key informants noted that decisions should be based on merit.

Expressions of interest

Within competitive processes, we noted differences of opinion about a two-step competitive process amongst the two groups of key informants (both providers) who discussed this option. Some key informants thought that the "EOI [expression of interest] process is worse than full tender. More work". On the other hand, some key informants felt that the EOI process was worthwhile as it gave providers an opportunity to 'sell' an idea or innovation prior to putting in all the work required in a full application. The EOI process, it was argued, has the potential to capture a broader market and it is useful for new innovations. It "allows agencies to demonstrate what they can do" and potentially relatively quickly eliminates inappropriate providers. The purchaser also does not need to review full applications until an EOI process has determined a smaller number of potential applicants. There are however disadvantages. As noted by key informants, a two-step process is more work for the providers, it potentially gives false hope to those shortlisted, and the process is longer. However, the Productivity Commission (2010) noted that a two-step process is a method for reducing costs to both parties.

Key informants' experiences with competitive processes have been that they have been poorly linked up with planning and, while this is not a limitation of competitive processes per se, it does reflect the importance of connecting planning and purchasing processes. As noted by one key informant, "a grants approach is not a planned approach; it relies on the nature and quality of

submissions from agencies. It does not support continuity or a sector wide approach to planning" (purchaser).

Consortia

Consortia — with the nomination of a lead agency which then coordinates service delivery on behalf of a range of providers - is a potential model for the choice of providers. Consortia provide the opportunity for providers to work together, and thus to leverage a wide range of resources (McDonald, Murphy, & Payne, 2001), and to share skills and experience (Office of the Third Sector, 2008). Therefore one strength of consortia is that they may provide opportunities for services to apply for projects that would not otherwise be open to them through pooling of skills (Office of the Third Sector, 2008). In theory such consortia models have the potential to produce improved client services and outcomes through better coordinated services, and promote reduced administrative costs through pooling of resources (Office of the Third Sector, 2008). Key informants identified that consortia have the potential to support better coordinated care, more sustainable services and fewer contracts to manage (by the purchaser). As noted by one key informant, "governments like it because they only have to fund one organisation, and can transfer the risk" (provider). Depending on the configuration of the consortia, they may allow better linking of localised planning processes, eg needs assessment, to payments (Robinson, Jakubowski, & Figueras, 2005) and can aim to promote decentralisation and more flexible decision making (Hancock & Mackey, 1999; Robinson et al., 2005). The Productivity Commission has noted that such consortia arrangements may potentially contribute to innovative ways of working on intractable problems (Productivity Commission, 2010). It appears that it is a model consistent with AOD given that "'…'joined up' problems require 'joined up' solutions." (McDonald et al., 2001). Key informants were aware that a number of services purchased by funders are well-suited to consortia type arrangements. Examples given included clinical supervision services (spread across a number of agencies), and residential rehabilitation services across large regional areas. In addition, AOD clients have many needs across health, social and welfare services. Consortia arrangements across sectors can facilitate better-coordinated care across these systems.

On the other hand consortia arrangements can be time consuming to form, and may have additional costs and administrative work. Different organisational operating systems and workplace cultures can be challenging to coordinate (Office of the Third Sector, 2008). Key informants to the Review were aware of poor consortia practices and were concerned about the potential "power imbalances" within consortia. Some felt that consortia arrangements "may not be in the best interests of the clients" (provider). There were also comments about the skills required to sustain successful consortia. "Partnerships in service delivery are well understood, but not sure we really understand consortia" (provider).The Productivity Commission notes that consideration needs to be given to consortium-related costs, such as sub-contracting cost, duplication of reporting requirements, and possible loss of diversity amongst service providers (Productivity Commission, 2010). Decisions taken by the lead organisation will affect other services, but these other services may have limited role in making those decisions (Office of the Third Sector, 2008). The third-party organisation and staff need to have appropriate skills in grants/tender management, stakeholder liaison and financial management skills (Department of Finance and Deregulation, 2013). Dedicated resources are required. It takes "time, humans, and skill — to lead partnerships over a period of time" (provider). The legal situation can be relatively complex (Office of the Third Sector, 2008). It has been argued (in a UK context) that consortia arrangements are likely to be more expensive to providers than tendering singly due to the need for specialised legal advice/legal work to form consortium (Office of the Third Sector, 2008). There is also a higher level of risk for lead contractor (Office of the Third Sector, 2008), and services can be legally liable for problems caused by other consortium members (Office of the Third Sector, 2008).

The Commonwealth led a major new mental health initiative, Partners in Recovery, using competitive grant scheme that was consortia-based. We provide summary details here by way of a case example of this approach.

Partners in Recovery (PIR) case example
(The full case example can be found in Chapter 17)

The objective of PIR is: "to improve the system response to, and outcomes for, people with severe and persistent mental illness who have complex needs by:
facilitating better coordination of clinical and other supports and services to deliver 'wrap around' care individually tailored to the person's needs
strengthening partnerships and building better links between various clinical and community support organisations responsible for delivering services to the PIR target group
improving referral pathways that facilitate access to the range of services and supports needed by the PIR target group and
promoting a community based recovery model to underpin all clinical and community support services delivered to people experiencing severe and persistent mental illness with complex needs." (see http://www.pirinitiative.com.au/about/overview.php)
The purpose of PIR is not to deliver services per se, but rather to provide coordination, integrated case planning and clinical collaboration through 'PIR organisations'. PIR organisations are described as "the mechanism that glue together all the services and supports within the region that an individual may require" (http://www.pirinitiative.com.au/about/piro.php).

While the invitation to apply was technically open to any organisation, in practice the process encouraged only one applicant from each region (because the emphasis was placed on coordination of care across multiple organisations). Multiple applications were received in only a few regions.
The eligibility criteria for applications for funding were outlined in the *Program Guidelines*, which noted that "[f]avourable consideration will be given to consortium applications. Consortium applications must identify the lead organisation to be contracted to the Department, and outline the role of each partner in the consortium". Given the vision of PIR organisations as coordination and collaboration mechanisms, the tender documents emphasised the establishment of partnerships:
"The Department encourages organisations to form collaborations, consortia or other joint arrangements to deliver PIR within a region. For the purposes of PIR, members of a collaboration, consortium or other joint arrangement are defined as having an integral role in the delivery of the proposed PIR model."
The invitation to apply document required applicants to be explicit about the operation of partnership arrangements (the 'Essential requirements to be covered in applications' are outlined in the Program Guidelines for the engagement of PIR Organisations 2012-13 to 2015-16, Department of Health and Ageing).

The invitation to apply document also specified that tenderers were required to have undertaken regional mapping beforehand to identify relevant services across sectors, and identify how the PIR organisation could best engage the services identified in the mapping. This again placed the onus on the tenderer to establish links and coordination, identify how partnerships would be established, and determine the capacity of partner organisations to undertake the commitments required of them.

The tendering process ensured that partnerships were developed that suited the local regions/areas. Organisations were required to generate partnerships as part of the tendering process, rather than having partnership arrangements put in place as a result of directives. It was suggested by key informants to this case study that the process would not have worked if a lead organisation had been chosen *a priori* then instructed to find local partners. Feedback received by the Department from organisations suggested that this had been a positive process, and collaborative processes put in place by organisations during the application development phase have been sustained into the future. Throughout the process, the sector was encouraged to be part of trying to create this new service model (rather than being seen as providers of services alone). It was suggested by informants to this case study that this too created a positive feeling across the sector. It was also noted that this approach to tendering required great commitment (and time) from the Mental Health staff at the Department of Health, to ensure this process proceeded effectively. It was noted that although there were benefits to the level of detail required in the applications (e.g. explicit descriptions of the partnerships) the

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applications did not have page limits which meant that very long applications were received.

This case example is relevant for considering the way the Commonwealth purchases non-service delivery (or coordinating and capacity building) functions for the AOD treatment sector. In considering the aims of PIR (as expressed in the Program Guidelines for the engagement of PIR Organisations 2012-13 to 2015-16 Department of Health and Ageing, p. 4)) it is clear that this approach seeks to address issues which are also relevant for AOD treatment services and clients. Indeed, the challenges associated with coordinating care to ensure that vulnerable clients do not 'fall through the gaps' when accessing multiple services across sectors are the same for AOD clients. Of particular relevance is PIR's emphasis on systematically facilitating coordination of services and building links between clinical and community care:

"The ultimate objective of the initiative is to improve the system response to, and outcomes for, people with severe and persistent mental illness who have complex needs by:

facilitating better coordination of clinical and other supports and services to deliver 'wrap around' care individually tailored to the person's needs;

strengthening partnerships and building better links between various clinical and community support organisations responsible for delivering services to the PIR target group;

improving referral pathways that facilitate access to the range of services and supports needed by the PIR target group; and

promoting a community based recovery model to underpin all clinical and community support services delivered to people experiencing severe and persistent mental illness with complex needs.

Through system collaboration, PIR will promote collective ownership and encourage innovative solutions to ensure effective and timely access to the services and supports required by people with severe and persistent mental illness with complex needs to sustain optimal health and wellbeing." (Department of Health and Ageing, no date, p. 4)

In this way, PIR creates a commitment to complex cases at the systems level. This is an issue of relevance in the AOD field, and provides a model for AOD services to provide coordinated and holistic care to clients. The funding, however, is directed towards the *coordination* of system responses for people with complex needs and not funding for service delivery per se. The PIR model builds a network of clinical collaboration, that is, it aims generate coordination across the service system within a local area. The competitive tendering process forced consortium arrangements and required organisations to generate partnerships (which have reportedly been maintained beyond the tendering process). However, in thinking about lessons for AOD, it is worth noting that in the case of PIR this funding was newly-allocated funding and was not provided at a cost to funding existing service delivery, which meant the initiative was positively received by the sector. The information sessions explicitly emphasised that PIR was designed to complement, not replace or usurp, the existing service system.

Key informants who commented on consortia were aware that successful consortia are driven by participants, not by funders (the notion of 'forced marriages' was not supported)[54]. Many key informants had both positive and negative experiences of consortia arrangements and it seems investment in capacity building around consortia leadership, maintenance, collaboration and communication across the AOD sector may be required before such a funding model can be maximised. In general, key informants felt that consortia arrangements were useful in certain circumstances and for some service types but as a general principle applied across all purchasing for AOD they would not work.

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[54] Key informants noted the difference between consortia arrangements and mergers. Here the discussion is limited to consortia, and does not apply to organisational mergers. One key informant noted that mergers are not the business of purchasers, but up to agencies themselves. "This is a particularly sensitive issue at the moment with the small to medium organisations very concerned about the upcoming …. re-tendering processes. We argue that it is not a decision for government to make whether individual organisations should merge in some fashion. There are legitimate circumstances where an organisation should consider winding down or merging, but this is a long considered and planned process".

Summary: Competitive processes

Almost all key informants saw some merit in competitive processes and argued that while competitive processes have a role to play, they should not be the sole mechanism for funding, and they need to be used judiciously depending on the service types, the potential pool of providers, and the particular needs of the sector. For example, competitive tendering may not be the best model to purchase peer outreach. Likewise, some highly specialised services should not be subject to competitive selection processes. "Competitive tendering does seem to be the best (of the worst) options".

Open competitive processes provide a transparent, accountable, and administratively efficient mechanism for purchasing AOD treatment services, and the prospect that competition may increase quality, reduce costs, and encourage new market entrants and innovations. However, service providers often felt that open competition tended to favour better resourced applicants, imposed an excessive administrative burden, and was unsuitable as a base funding mechanism given the tendency to fund the same services over time in a well-tested market: hence preferred-provider panels were preferred to open competitive rounds.

While competitive processes (open or targeted; consortia-based) are the predominant mechanisms by which the Commonwealth and state/territory governments select providers of AOD treatment services, there are other ways in which providers are selected. The next one we consider is individually-negotiated arrangements, often based on history.

Individually-negotiated and/or historical agreements

Historical or negotiated processes are associated with selection of organisations which have provided healthcare services in the past, and the funding amount is usually based on the costs of providing services in previous years (Duckett & Willcox, 2011).

> "Typically the negotiated budget was based on the previous year's budget, with or without a standard adjustment, increasing the budget for inflationary effects, or reducing budgets across the state for deemed productivity improvements." (Duckett & Willcox, 2011, p. 204).

The historical approach has evolved to become equivalent to the negotiated approach, which is usually formalised through a contract or agreement which can specify the amount of health services to be provided, or the goals or other indicators (Duckett & Willcox, 2011).

Historical or negotiated approaches to provider selection, unlike competitive approaches, are not obviously transparent and can be open to potential political influence / bargaining power (Langenbrunner & Liu, 2004). This approach tends to lock in the historical geographical distribution of healthcare services, even if this no longer meets population healthcare needs (Langenbrunner & Liu, 2004). Reform may therefore be stifled, and the system may not respond easily to new needs (Stefos, Lavallee, & Holden, 1992). In addition under historical processes existing inequalities – either in healthcare service delivery or in contracting between providers – are not readily able to be corrected (Langenbrunner & Liu, 2004). On the other hand historical approaches have been regarded as simple and easy to plan, monitor and control (Szende & Mogyorosy, 2004). They are less administratively burdensome for the service provider but may be more administratively burdensome for the purchaser if there are a substantial number of providers to be chosen (Szende & Mogyorosy, 2004).

Key informants who commented on historical or individually negotiated grants were aware of the limitations of this approach, commenting that they are sometimes lacking in transparency and difficult to change ("mired in history", "forget what they were originally about" - provider). While

other funding approaches were preferred (by those who commented) the importance of retaining flexibility for the purchaser was noted (such that a grant can be given out in a crisis situation).

Transparency and fairness are paramount, and as such individually-negotiated selection of providers cannot be a primary mechanism for the Commonwealth. An alternative to both competitive selection and individually-selected providers is where the Commonwealth effectively outsources the decision to a third party; that is a third party selects the providers, rather than the original source funder. This is the option we turn to next.

Transfer to states/territories (outsourcing the choice of provider)

Transfer of the funds to states/territories effectively devolves the purchasing decision to another party. Under this model, the funder transfers responsibility for purchasing to a third party agency. Alcohol and drug research literature on third party purchasing tends to focus on U.S. managed care, where a public funding body may transfer the funds to a separate managed care organisation to then distribute as required across a population (via the purchasing of alcohol and other drug services as required). This may involve pooling funds from several previously separate public funding sources, which may theoretically improve coordination of resources for particular populations (such as mental health and alcohol and drug clients under mental health "carve-outs") (Hoge, Jacobs, Thakur, & Griffith, 1999). It is difficult to generalise about the effects of third-party purchasing arrangements given the US focus of the literature and the fact that institutional structures can vary so greatly (Hogan, 1999). Bearing this in mind, US managed care research has shown that these type of arrangements for AOD treatment in the USA can contain costs, increase access to services, be responsive to the priorities set by the funders, but also limit the amount of services received, and are not necessarily linked to better client outcomes, nor better coordination of care (Hodgkin, Shepard, Anthony, & Strickler, 2004; Hodgkin, Shepard, & Beinecke, 2002; Olmstead, White, & Sindelar, 2004; Scheffler, Zhang, & Snowden, 2001; Shepard, Daley, Beinecke, & Hurley, 2005; Sindelar & Olmstead, 2005; Sosin, 2005; Sosin & D'Aunno, 2001). There is currently little direct evidence from Australia on third-party purchaser arrangements.

Key informants noted that an important principle of transferring responsibility to another body is that the third party is not also a service provider (that is for due process, the purchaser needs to be independent from the provider[55]). Key informants pointed out that "you can't outsource the government's job" (provider). Government systems (whether federal or state/territory) have the necessary accountability mechanisms, whereas these do not exist when other third parties are involved[56].

The transfer of federal funds to states/territories for which the state/territories subsequently purchase services is a common model in Australian healthcare. This is demonstrated in the extent of Special Purpose Payments made to state and territory health departments to fund the delivery of healthcare services. The rationale for this approach for AOD treatment funding by the Commonwealth largely resides in considerations of planning, coordination and contract management. Under third-party outsourcing to state/territory government, the planning, purchasing

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[55] This challenge also exists in some state/territory arrangements where the government service provider is also the contract holder for the NGO service providers. Key informants argued this was "an inherent conflict of interest".

[56] Such as Medicare Locals. Medicare Locals have had a mandate in relation to local service needs and local planning processes with a current funding line direct from the Commonwealth. Key informants (both purchasers and providers) were not enthusiastic about the possibility that Medicare Locals become the third-party purchaser of Commonwealth AOD treatment. A number of reasons were given. Experiences with Medicare Locals to date have been highly variable and Medicare Locals' commitment to AOD (as a priority area amongst the many other competing primary care needs) is perceived as generally low.

and contract management would be from one government body (not two or more as is currently the case). As noted by one key informant:

> "With multiple funding sources, which have different timeframes, reporting and data requirements, it is hard to maintain a rhythm of service delivery. In some situations there will be one worker doing different bits of work (ie, parts of an FTE) that involve multiple funding sources. Acquittal is required for every funding source" (provider).

Key informants noted that better service planning could occur under a single purchaser model, with articulation between planning, needs assessment and purchasing decisions. There may also be reduced administrative burden for service providers (who currently report multiple times to multiple funders).

Despite these apparent advantages, key informants also expressed concerns. The most significant concern is that this model could result in a loss of specified AOD treatment funds. Given the extent of unmet need and demand, any reduction in Australian AOD treatment funding is a significant problem. We were given examples where Commonwealth funds have been distributed through state/territory governments, such as the IDDI diversion money, which were regarded as less successful because it appears that the funds have now been lost to AOD ("we don't know what's happening with that investment now"). Any funding model needs to maximise the likelihood that funding is increased from whatever sources – the removal of direct Commonwealth funding therefore has the potential to decrease the overall pool of AOD treatment funding. A second concern was the loss of the 'checks and balances' created by a dual funding system. Put differently, having multiple purchasers reduces the risk that any one purchaser will make choices driven by politics, or engage in poor funding practices. Multiple funders were seen to improve the survival of the sector. Diversity was another issue raised. The AOD treatment sector in Australia needs to support a variety of treatment types, treatment philosophies and approaches. The removal of one level of funding from the mix raises the potential for loss of diversity. It was also noted that there are some agencies that are solely funded by the Commonwealth – the implications for these services are unclear under such a model.

One challenge with a transfer of the funds to state/territory governments is the extent to which such an arrangement may subsequently decrease the state/territory's own investment in the future. There is no direct evidence that Commonwealth funding reduces the likelihood of state/territory funding (and we take this up again in Chapter 12). There is one interesting research report from the USA. Cowell, McCarty, & Woodward (2003) found that federal block grants for AOD treatment were not associated with "reductions in state substance abuse spending" (p. 177). Thus, the risk that states/territories will reduce their own funding under this model may be over-stated.

This model may not be politically viable. As noted by key informants, the Commonwealth is likely to want clarity about the types of services it wishes to purchase and what it is getting for the funding, and it would be unlikely to want to leave this responsibility with the states/territories. Finally, there was some concern that while outsourcing may work well in some states/territories, it may not work well in others — it is very risky where there is poor faith in current state/territory processes. Interestingly, the views from both purchasers and providers were split — that is, it was not solely state/territory health department purchasers in support of this option, and indeed, views varied across all key informants.

Summary: transfer funds to states/territories
Transfer of the funds to states/territories retains the role of the Commonwealth in funding AOD treatment without direct involvement with selecting providers (or making payments to individual agencies). It potentially allows purchasing to be specialised by an agency that can potentially pool

funding streams and plan comprehensive services; and it reduces duplication of administrative requirements for services. However there are substantial risks associated with this model: loss of funding, loss of checks and balances, concern about some state/territory funding/purchasing processes and the potential loss of diversity if the Commonwealth was no longer a direct purchaser of services.

Thus far we have reviewed the following ways in which providers could be selected: competitive selection, individual negotiation, and transfer to states/territories.. There is a final, fourth option, registration and/or accreditation, which then permits access to a funding pool based on invoicing. We explore this option next.

Registration, accreditation of approved providers

Accredited providers describe a funding approach whereby providers who meet certain criteria (such as registration or accreditation) are eligible to receive reimbursement for services delivered, usually through fee-for-service arrangements. It is a common healthcare funding mechanism in Australia – all GPs operate under this model as individuals who have received 'provider numbers' and are hence funded through Medicare.

Accreditation is usually managed through professional registration board requirements. Processes adopted by professional groups may vary, and one tension is the economic incentive to limit entry. As Duckett & Willcox (2011) note "decisions about standards of entry into the professions are controversial". Thus this model may be perceived as unfair, although it has been argued that this funding approach has lower administrative costs relative to competitive processes. The approach is predicated on a long-standing notion of professional practice. The accredited provider model requires a clear definition and delineation of the profession, the requisite skills, the accredited training programs, and quality standards. These things are currently lacking in AOD[57].

Registration and accreditation is intimately linked with fee-for-service models. Given that the provider has been registered, they are then eligible to invoice for services rendered; that is payment occurs after the service is provided, usually at a fixed price. Fee-for-service is effectively a health care term for piece rates. Fee-for-service has in-built financial incentive to provide services — since providing more services generates more income for service providers. Consistent with the theory, reviewers of research on fee-for-service in healthcare note that fee-for-service models increase the amount of activity, and thus access to services, especially when compared to salaried healthcare providers (Brocklehurst, Price, Glenny, Tickle, Birch, Mertz, & Grytten, 2013; Duckett & Willcox, 2011; Gosden, Forland, Kristiansen, Sutton, Leese, Giuffrida, Sergison, & Pedersen, 2000; Hall, 2010; Langenbrunner & Liu, 2004; Silversmith, 2011). In theory fee-for-service provides high levels of access to healthcare, (Jegers, Kesteloot, De Graeve, & Gilles, 2002), presumably insofar as this payment system tends to be associated with open-ended payments, rather than capped amounts. (Jegers et al., 2002; Langenbrunner & Liu, 2004). Fee-for-service payments may provide increased access for disadvantaged groups to healthcare (Langenbrunner & Liu, 2004; Maynard, 2006). Fees can also be linked to providing 'best care' (Jegers et al., 2002) and/or the cost effective treatments. These features suggest that fee-for-service can produce better healthcare.

Perhaps not surprisingly, given that more activity generates more income, the fee-for-service approach has been noted as a preferred option for service providers (KPMG, 2012). However the key informants that were interviewed for the Review noted three limitations of this approach: the

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[57] Accreditation as a funding selection process should be distinguished from accreditation as quality assurance. A US study of AOD treatment has reported that accreditation of treatment centres was associated with reduced post-treatment drug use (Ghose, 2008).

potential for budget over-spending (from purchasers); concern about quality (from purchasers); and the level of financial viability for services (from providers), notably "cash flow" issues. In fee-for-service, costs are driven by demand for service, and if budgets are uncapped the consequence can be budget overspending. Given the extent of unmet demand in AOD this is a highly likely scenario under fee-for-service models.

One key informant was concerned that fee-for-service funding models may be associated with compromised quality. From the client's perspective, research has shown that fee-for-service models are associated with lower patient satisfaction compared to salaried clinicians (Gosden et al., 2000). In primary care settings, fee-for-service is associated with less preventative care and with shorter consultations (Gosden, Pedersen, & Torgerson, 1999). There is however evidence that fee-for-service can improve quality and outcomes. A Cochrane review (Flodgren, Eccles, Shepperd, Scott, Parmelli, & F., 2011) of payment incentives in primary care settings found fee-for-service payments generally to be effective, and associated with clinical care improvements in seven out of ten outcomes in five studies (four out of ten statistically significant).

On the disadvantage side, the critical issue with registration/accreditation of select providers is the need for defined entry criteria. The subsequent fee-for-service payment arrangement to those selected providers may provide few incentives for efficiency, since over-servicing may be rewarded (Jegers et al., 2002; Langenbrunner & Liu, 2004). (Jegers et al., 2002; Langenbrunner & Liu, 2004). Setting the fees at the most appropriate level is a critical issue for this model and can prove difficult; reimbursement levels also require regular review over time (Jegers et al., 2002). Inaccurate price setting can potentially disadvantage either purchasers or providers (Center for Substance Abuse Treatment, 2006; Jegers et al., 2002). Fee-for-service models have relatively high administration costs (for example when compared to block grants), since they require investment in efficient administrative systems for regular invoicing and payments (Jegers et al., 2002; Langenbrunner & Liu, 2004).

Whilst in theory, fee-for-service promotes increased service access, this funding method may not be sustainable for smaller healthcare services if there is no guaranteed funding base, and where there are unpredictable or low volumes of services: for example, in rural and areas activity levels may be too low to keep services viable (Health Policy Solutions & aspex consulting, 2012) The model requires a sufficient base or guaranteed funding to ensure that it covers costs where services do not have high activity levels (KPMG, 2012). Key informants raised this concern as well. The lack of certainty regarding a given flow of income for service providers was perceived as problematic for AOD services. Fee-for-service models were perceived by providers as generally short-term and not able to provide security for staff or sustainability for services in the longer-term. Fee-for-service works well when there is a base income for an organisation/service – thus fee-for-service may work in AOD as an additional funding stream (such as through Medicare in having a GP providing consultations) but not as the primary means of funding an AOD service. As noted by one key informant "it relies on an agency having another stable, recurrent funding source". In addition, fee-for-service generally suits single occasion services, whereas for AOD treatment the interventions can span a considerable period of time. For example, residential rehabilitation is not a service type amenable to a fee-for-service funding model (although some individual occasions of service may be appropriately funded through fee-for-service).

The above has reviewed four different approaches to selecting providers: competitive selection, individual negotiation, transfer to states/territories and registration as providers. These four approaches do not necessarily presume how the funds will actually flow (with the exception of the registration/approved provider notion – which is linked to fee-for-service and invoicing). We now turn to consider the possible options in relation to how the payment mechanism may work.

Choice of payment mechanism

At present there are four ways in which the Commonwealth and state/territory governments could provide the funds:

> 1. Through a block grant (lump sum)
> 2. Through a price per unit of activity
> 3. Through a capitation model
> 4. Through payment for outcomes.

Block grants

Block grants are where a lump sum is paid to an organisation. The extent to which a block grant includes specific deliverables can vary.

> "A block funding model allocates funds to service providers in a lump sum (a block) on a periodic basis, such as annually... The funding is not generally tied to the cost of inputs, outputs or performance benchmarks, although block funding arrangements can be associated with some form of performance measurement or auditing of funds." (KPMG, 2012, p. 10).

> "These contracts commit the purchaser to pay a fixed sum for access to services (irrespective of volume) by its responsible population… an extension is to include an indicative activity level … failure to achieve the indicative level will not be penalised (nor activity above it rewarded) with the most simple block grants." (Dredge, 2009b, p. 256).

Important advantages of block funding noted in the general healthcare literature are that it provides a known level of payment for service providers whilst also offering a relatively high degree of control of overall spending for the purchaser (Dredge, 2009a). This high degree of predictability for service providers suggests that block grants may produce a more stable service sector, although this is not necessarily the case, and will depend partly on the duration of any grants. Because the specifications for healthcare service delivery under block grants are often relatively loose, this mechanism can potentially be used to preserve a relatively high degree of NGO autonomy and flexible service delivery: thus this funding mechanism potentially assists adaptability to the changing needs of their client groups, insofar as contracts are not highly prescriptive (Berg & Wright Jr, 1981; KPMG, 2012). However, the extent to which this is true for block grants will depend on the nature of the agreement/contract associated with the grant (Dredge, 2009b; Duran et al., 2005). A contract may be highly specific in relation to performance criteria and outcomes, thereby reducing the flexibility and autonomy.

Another advantage of block funding highlighted in healthcare research, is that it can be used to ensure continued access to services in rural and remote areas where the small size of the population would provide insufficient income for providers under fee-for-service arrangements as a result of low client numbers (Dredge, 2009a; Health Policy Solutions & aspex consulting, 2012). This is the principle on which block funding is provided to some rural and remote hospital services in Australia (Independent Hospital Pricing Authority, 2014). Eager (2010) argues that healthcare block grants are administratively straightforward, with lower administration and information costs compared to other funding models.

Block funding may have mixed effects on economic efficiency. Block grants do incentivise health services to remain within the allocated funding amount (Dredge, 2009a). However, if this funding is relatively generous (for example, reflecting historical funding levels) there may be few incentives for innovation to reduce costs (Dredge, 2009a). Duran et al. (2005) argue that block grants tend to

preserve pre-existing excess healthcare capacity, and provide little incentive to increase workload, since increased efforts are not directly financially rewarded (as they would be under fee-for-service or activity based payments), thus ultimately limiting client access to programs. However, effects on workload will also depend on the nature of the contract associated with the grant, and whether the contract includes output targets. It is arguable also that AOD funding has not been at high levels in the past, and therefore there may not be substantial issues of excess capacity in the sector. Another financial disincentive to reducing costs under block funding arrangements is that they may incentivise health services to spend up to budget at year end to preserve funding levels in future years (Langenbrunner & Liu, 2004).

In block grants, the financial risk is borne by the healthcare service provider if activity or costs exceed expected levels, since the funding amount is pre-set and therefore effectively capped (Dredge, 2009a; Duran et al., 2005; Eagar, Garrett, & Lin, 2001). This contrasts, for example, with (uncapped) fee-for-service arrangements where the service bills the funding body for additional activity. Whilst this aspect of block funding is an advantage for spending control of the service funder, it may be inequitable insofar as the service providers may be less able to afford the additional financial risk than funders (Eagar et al., 2001).

Summary: block grants

In summary, block grants appear to afford greater certainty to both purchasers and providers and may facilitate greater service delivery flexibility depending on the nature of the contract. They are arguably administratively easy compared to other funding approaches. There is debate in the literature about the extent to which block grants may stifle innovation and limit incentives, and concern about a potential lack of incentives for increased output. Block grants are the current Commonwealth mechanism for providing grants under the NGOTGP and the SMSDGF.

Price per episode

An alternate payment mechanism to a block grant is payment for activity or payment for an episode of care. The most significant example of this in Australia is the hospital funding system, termed Activity Based Funding (ABF). There have also been episode-based unit cost funding approaches in AOD in Victoria.

> "Activity-based funding (ABF) is a new term being used to describe funding on the basis of cases or outputs."(Duckett & Willcox, 2011, p. 207)

> "An activity funding (ABF) model provides funding based on the expected cost for an episode of care… ABF is similar to a fee for service model as it provides funding based on activity undertaken by the service provider. Rather than paying for specific services delivered, ABF pays based on an episode of care." (KPMG, 2012, p. 10)

This is a complex area, difficult to summarise succinctly but also of importance as we suspect that this could be a preferred option into the future (hence this section is lengthier than others). There are at least three variants of the price per episode that require examination:
>   1. Australian hospital Activity-Based Funding (ABF)
>   2. Victorian AOD ABF (newly implemented)
>   3. Fixed price/unit cost arrangements.

Australian hospital ABF system

The basis of activity-based funding (also called casemix or episode of care funding) is the grouping of care for similar conditions with similar costs (that is, the activity is defined and classified into a discrete number of groups based on data about costs). These are termed Diagnostic Related Groups

(DRGs). The development of the bundled activities (into DRGs or some other classification) is a research-intensive exercise and involves substantial and highly technical analysis of large representative datasets. Australian hospital services ABF[58] has an elaborate classification system of several hundred diagnostic related groups. Each care episode is allocated a DRG code by computer software based on clinical coding in medical records, which forms the basis of the payment. Casemix is the mix of services undertaken by a particular hospital or health service, reflecting the different specialities of different institutions.

A price is assigned. There is a difference between the 'price' – which is the payment amount - and the 'costs' which is the total cost of providing the services for that specified DRG. While cost data are used to determine the DRG categories, the setting of the price paid is a different exercise. The agreed price paid may be set low to encourage technical efficiency, or it may be set high to encourage certain types of practices/care (allocative efficiency). The prices for public hospital services (activities) are set by an independent body, the Independent Hospital Pricing Authority (IHPA), in order to minimise the political influence on price setting.

Setting the price can either occur for each DRG (segmented approach) or by using a standard price (national efficient price) and then each DRG is weighted against that price. The latter system is used in Australia. The IHPA sets a single benchmark efficient price for all hospital services, called the National Efficient Price (NEP) and payments for specific activities (episodes of care payments) are then calculated using payment weights, National Weighted Activity Units (Independent Hospital Pricing Authority, 2014). At the time of writing, the National Efficient Price is $5,007 per National Weighted Activity Unit (Independent Hospital Pricing Authority, 2014). A tonsillectomy has weight of 0.7058, and therefore an efficient price of $3,534 per admission, whilst a hip replacement has a weighting of 4.18555, amounting to $20,957 per admission (Independent Hospital Pricing Authority, 2014). A new national price is calculated each year based on cost and activity for the financial year three years previous to the current financial year and adjusted for indexing and out of scope costs. The Independent Hospital Pricing Authority acknowledges that payment for some functions, such as training, teaching and research, currently need to be financed by other mechanisms as they are "not yet able to be described in terms of 'activity'", and these are currently paid for through block grants (Independent Hospital Pricing Authority, 2014, p. 2).

Adjustments (to either the DRG or the subsequent price per DRG) can occur for "legitimate and unavoidable variation in costs" including clinical factors such as complications and comorbidities, or admission to intensive care, and for patient factors such as Aboriginal status, or living in a remote area. (Thus, either the DRGs differentiate complexity associated with costs, or loadings are applied to the NEP to reflect those complexities).

The activity-based funding system can be used either as a budget allocation method or as a case payment mechanism. In the former, a hospital's casemix (that is the mix of DRG's) plus consideration of price results in a determination of the overall budget for that hospital for any one year. Alternately, the hospital can be paid based on the actual number of episodes of care that were delivered (notwithstanding caps on volume for some services). In Australia, both mechanisms are used: the state/territory governments mainly use the casemix system to determine hospital budget allocations each year, whereas the Commonwealth uses the same system to determine the payments made into the National Health Funding Pool (that is, the Commonwealth's contribution to hospital funding is via case payment, whereas the state/territory contribution is via budget allocation). The use of the National Efficient Price provides clarity to the Commonwealth about the

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[58] Australian public hospital services ABF is reputed to be one of the most sophisticated ABF systems in the world and has been sold to a number of other countries.

level of activity that it is purchasing. Use of a national price, rather than individual state prices, also provides a national benchmark to services to assess efficiency of service delivery.

This highlights one feature of the Australian public hospital funding/payments system – it occurs in the context of shared funding between Commonwealth and states and territories. Therefore an important feature of activity-based funding is that it provides transparency about what the Commonwealth is paying for when funding is transferred to states/territories or to local hospital networks.

Is the Australian hospital ABF funding model relevant for AOD treatment funding in Australia? Yes, to the extent that currently, inpatient hospital services for AOD DRGs are being paid for through this system. Not all activity in AOD treatment within hospitals is, however, covered and the extent of current implementation seems highly variable. Perhaps more importantly however, is that most AOD treatment occurs in outpatient settings and the ABF system for ambulatory care is significantly under-developed. Work has recently been done on expanding and improving mental health coding under the ABF, and researchers involved in this work noted the need for similar improvements in alcohol and drug codes in the future, including for outpatient and community delivered services (Whiteford, Eagar, Harris, Diminic, Burgess, & Stewart, 2013a). Our impression is that the extensive work underway in mental health has to date been focused largely on public hospital admitted mental health care (rather than outpatient care) (Eagar, Green, Lago, Blanchard, Diminic, & Harris, 2013). Furthermore, review of this work demonstrates clearly the substantial data and technical requirements to define and operationalise the unit of activity (reports are available Eagar et al., 2013; Whiteford et al., 2013a). It seems some years away at this time.

Perhaps more importantly however, the ABF system could provide a way for the Commonwealth to contribute funds to AOD treatment (planned, managed and delivered through state/territory government processes) without direct contracting of service providers.

The Victorian AOD ABF system

Activity-based funding has also been used since 1994 as the basis for payments to Victorian alcohol and drug treatment services, all of which are NGOs.[59] Costs, and thence payment amounts, were calculated for episodes of care under 16 main activity types (based on classifications as of 2010-11)[60]. Like public hospitals ABF, Victorian ABF AOD payments could be adjusted for such factors as Aboriginal status, or age. A significant difference to hospital ABF was a focus on treatment outcomes: to classify as an episode of care, a course of treatment had to be classified as successful. Another feature has been specifications of activity targets from the funder. Although the definition of success changed over time, it was essentially based on achievement of one or more client treatment goals. A third differentiating feature between the original Victorian price per episode approach (unit costs) and the hospital ABF was that the Victorian system was originally a segmented approach – that is, each service type had its own unit cost (rather than a fixed efficient price, adjusted by service type).

Under the original Victorian AOD ABF system, a robust process for updating payment amounts was not in place. The Victorian Auditor General criticised payment amounts for falling below costs over time. The Victorian ABF system has recently been undergoing a reform process which will result in it becoming more technically similar to public hospitals ABF, using an efficient price benchmark and

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[59] See the case study on Victorian ABF for more information, Chapter 17.
[60] For example, activities and prices for 2010-11 included: individual/group counselling $818.58; home-based withdrawal $1,377; residential withdrawal $2,395; residential rehabilitation $12.387. The old Victorian system is an example of segmented ABF – price per type of episode of care, as compared to the national efficient price model.

activity weights. We provide the details of the new Victorian AOD ABF system in the below case example.

Case example: Victoria's Activity-Based Funding Model for AOD services
(For the full case example, see Chapter 17)

Our focus in this case example is the Victorian Government's activity-based funding (ABF) model which was launched in October 2013 as part of the first stage of the recommissioning of Victorian AOD treatment services. It was noted that the Victorian reconfiguration and streamlining of service delivery responsibilities "will be accompanied by a new activity based funding model that will enable flexibility in the development and delivery of services at the local level" (Victorian Department of Health, 2013b, p. 5). Stage One involves the consolidation of 18 'activity types' (which were subject to unit costs per episode of care for each activity, see Chapter 17) into six 'service streams':
Counselling;
Care and recovery coordination;
Care and recovery coordination/Intake and assessment;
Counselling/Care and recovery coordination;
Counselling/Care and recovery coordination/Intake and assessment;
Withdrawal non-residential.

Each of 16 catchment areas (9 in metropolitan Melbourne, and 7 in the non-metropolitan area) will receive a defined budget allocation. The allocations to each catchment were derived according to population figures and existing service provision, and there is a higher level per capita for rural catchments. Weighting for disadvantage has also been applied (Victorian Department of Health, 2013b).
The allocations for the delivery of five non-residential services/functions[61]:

Catchment based intake and assessment	$13.7M
Care and recovery coordination	$5.4M
Counselling	$17.3M
Non-residential withdrawal	$3.5M
Catchment based planning function	$768K (block grant)

The Drug Treatment Activity Unit (DTAU): Whereas the old episode of care (EOC) involved a specific price per service type, the 2014 reform of the AOD sector uses the Drug Treatment Activity Unit (DTAU), which is a single price common counting tool. The price of all funded activities is expressed as a multiple of this unit price. For 2013-14, the DTAU price is $644 (Victorian Department of Health, 2013b). Adjustments will be made prior to funding agreements in 2014-15.

A weighting is attached to each activity to determine the activity price. For example, the weighting for 'intake and referral – phone contact (completed referral)' is 0.091, meaning that the activity price is $644 x 0.091 = $58.60. In another example, the weighting for 'counselling – standard (course of counselling)' is 0.91, meaning that the activity price is $644 x 0.91 = $58662. It is important to note that prices are for completed activities[63] and that the prices are intended to cover direct costs, fixed costs and overheads (Victorian Department of Health, 2013b). DTAUs include loadings for Aboriginal (30%) and forensic (15%) clients based on average prevalence in the client population.
For some service types, there are different levels of pricing to account for variations in the mode of delivery (phone, face to face, via internet, for intake and referral) and the intensity of treatment ('standard' and 'complex' involving counselling and withdrawal). The catchment-based planning function is a block grant.

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[61] Figures are indicative funding of up to the amounts shown (Victorian Department of Health, 2013b, p. 13). Funding is for Stage One only and does not include residential services or youth services. Some programs and treatment types are entirely excluded from the recommissioning process. Separate funding is provided for a statewide intake and assessment service.
[62] For details of the unit price for each service type, refer to (Victorian Department of Health, 2013b Table 2 on p. 19) Table 2 on p. 19.
[63] That is, completed referrals, comprehensive assessment and initial treatment plan, course of coordination / counselling / withdrawal.

The volume of DTAUs has been calculated based on the total resources assigned to each catchment and current met need (ie, 2012-13 client numbers for the treatment streams included in Stage One). See Chapter 17 for details of two catchments. Providers will be able to vary the mix of activities as only 80 per cent of their total allocation of DTAUs will be tied to specific activities. The remaining 20 per cent will be available for flexible use across all activity types delivered by the service, "as long as the total mix of services delivered by that 20 per cent equates to an agreed volume" of DTAUs, (Victorian Department of Health, 2013b, p. 20).

Indicative prices: Some indicative prices for the various activities are as follows:
Catchment-based intake assessment activities involve three different modes of contact as well as the development of a comprehensive assessment and preliminary treatment plan:
Intake and referral – phone $58.60 per completed referral
Intake and referral – face to face $58.60 per completed referral
Intake and referral – via internet $46.40 per completed referral
Care and recovery coordination, involving "a course of coordination of up to 12 months duration" (Victorian Department of Health, 2013b, Annex 1, p. 15), $1,431.00 per course of coordination
Counselling, incorporating "face-to-face, online and telephone counselling for individuals and families, as well as group counselling and day programs", which are classified as standard or complex and can range from a brief intervention to extended periods:
Standard $586.00 per course of treatment
Complex$2,198.00 per course of treatment
Non-residential withdrawal
Standard $546.80 per course of treatment
Complex$1,367.90 per course of treatment

An outcomes focus? The Call for Submissions provided "a summary of indicative types of outcomes the Victorian Government is seeking to achieve for people with an alcohol and drug problem through the delivery of accessible, efficient, effective and responsive alcohol and drug treatment services" (Annex 1, p. 5)[64]. The outcome domains are: effectiveness, efficiency and sustainability, responsiveness, accessibility, continuity, and safety. For each of these there are indicative outcomes, for example the outcome domain of effectiveness has indicative outcomes including "reduced frequency and/or level of AOD use" and "increased protective behaviours associated with AOD use". AOD treatment services will be required to meet the accountability and reporting requirements set out in a new "outcomes - focused performance management framework". This framework is in development.

Conclusion: Victoria has used some form of unit price to purchase AOD services since the mid-1990s. The introduction of a single unit price to Victoria, with total funds set by catchment, brings a level of transparency and clarity regarding what is being purchased and for how much. The level of articulation with the actual cost of service delivery is not apparent. Importantly, the introduction of the ABF model is being accompanied by major structural reforms (e.g., catchment based planning, reduced service types, an indicative outcomes framework, centralised intake and assessment). Unravelling the advantages and shortcomings of the new payment model within this context will be challenging.

Strengths and weakness of ABF

Activity-based funding in theory incentivises the provision of a greater quantity of care, and thus should promote increased access to services (Dredge, 2009a) where the process entails uncapped payment for the number of episodes of care. Activity-based funding systems can reorientate healthcare services from regarding activities as costs incurred, to regarding them as revenue streams, and adjusting their activities to increase their revenue (Canadian Institute for Health

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[64] See https://www.tenders.vic.gov.au/tenders/tender/display/tender-details.do?id=5715&action=display-tender-details&returnUrl=%2Ftender%2Fsearch%2Ftender-search.do%3Faction%3Dadvanced-tender-search-new-tenders
(accessed 13 June, 2104)

Information, 2010). However, ABF also may also incentivise reduced length and intensity of AOD treatment episodes since there is an incentive to limit the services provided within the episode in order to limit costs (Horgan & Merrick, 2001). A number of commentators have argued that price per episode provides procedural fairness and transparency compared to historical budgets, since under ABF prices are centrally set and available for all, and payments are therefore less likely to be influenced by political factors, or historical funding levels (Duckett, Breadon, Weidmann, & Nicola, 2014; KPMG, 2012)[65]. Price per episode or ABF provides inbuilt incentives for efficiency because services do not want the average cost of episodes to exceed the allocated price (Duckett et al., 2014; KPMG, 2012; Silversmith, 2011). However, within these financial limits the provider still has some freedom to determine the service mix within the overall episode pricing structure (KPMG, 2012).

There are arguably fewer incentives for over-servicing than with fee-for-service since a set price is paid for the entire episode rather than for each individual component of service, thus encouraging providers to limit the number/cost of individual services provided within each episode of care (KPMG, 2012). However, whilst this funding model encourages services delivering above the average cost to reduce costs, it will not incentivise additional efficiency for those already delivering below the average cost (KPMG, 2012).

Another concern noted by reviewers of healthcare payment research is that whilst price per episode does not encourage unnecessary individual services, it does not necessarily control episodes of service (Horgan & Merrick, 2001), and may even encourage unnecessary episodes of service (Silversmith, 2011). It has been argued that price per episode may lead to data manipulation, for example transfer amongst internal programs to inflate the number of episodes of care (Dredge, 2009b). Indeed the Victorian Auditor General commented in a 2011 review of alcohol and drug treatment that the episode of care funding model provided such incentives to 'game' the performance reporting system, and observed that 40 per cent of service providers recording multiple continuous EOCs for the same client in the same treatment type during 2009–10" (Victorian Auditor-General, 2011, p. 40).Other ways of services manipulating this casemix/episode of care/activity based funding is to concentrate on providing services to less severe clients ('cream skimming') in the expectation that this will reduce the individual services within each episode (KPMG, 2012), or by undertreating within the episode, or discharging clients early (Horgan & Merrick, 2001). Such activities may be especially worrying in relation to alcohol and drug clients with comorbid mental health problems (Horgan & Merrick, 2001; Horgan, Reif, Ritter, & Lee, 2001) unless adequate adjustments are made to payment rates.

Under activity-based funding, both purchaser and provider can potentially bear some of the financial risk of price per episode. To the extent that payments for episodes are uncapped the funder/purchaser bears the financial risk (Dredge, 2009a). However, service providers bear the risk that some episodes may involve a lot of individual services and therefore work out as more expensive than the average set price. However, in practice Australian hospital payments have been weighted for different severities to alleviate such effects (Duckett & Willcox, 2011), although this process may be imperfect. On the other hand if activities are not coded properly it is possible for hospitals to be underpaid for work that was performed but not properly recorded. As under other funding systems, the point at which the price is set is very important. The IHPA is currently using the average price of hospital services in order to set the National Efficient Price (Sherbon, 2013). This is where the IHPA believes a balance is to be found between price and quality (Sherbon, 2013). However, the price could be set lower – for example to reflect the price achieved by the 25% most

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[65] This would also be true of other funding models that use centrally determined fixed price funding arrangements, such as fee-for-service. In these arrangements the problem is less likely to be that providers are paid different amounts for providing similar services, and more likely to be due to incorrect price setting, or inappropriate weighting for complexity (or lack of weighting).

efficient hospitals – to achieve greater economy for government funders (Sherbon, 2013). Such trade-offs are to an extent a political value judgement about system priorities rather than being solely technical funding issues (Sherbon, 2013).

Given the extensive use of ABF, the Victoria model for AOD, and the move by the IHPA to develop activities and NEP for mental health, it seems that the Commonwealth should take seriously the notion of providing NGOTGP and SMSDGF funds through a version of ABF. Indeed, some AOD treatment in Australia is currently funded through ABF, although this is only for hospital admissions. Key informants to this Review noted that ABF is relatively easy to understand and administer (although the literature notes the substantial data requirements for such a system). Key informants familiar with ABF and/or the Victorian unit cost model argued that a national ABF model was not a radical shift from existing Victorian episode-of-care-based funding. However, others argued that there were significant problems associated with ABF-type models; complexity of care can be poorly recognised in such system, cherry-picking can occur (selecting the more simple cases), managing different lengths of stay is challenging, and there are administrative burdens and the potential for "figures [to] get fudged to make it viable". "There is a real risk that organisations would have to manipulate what they've done to fit in with what they said they'd do" (provider). Another concern with ABF-type funding approaches noted by key informants is the potential loss of flexibility and responsiveness. Key informants were concerned that an agency may need to ration services once it meets its targets (to avoid over reaching the budget), which would limit flexibility, although this problem is a result of capped rather than uncapped ABF.

The key challenge with an application of ABF to AOD is the substantial technical and data requirements (many years of work) to establish the appropriate units of activity. This is a long way into the future.

An Australian review on ABF and payment reform includes a number of "lessons and implications" considered important "to help stimulate the debate that will be vital in developing a comprehensive Pricing Framework" (Health Policy Solutions, Casemix Consulting, & aspex consulting, 2011, p. 36). These issues flag some possible challenges and benefits in moving towards a nationally suitable ABF-type system for AOD:
- An efficient price is one that supports cost-effective clinical innovation and high-quality care
- Economic approaches to measuring efficiency do not account for the complexity of health service provision and a grounded approach is needed based on an empirical and incremental approach
- Price-setting involves policy choices based on priorities, both short and longer term
- Price-setting is closely linked to choices about the scope of services that will be funded (eg, in-patient only)
- The implementation of ABF is highly context specific and depends on history, finances and the political climate
- ABF implementation is generally phased in over some years
- Price-setting has to consider the optimal balance between the national efficient price and the use of price adjustments to allow for unavoidable variations in costs across services
- The implementation of ABF is long and has far-reaching implications, it is important to commence the journey and remain open to adjustment as the model evolves (Health Policy Solutions et al., 2011, pp. 36-37).

The advent of activity-based funding for Australia's hospitals is regarded as key to minimising expenditure on avoidable costs, while letting "hospital leaders, managers and clinicians find the best ways to improve" (Duckett et al., 2014, p. 1). Use of an 'efficient price', which is "set at the average cost but only after avoidable costs are removed" is described as an important way to limit unnecessary expenditure while maximising clinical benefit (Duckett et al., 2014, p. 1). Inherent in this

argument is the role of government as funders/purchasers of services, while organisations manage how best to deliver the services.

Fixed prices/unit costs

While both the hospital ABF system and the Victorian system effectively set a fixed price, there is a third variant of the price per episode, which is simply the specification of a unit cost for each service type that the Commonwealth purchases.

There are many challenges associated with establishing a unit cost per episode of care for each service type. These challenges are the same whether they apply to the ABF system or the Victorian system. Nonetheless, the Commonwealth could pursue a fixed unit price for its direct purchasing of AOD treatment. USA research has documented the challenges of establishing unit costs for AOD services (see for example Alexandre, Beulaygue, French, McCollister, Popovici, & Sayed, 2012; Anderson, Bowland, Cartwright, & Bassin, 1998; Cartwright, 2008; Flynn, Broome, Beaston-Blaakman, Knight, Horgan, & Shepard, 2009; French & Drummond, 2005; French, Dunlap, Zarkin, McGeary, & McLellan, 1997; French & McGeary, 1997; Substance Abuse and Mental Health Services Administration, 2003; Zarkin, Dunlap, & Homsi, 2004).

Comprehensive data and surveys of existing providers would be required. There are standardised tools such as the Drug Abuse Treatment Cost Analysis Program (DATCAP) which could provide accounting-based cost estimations at the treatment program level (French et al., 1997). (Note: that for the purposes of defining a fixed price at which the Commonwealth purchases services, we are referring to accounting methods, not to economic evaluation methods). The DATCAP has been trialled quite widely in the United States. Results have been published from costings of 110 services programs, including methadone maintenance, various models of outpatient programs, residential treatment, therapeutic communities, prison, and drug court programs (French, Popovici, & Tapsell, 2008). The cost per service type can vary. For example the costs reported for an episode of adult residential AOD treatment ranged from USD$18,427 (Alexandre et al., 2012) to USD$3,132 (Substance Abuse and Mental Health Services Administration, 2003). In another example, five sessions of motivational enhancement therapy/cognitive therapy cost USD$837 in Illinois but USD$1,134 in Connecticut (French, Roebuck, Dennis, Diamond, Godley, Tims, Webb, & Herrell, 2002; French, Salomé, & Carney, 2002).

Dealing with the potential for substantially variable unit costs between service providers - which may or may not be based on real cost differences such as those driven by rurality, client complexity and so on – is another significant issue. The use of weightings or loadings can overcome this challenge, but also require intensive data.

Key informant views about unit cost, or fixed pricing, were mixed. On the one hand, a number of key informants said they would welcome a unit cost or fixed price approach (both purchasers and providers). They argued that it would provide fairness and equity; it would be more "sophisticated" and "fairer". The purchaser would benefit from using benchmark costings, or some version of a unit cost approach, although unit costs undermine the market notion behind competitive processes. However, it is arguable that because Commonwealth grants are distributed for such a wide range of activities in such dispersed locations that there is no uniform market currently. Where unit costs or benchmark costs are used this can misrepresent the market. The "best provider" may not tender if they cannot do what they feel is necessary for the money they believe the purchaser is prepared to pay, although this will depend in practice on where the payment level is set. Key informants also argued that the cost per unit does not support decisions around quality (provider).

There are inherent difficulties in setting a national price in a country like Australia, where states and areas within states are so different and there are multiple funders. In a state with the population size of Tasmania, for example, costs are relatively high because of transport issues. Arguments in support of variable pricing are that it allows the "market forces [to] determine the price" (purchaser). An argument against variable pricing was that the purchaser may then choose the cheapest option, rather than one representing quality. However, fixed price may avoid the problem of under-funding – where services put in too small budget requests. Prices are theoretically able to be set at a point that balances both quality and efficiency. For example, if the price point is set at the average price this encourages above-cost services to be more economically efficient, but is unlikely to reduce quality to the extent that setting a price at the level of the 25% most efficient services would lead to. In addition if adjustments can be made, for example for remoteness or Aboriginality, this will arguably reduce differences that are perceived to be state based, but in fact relate to nationally applicable factors influencing costs.

Purchasers would arguably benefit from a more formalised approach to assessing costs for services/projects. The current approach was described as "not highly scientific" and it was suggested by key informants that a more sophisticated approach to costing was required. As noted by one key informant, the sector is left confused and without guidance about appropriate costs/funding requests (purchaser).

Setting the most appropriate unit cost or benchmark is enormously challenging. Key informants noted that any pricing needed to consider client complexity, location of the services (rural/remote), accommodation of services that do not have efficiencies of scale, inclusion of infrastructure within the unit cost, and other 'hidden' costs such as the cost associated with developing and maintain relationships with partner organisations. However, existing ABF systems do provide potential models of how to accommodate such adjustments.

Summary: price per episode
In summary price per episode is regarded as a fair and transparent system for funding, which directly links services delivered to payment, and has inbuilt incentives for controlling the cost of each episode of care. At the same time it can be administratively complex for the purchaser in particular, especially in the establishment phase, and can be subject to negative consequences (such as cream skimming). ABF, as a funding model applied to AOD treatment would involve specification of the nature of activities (episodes) and then alignment of those activities with an appropriate unit cost. Appropriate adjustments applied to the unit costs would also be required (for remoteness, complexity, and so on). There are useful lessons from the Victorian model of AOD ABF.

ABF can be considered in three different ways in this Review: as a way to determine the Commonwealth's contribution towards AOD treatment where those funds are then used by states/territories (this is how the current hospital ABF system is used by the Commonwealth to determine its financial contribution, currently at 36.5% of the NEP); as a way to fund AOD treatment services provided by states/territories outside the NHFP mechanics (payment to states/territories for selected episodes of care at an agreed fixed price), or as a way of establishing unit costs per service type for which the Commonwealth will directly purchase treatment from providers (for example, competitive grants programs have a listed unit price for each service type and applicants then compete on quality, but not on price. Block grants are then used to contract the service). These options are discussed in Chapter 14.

Thus far we have reviewed two ways in which the funding is provided — through a block grant or through activity-based funding (price per episode). A third option is capitation (price per population). This model is not fully operational in Australia, and hence we summarise it only briefly (the interested reader can see further details in Working Paper # 10).

Capitation

Capitation provides payment to a healthcare organisation per head of population. In the USA, managed care organisations are capitation models. The managed care organisation is given a sum to deliver care (usually over a year) to a fixed population and payment is usually prospective (Horgan & Merrick, 2001). There are few examples of capitation in Australia, but the new Disability Scheme appears to be a version of capitation (set amount per). Capitation has been defied as:

> "Providers receive a periodical (mostly annual) lump sum per patient under their supervision during a certain period (mostly a year). The total income for a provider is a function of the number of patients enrolled on the list, irrespective of the number of performed activities and contacts." (Jegers et al., 2002, p. 266)

We reviewed capitation models in Working Paper # 10, and provide a brief summary here. Capitation is not a funding model that is generally used in Australia (see Duckett & Willcox, 2011 for some history of attempts at capitation in Australia). The majority of the research literature on capitation comes from the US, and sits within the managed care/health maintenance organisation systems. Several US studies have examined the effect of third-party managed care financing arrangements for AOD treatment services, a funding model strongly associated with capitated payment systems (Abraham, Knudsen, Rieckmann, & Roman, 2013; Zarkin, Galinis, French, Fountain, Ingram, & Guyett, 1995). These studies have found cost reductions (but also potential cost-shifting), sustainability of services, changes in the nature and type of treatment offered (a shift from inpatient to outpatient services), but not changes to accessibility of the services or reduced provision of services (Beattie, Hu, Li, & Bond, 2005; Bigelow, McFarland, McCamant, Deck, & Gabriel, 2004; Ettner, Denmead, Dilonardo, Cao, & Belanger, 2003a; Ettner, Denmead, Dilonardo, Cao, & Belanger, 2003b; Johnson & Roman, 2002; McCarty & Argeriou, 2003; McCarty, Dilonardo, & Argeriou, 2003; Miller, 1992; Sullivan, 2001; Wells, Lemak, Alexander, Roddy, & Nahra, 2007; Wells, Lemak, & D'Aunno, 2005b).

The evidence on the effect of managed care on client treatment outcomes is somewhat mixed. Some studies find no negative effects on AOD treatment outcomes (Beattie et al., 2005; McFarland, Deck, McCamant, Gabriel, & Bigelow, 2005; Renz, Chung, Fillman, Mee-Lee, & Sayama, 1995; Shepard, Beinecke, Reif, & Cavanaugh, 2003). Others found that this model of funding was associated with poor treatment outcomes, shorter treatment duration, and reduced intersectoral collaboration (Friedmann, Alexander, Yey, Nahra, Soliman, & Pollack, 2006; Ghose, 2008; Wells, Lemak, & D'Aunno, 2005a, 2006).

A cautionary note about setting the capitation payment rates has been sounded by alcohol and drug sector research. Drawing on key informant interviews and research from Tennessee, Hoag, Wooldridge, & Thornton (2000) found that rates were initially set too low during a move to managed care arrangements. The authors commented that good estimates of current costs and enrolment were not easy to obtain. They also noted that costs were affected by what services could feasibly be delivered, rather than being based on client need. After six months the system had to be changed to separate the more severe client group from the less severe, increase funding for more severe clients, and to set a minimum monthly spending amount.

In summary capitation is a transparent system of funding that encourages cost containment, and potentially preventive care. However, it may also be associated with under-provision of services, a serious issue in the health field, and data manipulation. In alcohol and drug settings managed care capitation approaches have been associated with cost reductions in the US in the context of changes from inpatient hospital-based care to outpatient care. Capitation approaches do not appear to have

threatened service survival, and findings on the impact on client outcomes have been mixed. Like other fixed cost models setting prices is complex and data intensive.

The fourth and final funding mechanism model is payment for outcome, which we turn to next.

Payment for outcome
Payment for outcome is defined as:

> "payment for providing a pre-specified level or change in a specific behaviour or quality of care." (Eijkenaar, Emmert, Scheppach, & Schoffski, 2013)

> "…those in which the price, level, or nature of reimbursement are tied to future performance measures of clinical or intermediate endpoints ultimately related to patient quality or quantity of life."(Carlson, Sullivan, Garrison, Neumann, & Veenstra, 2010, p. 180)

Payment for outcome should be distinguished from price per episode (or ABF) – neither price per episode nor ABF explicitly link the payment amount to health outcomes. We have separately extensively reviewed pay-for-performance (a common term for outcome-based payments) in both the general healthcare and AOD literature — see Working Paper # 5. Here we provide a brief summary of the advantages and limitations of this model. The key advantage of payment for outcomes is that this system provides explicit financial incentives for improved patient health outcomes (Eijkenaar, 2013; Eijkenaar et al., 2013), or for quality care (Eijkenaar et al., 2013). In practice pay-for-performance has often been implemented in healthcare generally based not on direct measures of patient outcomes, but on process measures of health system performance: for example delivering a certain number of tests to patients, or reducing waiting times (Eijkenaar et al., 2013; Emmert, Eijkenaar, Kemter, Esslinger, & Schoffski, 2012) Therefore outcome-based funding encompasses a range of possible payment types, at the process-based end of the spectrum it can be seen as a type of activity-based funding, and at the other end of the spectrum it is client health outcomes funding, with blended systems in the middle (Maynard, 2012). Often in practice, only a proportion of the overall funding is subject to payment for outcome (Eijkenaar, 2013), therefore it cannot currently be seen as a standalone purchasing model.

There have been a relatively large number of studies of pay-for-performance in health care settings. Whilst incentivising outcomes sounds like common sense in theoretical terms, a recent systematic review of systematic reviews concluded that overall the results for pay-for-performance in health care are "mixed, justifying the conclusion that there is insufficient evidence to support or not support the use of pay-for-performance" (Eijkenaar et al., 2013). Many studies have found positive effects on some measures, but no change or sometimes negative results on others (Eijkenaar et al., 2013). Based on current studies available, there is stronger evidence for improvements in performance on measures of treatment processes than client health and wellbeing outcomes (Eijkenaar et al., 2013; Flodgren et al., 2011). In addition, evidence suggests that payment for outcome purchasing is more effective when it is associated with a new source of funds, rather than existing base funding (Eijkenaar, 2013).

Results in alcohol and other drug settings so far have reflected the general health care literature: findings have been mixed, some studies reporting positive effects and others finding mixed effects, little or no change, or possible negative effects (Brucker & Stewart, 2011; Commons, McGuire, & Riordan, 1997; McLellan, Kemp, Brooks, & Carise, 2008; Stewart, Horgan, Garnick, Ritter, & McLellan, 2013; UK Government, 2013). Overall it is difficult to draw a conclusion about the potential benefits of pay-for-performance given the mixed findings, methodological concerns, and the lack of peer-reviewed evidence from outside the United States. On the other hand there is some evidence that US service providers found the model helpful in AOD (McLellan et al., 2008) and felt that it can encourage innovation to meet targets (McLellan et al., 2008). Alcohol and drug services with

government financial incentives for inter-organisational relationships have been found to work well (Wells et al., 2005a).

The limitations of pay-for-performance include the challenge of designing and measuring "outcome" (Eijkenaar, 2013; Hall, 2010; Productivity Commission, 2010; Ritter, 2011). Linking payment directly to *long-term* client abstinence following treatment is highly ambitious given the variety of factors outside the treatment setting that can affect long-term outcome (McLellan et al., 2008). Payment for outcome is also a data intensive model, like other fixed payment funding systems, requiring accurate and timely data collection and payment systems (Eijkenaar, 2013). Outcome payments have the potential to encourage false reporting by services to funders, and therefore need to be carefully monitored and evaluated (Eijkenaar, 2013; Hall, 2010; Lu & Ma, 2006). Overall, there are substantial design challenges in implementing pay-for-performance (Eijkenaar, 2013). The development of outcome payment systems is in its infancy (Duckett & Willcox, 2011).

Outcome-based funding was not seen as a viable option by most key informants. The issue most commonly raised was the inability to ascribe outcomes to any single intervention or episode of care along with the problem of measuring outcomes that occur some time after the intervention itself. Outcome-based funding rests on being able to capture the long-term effect of an AOD intervention on someone's alcohol or drug use, after they leave a program/service. The second issue raised by almost all key informants is the challenge of agreeing to and then measuring an 'outcome'. For example, they asked; "what would be a 'success' in our business" (purchaser) and, "how do you accommodate what the patient wants from treatment" (purchaser), noting that, "success in AOD treatment is difficult to achieve and assess" (purchaser) and "at what point do we say we have an outcome?" (provider). What is the relationship between all the activity undertaken in an AOD service and the client outcomes (do you have to pay for every piece of work regardless of outcome?). Some key informants questioned whether funding should only be provided when treatment is successful; despite the best efforts of workers the desired outcomes may not be met. Do these efforts get paid for? The measurement of outcomes (including 3, 6 or 12 month follow-up interviews with clients) would be costly for services, and require a funding program of its own. These are fundamental problems with any outcome-based funding approach, and it is worth noting that no area of healthcare in Australia uses outcome-based funding.

Importantly, key informants noted that rejection of outcome-based funding models should not be interpreted as a rejection of the commitment to achieving sustained outcomes for clients, nor the importance of accountability and services having reflective feedback and evaluation processes such that they strive for continuous improvement in client outcomes. It is the explicit linking of client outcomes with the mechanisms for funding that is not supported by key informants. For example, "we should report on outcomes but don't link it to funding" (provider).

Summary: payment for outcome
It is difficult to accurately characterise the research studies in this area, given the diversity of terminology and design of pay-for-performance schemes. In relation to the 'performance' part of pay-for-performance, there are two main types of 'performance':
1. Process performance measures — for example, how much of treatment capacity was used, how long people were retained in treatment, whether treatment protocols are closely followed and so on
2. Outcome performance measures — whether clients achieved changes in drug use, improvements on other health behaviours, improvements on other health outcomes, changes in employment status, criminal behaviour etc. Outcome performance measures can be measured at end of treatment (eg the Commons et al., 1997 study) or at some point post treatment.

In relation to the 'payment' part of P4P, programs differ in relation to whether the payment **is** the base funding (and/or what proportion of the base funding: in the UK 'payment-by-results' (PbR) outcomes-based AOD funding pilots it varies between 10% and 100%), or whether the payment is a bonus over and above base funding. There are also programs with penalties (that is a reduction in funding if performance is not met).

When all this is taken into account, and we revisit the literature, we can only confirm our conclusions from Working Paper # 5. There is no peer-reviewed evidence that P4P in AOD treatment improves client outcomes post-treatment[66], some evidence that it can improve process measures, and a paucity of high quality research.

Choice of provider and choice of payment mechanism: summary

In summary, at present there are four ways in which the Commonwealth and state/territory governments select AOD treatment providers:
>   1. Through competitive selection processes
>   2. Through individually-negotiated arrangements (often based on historical agreements)
>   3. Through transfer of funds to state/territories
>   4. Through an accreditation and/or registration process.

At present there are also four ways in which the Commonwealth and state/territory governments could provide the funds:
>   1. Through a block grant (lump sum)
>   2. Through a price per episode
>   3. Through a capitation model
>   4. Through payment for outcomes.

Each of these has strengths and challenges. An important overarching question is the extent to which the funding mechanisms for AOD treatment are regarded as part of the health system, or the social welfare system. It is striking that the way in which AOD treatment is currently purchased by the Commonwealth and states/territories through the NGO sector is predicated on models that exist for social welfare services, not those for health. Thus, governments purchase social welfare services, such as employment services, and homelessness services, largely through competitive grant schemes. Arguably, alcohol and other drug treatment services have simply been subject to these social welfare processes because the providers are NGOs. However, if one considers AOD treatment as a health service, then the usual mechanisms for health funding (such as ABF or fee-for-service) would be more appropriate. We have not conducted a systematic analysis of the differences between state/territory government service funding and state/territory NGO funding, but would point out that in jurisdictions where government AOD services predominate, the funding mechanisms are consistent with those used across health (eg NSW, via Local Health Districts, and a combination of ABF and block grants to hospitals).

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[66] The only peer-reviewed study to report positive client outcomes in association with P4P (Commons et al., 1997) assessed outcomes at point of discharge from treatment (not after treatment), used clinician discharge summaries as the data, and has been shown to be subject to some bias (Lu & Ma, 2006). More importantly, this study appears to not strictly be P4P, as agencies were given annual (block) grants which in future years "may" have been subject to adjustment based on outcomes. In this sense it was more an example of performance contracting, rather than direct payment for outcomes. The UK PbR results are preliminary only, but across the five outcomes measures, show no change or poorer performance for the PbR sites than national average (UK Government, 2013).

In considering the options for the Commonwealth, detailed in Chapter 14, the current processes within each state and territory and the Commonwealth provide important background information. We turn to this next.

State and territory AOD treatment funding processes

The purpose of this Review was not to evaluate the state and territory purchasing processes. However, some basic information about how the states and territories approach their purchasing, and the associated timelines is important information for the Commonwealth.

The section below summarises our understanding of current state/territory purchasing processes. As can be seen below, there are substantial differences between how the states and territories purchase services for the government sector compared to the non-government sector. There are also inter-state differences. (This information is also summarised in Chapter 11, along with planning and contracting arrangements for each jurisdiction).

In the NT, government services are funded on a recurrent basis. The providers are the existing historical government services. Non-government services in the NT use individually-negotiated processes to select the NGO providers, and a block grant approach for funding, with contracts generally for 3 years. There is some competitive tendering (for example, minor grants and capital works). Prices for services are not fixed, and are based on historical amounts funded and/or negotiated with individual providers. At the time of the site visit, it was suggested that a competitive process would be implemented in 2014, to "move toward submission-based funding" and open up the market to new providers. The suggestion was also made that clinical services would move to a regionally-based health and hospital network system (similar to the Queensland model). There will be a one-year extension of NGO contracts to June 2014. In 2014 the intention is to introduce submission-based funding, but details were not released as of March 2014.

In Queensland, the government AOD treatment services form part of the 17 Health and Hospital Services (HHS), that is the providers are the existing historical government services. Funding for government AOD treatment services is not distinguishable from the Queensland government's funding of all health and hospitals services. For NGO services, block grants have been provided through competitive tender, for a 3-year period, just recently undertaken (the Request for Offer was released on Monday 3 March, and submissions are due on Wednesday 2 April). Residential withdrawal support and/or rehabilitation and NGO AOD sector data support services are considered 'non-contestable' and they are exempt from the competitive process[67]. There is no fixed price per unit/service/activity for the Government or NGO AOD services. Current grant end dates are in June 2014. Outpatient services are currently under competitive process, with 3-year service agreements for implementation from 1 July 2014. Residential withdrawal and rehabilitation, and NGO sector data support services will be given a3-year extension of current agreements.

To date, Victorian AOD services have been provided by health services, community health services and NGOs. Providers are chosen through competitive selection processes, and the funding mechanism was based on unit costs per episode of care. Unit costs (fixed contract amounts per fixed quantum of episodes of care) were in place from the mid-1990s. The recent reform process involves set costs based on a core Drug Treatment Activity Unit with weightings for particular populations, described as 'activity-based funding' (see case example, Chapter 17).

In WA, government services are provided by Next Step. Funding is recurrent. NGO providers have

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[67] Queensland Department of Health. Non-government alcohol and drugs sector. Communique March 2014. www.etender.qld.gov.au. Accessed 7 March 2014.

historically been funded through a mix of competitive and select provider processes. A major reform is under way that involves the development of a 10-year 'Alcohol and other Drug Services Framework 2015-2025', to guide the provision of alcohol and other-drug prevention activities and treatment and support programs and services. This has been developed as a Partnerships approach (See case example in Chapter 11, and Chapter 17). The WA reform will focus on services being purchased on an outcome basis, that is, the government determines what outcomes it wants to purchase (which are defined through consultation with the sector), and services submit applications whereby they demonstrate how they will achieve those outcomes, and at what cost (in this sense it is not P4P, or activity-based funding but relies on the application process as demonstrating the link between services and outcomes). Competitive processes will be used to select providers, across open, preferred provider, or closed processes for procurement[68]. An agreed price for services (that are matched to outcomes) is individually negotiated with providers. The WA reforms are also associated with increased funding, and represent a shift in the approach to funding, 'We don't fund organisations, we buy services'. A substantial amount of preparation and partnership building has taken place to enable the process of change. There is an ongoing cycle of procurement that generally involves 3-year agreements with 2 options for expiry (review and possible extension). Restricted processes or a preferred-provider model will be used for the majority of services (ie where they are considered 'specialist' or have significant infrastructure).

Government services in SA, provided by DASSA, are block funded, based on historically negotiated amounts. There is no fixed price per activity/output/outcome. The providers are the existing historical government services. All services have key performance indicators to meet. NGO AOD treatment services in SA are funded with two pools – the Illicit Drug Diversion Initiative and Drug and Alcohol Services Program pools. They are predominantly subject to open competitive tendering (with the exception of direct negotiations with some sole providers, such as the South Australian Network of Drug and Alcohol Services, and Family Drug Support). Detailed tender specifications are used (eg type of service, staff qualifications and so on). All services have key performance indicators to meet. From each agency SA purchases a certain amount of activity at the agreed upon price. DASSA is working on defining a set of clinical outcomes (which should be in place by the end of 2014) for its own clients/services, eg level of substance use, level of mental distress, injecting risk, self-reported quality of life.

Government AOD services in Tasmania, provided by Tasmanian Alcohol and Drug Service, are funded through annual block funding (negotiated based on previous year). There is no fixed price per activity/output/outcome. The Tasmanian government purchases most AOD treatment from NGOs services through historically-negotiated, 3-year block grants at an agreed amount specific to that agency, contingent on performance. The Future Services Direction funding (which commenced in 2008/09 as a result of a review) continued existing purchasing arrangements but also introduced competitive tendering (no fixed price). The decision as to what would be competitively tendered was based on Treasury determination regarding whether the services were new/different (these had to be tendered), whereas funding to extend the capacity of existing services need not be tendered out. Unlike South Australia and Victoria, Tasmania does not stipulate the construct of the treatment it is purchasing. Hence its purchase approach is more akin to that of the Commonwealth. All NGOs are not on the same cycle, by virtue of when the services went to tender. Some expire in 2104; some in 2015, and some in 2016 (3-year contracts). There is no on-going competitive tendering for continuing direct service delivery. There may be tendering for new services under the Future Services Directions funding.

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[68] The *Funding and Purchasing Services Policy and Procedures* (March 2013) identifies a two-stage process for procurement planning. First, decide whether to proceed using a grant or service agreement. Then, decide whether to openly tender or use a restricted negotiation with a preferred service provider (PSP). Variations on the open tender include a registration of interest, expression of interest and request for proposal. See p. 11.

Government AOD services in NSW form part of the Local Health Districts (LHDs). Funding to LHDs is largely driven by historical amounts, and are block funded; it is up to the LHD to determine how to spend the block AOD treatment funds. Note this block funding has been quarantined. Drug and alcohol inpatient beds are using the Activity-Based Funding as per the national hospital funding processes. The NSW Ministerial grants program has been the primary funding mechanism for the NSW NGO AOD treatment services. The NSW government purchases most AOD treatment from NGO services through historically-negotiated block grants at an agreed amount specific to that agency. There is some competitive tendering. Fixed prices are not used. The NSW NGO system is under reform at present: moving from a grants arrangement to a contract arrangement, under the 'Partnerships for Health' reform. The 'Partnerships for Health' will allow government to be transparent, with clear purchasing frameworks and contract performance management systems. AOD and Mental Health have started contract negotiations with the Ministry for the 2014/2015 year but it could be up to two years until fully implemented. Current grants have been extended to 30 June 2015 pending the reform. A contestable tender process is to occur from 1 July 2015. The proposed process is still being finalised, but may be largely through contestable tendering processes, open to all providers.

Government AOD services in the ACT are funded through hospital block grants, based on historically-negotiated amounts. There is no fixed price per activity/output/outcome. The ACT government purchases AOD treatment from NGO services through historically-negotiated block grants at an agreed amount specific to that agency. NGO contracts are renegotiated every three years. Current contracts for the NGOs are (largely) 2013 to 2016.

Conclusions

- Multiple purchasing mechanisms are in play at present. For example, the Commonwealth currently purchases AOD treatment through four mechanisms: competitive processes (grants schemes), fee-for-service (Medicare), activity-based funding (hospital services), and transfers to states/territories (special purpose payments).
- The way in which AOD treatment is currently purchased by the Commonwealth and states/territories through the NGO sector is predicated on models that exist for social welfare services, not those for health. Thus, governments purchase social welfare services, such as employment services, and homelessness services, largely through competitive grant schemes. Arguably, alcohol and other drug treatment services have simply been subject to these social welfare processes because the providers are NGOs. However, if one considers AOD treatment as a health service, then the usual mechanisms for health funding (such as ABF or fee-for-service) would be more appropriate.
- It is useful to distinguish the mechanism by which the provider is chosen (eg: competitive selection, historical or negotiated, preferred-provider, or via accreditation/registration processes) from the mechanism by which the payment occurs (block grant, activity/episode-based, capitation and outcome-based).
- Each of these has advantages and disadvantages. Existing literature and key informants to the Review have informed our analysis of the relative strengths and limitations.
- Competitive processes to select the providers of AOD treatment are widely used. These approaches have a number of general advantages, particularly transparency and fairness. There is also a perception that competition is a driver of quality and may involve reduced price. However, there are a number of disadvantages that apply to AOD. A limited number of potential providers exist. Funders risk undermining sector viability through processes that do not account for a) organisational characteristics (eg, size and capacity to write proposals) and b) the vulnerability of organisations to uncertain funding arrangements.

- The competitive process, if effective, needs to be designed with consideration of the pool of potential providers and it should be well-resourced. Assessment panels need to include experts with a sound understanding of service delivery and clinical excellence. A selective process, possibly focused on a pool of preferred providers is worth consideration.
- Individually-negotiated processes to select the provider are common for government service provision. In some cases, individually-negotiated selection of providers occurs with NGOs. The key criticism of this process is the lack of transparency and fairness.
- Transfer of funds to states/territories is the way in which healthcare in Australia has evolved through special purpose payments and the National Health Funding Pool (NHFP). The advantages of such an approach are the reduced administrative costs to the Commonwealth, and the increased potential for coordinated planning and purchasing. The key disadvantages are the risk of loss of funds, and the lack of checks and balances provided by the two levels of government.
- Accreditation of approved providers who can then submit invoices for services rendered (ie the Medicare model) is unlikely to be feasible for AOD treatment that is funded by the Commonwealth. This model increases the amount of services provided but operates in a largely uncapped budget environment.
- The use of block grants (whether with or without specifications of activity within the contract) is a common mechanism for funding flows – and is the one currently used by the Commonwealth for the NGOTGP and SMSDGF. The advantages are its simplicity and flexibility. The disadvantages include potential inconsistency in funding between agencies (no fixed or unit price), limited incentives for efficiency, and potential limitations on the specificity regarding what is sought and delivered (depending on the nature of the agreement).
- Price per episode is becoming the prevailing model for funding healthcare in Australia. The hospital funding through ABF and the Victorian AOD ABF are important developments for consideration. ABF models provide clarity about what is being funded, can promote efficiency and increase budget control (assuming funding is capped), and provide benchmarks for service pricing. One way in which the Commonwealth can use an ABF model is to specify its funding contribution to AOD treatment (which is then managed by the states/territories). However, establishing high quality ABF systems can be expensive, prices need to be set correctly, and infrastructure established to adjust prices over time.
- Capitation, a price per population, is a model widely-used in US healthcare. It has not yet been fully implemented in Australia. It is unlikely to be the solution to funding Australian AOD treatment services.
- The use of outcome-based payments has not shown the necessary positive results to make it a viable model for implementation at this time.
- In considering all the options, it is important to bear in mind that:
  - Mixed models are most common (for example an ABF and a block funding approach for the same organisation, and perforce across the sector);
  - The state/territory approaches are important to consider;
  - Each option has both strengths and weaknesses; and
  - There needs to be acknowledgement of current systems and effective change management processes should reform be indicated.

Chapter 7: Meeting needs – current service utilisation

An understanding of the numbers of people in alcohol and other drug (AOD) treatment in relation to the numbers of people in need of treatment is integral to planning. It is a challenging task to estimate the extent of unmet demand for treatment (See Working Paper # 1).

This chapter has three aims:
> 1. To document the amount of AOD treatment provided in Australia (over a one-year period)
> 2. To describe the characteristics of treatment recipients
> 3. To estimate the number of people in receipt of treatment in one year.

It draws from Working Paper # 8, which provides the technical details for the current service utilisation analysis. Previous chapters have illustrated the many types of treatment providers in Australia and the various distinct sites of treatment provision from publicly accessible institutions like hospitals, and freely-accessible phone treatment lines and online services, to private rehabilitation centres and private psychiatrists. They have also shown the range of institutions (government, non-government and private) that fund AOD treatment. There is no population-level survey in Australia of AOD treatment usage. . We rely on the funders and treatment providers for data on treatment utilisation. As a consequence, we were not able to document all treatment.

Amount of AOD treatment provided in one year

The data to estimate treatment utilisation were obtained from multiples sources:
- Treatment provided by general practitioners: Bettering the Evaluation and Care of Health data (BEACH).
- Treatment provided by publicly-funded specialist treatment services: Alcohol and Other Drug Treatment Services National Minimum Dataset (AODTS-NMDS).
- Treatment provided by hospitals as in-patient services: National Hospital Morbidity Database National Minimum Data Set (NHMD-NMDS).
- Opioid pharmacotherapy treatment: National opioid pharmacotherapy statistics annual data (NOPSAD).
- Treatment provided by substance use agencies funded by the then Office for Aboriginal and Torres Strait Islander Health: On-line Services Report (OSR).
- Treatment provided by state/territory-government-operated mental health services: Residential Mental Health Care National Minimum Data Set (RMHC-NMDS) and Community Mental Health Care National Mental Health Care National Minimum Data Set (CMHC-NMDS).
- Treatment provided by allied health services (psychologists, psychiatrists, and appropriately trained social workers and occupational therapists) through the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative and the Access to Allied Psychological Services (ATAPS) initiative.

Table 7.1: Summary of data sources

Data Source	Agency responsible for data source	Time frame	Sample/census*	Type of data
BEACH	Family Medicine Research Centre (University of Sydney)	Averaged over 2008–2013	Sample of GPs (1,000 GPs, 100 consecutive encounters)	Treatment encounters with a GP
AODTS-NMDS	Australian Institute of Health and Welfare (AIHW)	2011–2012	Census of treatment providers	Closed episodes of care provided by publicly-funded treatment agencies
NHMD-NMDS	AIHW	2011–2012	Census of treatment providers	Closed episodes of in-patient treatment provided by hospitals
NOPSAD	AIHW	Snapshot day in June, 2012**	Census of treatment recipients	Point-in-time (day) measure of people in opioid pharmacotherapy treatment
OSR	AIHW	2012	Census of treatment providers	Numbers of people treated by Commonwealth funded Aboriginal and Torres Strait Islander substance use services and episodes of care
CMHM- NMDS RMHC- NMDS	AIHW	2010–2011	Census of treatment providers	Client contacts with government-operated-and-funded community and hospital-based ambulatory mental health care services (consultations/contacts) and government-funded residential mental health care services (episodes of residence)
Better Access	Department of Health	2009	Sample of 129 service providers (psychologists and GPs) and 833 of their patients.	Number of mental health consultations with allied health professionals under Better Access scheme
ATAPS	Department of Health	2010–2011	Census of treatment providers	Number of mental health clients treated by allied health professionals under ATAPS scheme and number of consultations

* A census is the collection of data from the whole population, whereas a sample is a subset of units in a population, selected to represent all units in a population of interest.
**The snapshot day varies between states and territories. Western Australia counts over the month of June (Australian Institute of Health and Welfare, 2013c)

This section provides estimates of the amount of treatment provided in Australia; we focus here on episodes of care, separations and encounters (not number of people). We also do not at this point consider the issue of double-counting between services — that is, those people who receive treatment from more than one service in a year. Nor do we consider the potential for a person to receive treatment. These three issues are accounted for later in this chapter.

BEACH data (Annual estimated encounters with a GP)

Table 7.2 sets out the estimates of annual encounters with a GP for drug (medicinal and non-medicinal) and alcohol use disorders. We excluded encounters associated with drug use disorders where an opioid substitute was prescribed, since these will be covered under opioid pharmacotherapy treatment using the NOPSAD data. An encounter with a GP does not necessarily translate to a treatment episode. An encounter could, for example involve a brief intervention, or be one of the (up to 10) encounters that form part of a GP mental health service under the Better Access initiative.

The BEACH data national estimate for annual encounters with a GP where no opioid substitute was prescribed or provided is 826,000. Almost three-fifths (58%) of the encounters were for an alcohol disorder, one-third (33%) for a non-medicinal or illicit drug use disorder and the remaining 8% for medicinal drug use disorders.

Table 7.2: Estimated national annual number of encounters with a GP for AOD use disorders where no opioid substitute is prescribed or provided (annual average 2008-2013, BEACH data)

		National estimate	**Lower (95% CI)**	**Upper (95% CI)**
Alcohol use disorder	1,998	487,000	457,000	517,000
Non-medicinal drug use disorder	1,112	271,000	245,000	297,000
Medicinal drug use disorder	278	68,000	58,000	77,000
Total	3,388	826,000	760,000	891,000

According to Table 7.3, the majority of encounters for AOD use disorders were with men. This divide between the sexes was largest for alcohol use disorders and smallest for medicinal drug use disorders. Over 70% of encounters were with clients aged 25 to 44 years. Clients with alcohol use disorders were more likely to be older than 45 years of age than those with illicit and medicinal drug use disorders. But Australians with medicinal drug use disorders were more likely than members of the other two groups to be older than 75 years of age.

Table 7.3: Characteristics of patients associated with each encounter with a GP for AOD use disorders where no opioid substitute is prescribed or provided (annual average 2008–2013, BEACH data)

	Alcohol use disorder	**Non-medicinal drug use disorder**	**Medicinal drug use disorder**
Women (%)	36.7 (34.4–39.1)	41.7 (38.5–44.9)	47.8 (46.3–58.1)
Men (%)	63.3 (60.9–65.6)	58.3 (55.1–61.5)	52.2 (41.9–53.7)
Age			
5–14 (%)	0.1 (0–0.1)	0.4 (0.0–0.7)	0
15–24 (%)	6.6 (5.5–7.7)	15.7 (13.3–18.1)	6.3 (3.3–9.0)
25–44 (%)	35.1 (32.8–37.4)	59.0 (55.9–62.2)	48.2 (42.2–54.1)
45–64 (%)	45.5 (43.2–47.9)	21.8 (19.3–24.4)	28.6 (23.2–34.0)
65–74 (%)	9.4 (8.0–10.8)	1.3 (0.6–1.9)	6.2 (3.3–9.0)
75+ (%)	3.3 (2.5–4.1)	1.7 (1.0–2.5)	10.9 (7.1–14.7)

AODTS-NMDS 2011/2012 (Closed treatment episodes provided by publicly-funded AOD treatment agencies)

According to our calculations of unit record data provided by the AIHW, in 2011–2012 there were 145,226 closed treatment episodes for alcohol and other drugs provided to clients for their own use, excluding treatment episodes where nicotine or tobacco was the primary drug of concern. This figure corresponds to the number reported in the associated AIHW report (Australian Institute of Health and Welfare, 2013b). In almost half (46%) of those treatment episodes alcohol was the principal drug of concern, and counselling was the most common form of treatment (41% of those episodes) (Table 7.4).

Table 7.4: Closed Treatment Episodes provided by specialist, publicly -funded AOD treatment agencies by principal drug of concern and main type of treatment provided (AODTS-NMDS, 2011/2012)

	Principal drug of concern		
	Alcohol (%)	Other drugs* (%)	All (%)
Main treatment type			
Withdrawal management	18.5	14.9	16.6
Counselling	43.8	39.0	41.2
Rehabilitation	6.0	5.9	5.9
Support and case management only	6.6	10.5	8.7
Information and education only	3.1	7.0	5.1
Assessment only	14.8	14.4	14.6
Other (includes pharmacotherapy)	7.3	8.4	7.9
Total (N)	67,370	77,856	145,226

*Excluding episodes where nicotine or tobacco is the principal drug of concern

Table 7.5 summarises treatment episodes of care by the sex and age of the client excluding episodes of care relating to people whose sex was not stated or inadequately described (N = 123) and people whose age at the end of the treatment episode was reported as being 90 years or older (N = 164). Over two thirds (68%) of the closed treatment episodes were provided to men; and the gender split was identical for treatment where alcohol was the principal drug of concern and where other drugs were the primary drug of concern. The majority of clients associated with the episodes of care were aged 25 to 44 years. Clients associated with episodes of care where alcohol was the principal drug of concern were more likely to be older than 45; whereas clients associated with episodes of care where other drugs were the principal drug of concern were particularly more likely to be younger than 25 years of age.

Table 7.5: Closed Treatment Episodes provided by specialist, publicly-funded AOD treatment agencies by principal drug of concern and by sex and age of client at end of treatment episode (AODTS-NMDS, 2011/2012)

Principal drug of concern	Age at end of episode	Women		Men	
Other drugs *		*N*	*%*	*N*	*%*
	5–14	232	0.9	622	1.2
	15–24	7,250	28.9	16,214	30.8
	25–44	14,798	59.1	30,179	57.3
	45–64	2,688	10.7	5,516	10.5

Principal drug of concern	Age at end of episode	Women		Men	
Other drugs *		*N*	%	*N*	%
	65–74	67	0.3	97	0.2
	74–89	25	0.1	15	0.0
Total		25,060	100.0	52,643	100.0
Alcohol					
	5–14	326	1.5	409	0.9
	15–24	2,823	13.1	7,920	17.4
	25–44	11,273	52.1	23,474	51.5
	45–64	6,641	30.7	12,548	27.5
	65–74	495	2.3	1,057	2.3
	74–89	79	0.4	193	0.4
Total		21,637	100.0	45,601	100.0

*Excluding episodes where nicotine or tobacco is the principal drug of concern

However, as outlined in Section 2.2 of Working Paper # 8, the jurisdictions do not follow a consistent approach to counting episodes of treatment. All jurisdictions, bar Western Australia and Victoria, report against the main form of treatment. In contrast Victoria counts all forms of coincidental treatment as separate episodes of care and most treatment provision in Western Australia is similarly reported. To capture all forms of treatment provided, we count the 18,695 other forms of treatment provided as episodes which increases total Australia-wide episodes of care to 163,921.

NHMD-NMDS (2011/2012) (inpatient closed episodes of AOD treatment provided by hospitals)
According to our analysis of the unit record data provided by AIHW we estimate that there were 69,236 inpatient closed episodes of AOD treatment provided by public and private hospitals in 2011-2012. The majority of the closed treatment episodes were for alcohol treatment (72%) and the main diagnosis-related group associated with 60% of the closed treatment was "disorder and dependence" (Table 7.6).

In comparison, the AIHW estimated that there were about 107,800 hospital separations with a drug-related principal diagnosis in 2011–12, based on its broader collection of separations (see Section 2.3 of Working Paper # 8) (Australian Institute of Health and Welfare, 2013b Table 6.1)).

Table 7.6: Closed inpatient treatment episodes (separations) provided by hospitals by principal drug of concern and main DRG (AODTS-NMDS, 2011/2012)

	Alcohol treatment		Other drug treatment		All	
	N	%	N	%	N	%
Intoxication and withdrawal	18,678	37.6	9,117	46.5	27,795	40.1
Disorder and dependence	30,971	62.4	10,470	53.5	41,441	59.9
Total	49,649	100.0	19,587	100.0	69,236	100.0

As Table 7.7 shows, the majority of treatment episodes were with men (58%). Whereas over 40% of the clients attached to the alcohol treatment episodes were aged from 45 to 64 years and a further 10% older still, over 80% of clients associated with other drug treatment episodes were younger than 45 years of age.

Table 7.7: Closed inpatient treatment episodes (separations) provided by hospitals by principal drug of concern and by sex and age of client at end of treatment episode

		Women**		Men	
Other drug treatment*	**Age at separation**	*N*	**%**	*N*	**%**
	5-14	35	0.5	43	0.4
	15-24	1,608	21.9	2,999	24.5
	25-44	4,065	55.4	7,373	60.2
	45-64	1,465	20.0	1,758	14.4
	65-74	120	1.6	54	0.4
	75-89	47	0.6	20	0.2
Total		7,340	100.0	12,247	100.0
Alcohol treatment					
	5-14	170	0.8	154	0.6
	15-24	2,222	10.2	2,727	9.8
	25-44	8,495	38.9	10,441	37.6
	45-64	9,546	43.7	11,404	41.0
	65-74	1,230	5.6	2,648	9.5
	75-89	201	0.9	416	1.5
Total		21,864	100.0	27,785	100.0

*excludes nicotine treatment
**AIHW grouped indeterminate/not stated into female

NOPSAD (2012)

On a snap-shot day in June 2012, there were 46,697 opioid pharmacotherapy treatment clients. Of those 3,062 were prescribed in correctional facilities, leaving 43,635 prescribed in the community. Because this metric is number of people, we need to convert it to episodes of care for the purposes of this section of the report. If we assume that average length of stay per episode of continuous treatment is 6 months, and the time outside of treatment is the same as the time within treatment, then doubling the number of people will give an approximation of the number of episodes of care. Thus, we estimate that this translates to 87,270 episodes of opioid pharmacotherapy treatment over 2011–12 (Australian Institute of Health and Welfare, 2013c). Note that the clients prescribed in correctional facilities cannot be excluded from the demographic analyses reported in Table 7.8.

On the snapshot day 65% of the clients (including those prescribed in correctional facilities) were men. Almost 70% of the clients were aged in the 30s or 40s.

Table 7.8: Opioid pharmacotherapy treatment clients (snapshot day in June 2012)

	N	**%**
Women	16,422	32.2
Men	30,203	64.7
Not stated	72	0.2
Age		
<30	6,054	13.0
30–39	18,303	39.2
40–49	14,003	30.0
50+	8,306	17.8
Not stated	31	0.1
Total	46,697	100.0

OSR 2011/2012

In 2011–12, Aboriginal and Torres Strait Islander substance use services provided treatment and assistance for substance use issues in at least 73,991 episodes of care provided to individual clients. Treatment provided on a group basis is not reported. The majority of those episodes of care (56%) were provided to men and the great majority of those episodes of care (82%) were non-residential, follow-up and aftercare services. Residential treatment accounted for less than 5% of the episodes (Australian Institute of Health and Welfare, 2013a).

Residential treatment is perhaps the most comparable form of treatment in the OSR data set and AODTS-NMDS data set (which covers all other publicly-funded AOD treatment agencies). The OSR count for residential treatment episodes is approximately one-third of the AODTS-NMDS count.

Table 7.9: Estimated episodes of care by Aboriginal and Torres Strait Islander substance use services, by treatment provided by residential service and sex of client, 2011/12

	Residential treatment	Sobering up, residential respite and short-term care	Non-residential, follow up and after care*	Total (N)	Total (%)
Male	2,108	6,523	32,864	41,315	55.8
Female	720	3,724	28,052	32,496	43.9
Total	2,828 (3.8%)	10,247 (13.8%)	60,916 (82.3%)	73,991	100.0

*Counselling, assessment, treatment, education, support and home visits, follow-up care from residential services, mobile assistance patrol and night patrol.

Community Mental Health Care (CMHC-NMDS) and Residential Mental Health Care (RMHC-NMDS) (2010/2011)

In 2010–2011 we estimate that there were 205,832 AOD treatment services provided by government-operated community and residential mental health services for AOD treatment, using the data cubes for these collections available on the AIHW web-site[69]. As Table 7.10 shows, almost all (205,764) were undertaken in community mental health care services and, in contrast to all other types of treatment provision that we have documented, the majority of the services (64%) were for drug treatment other than alcohol.

Table 7.10: Estimated service contacts for AOD treatment with government operated community and residential mental health care services, 2010/11

	Alcohol treatment	Other drug treatment	All
Community mental health contacts	74,359	131,405	205,764
Residential mental health contacts	27	32	59
Total	74,386	131,437	205,832

Table 7.11 shows the demographic make-up of community health service treatment recipients. Almost two-thirds (64%) of the alcohol treatment recipients were men. Regardless of sex, close to

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[69] http://www.aihw.gov.au/mental-health-data-cubes/

50% of alcohol treatment recipients were aged 25 to 44 years, with fewer than 20% were younger than that. Men comprised almost three-quarters of treatment recipients for other drugs (72%). In this case almost 60% of treatment recipients were aged from 25 to 44 years. However, close to 30% of other drug treatment recipients were younger than that.

Table 7.11: Estimated service contacts for AOD treatment with government-operated community mental health care services by sex and age of treatment recipient, 2010/11*

		Women	Men
Other drug treatment	**Age**	*%*	*%*
	<14	1.1	0.9
	15–24	26.7	31.1
	25–44	58.9	59.1
	45–64	10.3	8.4
	65–74	4.3	0.4
	75+	0.8	0
	Unknown	1.6	0.1
Total		37,088	94,258
Alcohol treatment			
	<14	0.2	0.4
	15–24	10.5	15.6
	25–44	44.4	46.5
	45–64	37.6	30.8
	65–74	4.1	5.3
	75+	1.5	1.3
	Unknown	1.7	0.0
Total		26,732	47,622

* Note that the totals in Tables 10 and 11 vary slightly, reflecting variations in the data cube extracts.

In 2010–2011 there were a total of 7.17 million community mental health care service contacts, of which 4.9 million or 68.1% were contacts where the patient was present. Assuming that the same ratio holds for contacts relating to AOD treatment, we estimate that there would have been 205,764 x 0.681 = 140,125 community mental health contacts. Combining these with residential mental health contacts gives a revised figure of 140,125 + 59 = 140,184 contacts where the patient was present.

Better Access and ATAPS

Based on information obtained from the Better Access evaluation team (email 11/2/14), approximately 8% of the clients seeing a Clinical Psychologist or a Registered Psychologist were in treatment for AOD disorders.[70] We use this proportion to attribute the services provided by allied health services other than GPs. Recall that we exclude from this those clients who only saw their GP because that is accounted for in the BEACH data. By extension, we assume that 8% of the Better Access services provided by these practitioners were for AOD treatment.

In 2009, 3,004,447 mental health consultations were provided to 671,648 clients by consultant psychiatrists, clinical psychologists, general psychologists, occupational therapists and social workers

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[70] This included alcohol and drug use disorders alone; alcohol and drug use disorders with depression and anxiety; alcohol and drug use disorders, with depression without anxiety, and alcohol and drug use disorders with anxiety without depression.

(Pirkis, Harris, Hall, & Ftanou, 2011, Table 5, p. 24). If we assume that 8% of these were for AOD treatment; this results in 240,356 AOD consultations with 53,732 clients.

The latest evaluation report for ATAPS, undertaken in 2012 shows that between July 2003 and December 2011, 14,505 clients with alcohol and drug use disorders were referred to ATAPS services, representing 7.4% of all 196,227 referrals for which diagnostic information is available (Fletcher, King, Bassilios, Reifels, Blashki, Burgess, & Pirkis, 2012: Table 17, p36). Note that multiple diagnoses could be made for each referral[71]. Of the total referrals made in that 8.5 year period, 78% received services.

In the 2010–11 financial year 42,649 referrals were made and 33,994 (80%) of these referrals received sessions of treatment (199,531 sessions). Information on referrals for alcohol and drug use disorders was not supplied for the 2010–11 financial year. We assume that 7.4% of the referrals that received sessions and 7.4% of the sessions were associated with AOD treatment ie 2,516 referrals and 14,765 sessions.

Summary: amount of treatment received

Table 7.12 summarises our estimates of the quantum of AOD treatment provided in Australia across settings, where that treatment provision is documented in administrative data sets or in official surveys reported here. Comparison of the quantum of treatment provision between treatment settings is complicated by the various ways in which treatment provision is measured, from encounters with GPs, sessions with allied health professionals for people with mental health problems and contacts with government-run community mental health care agencies, to episodes of opioid pharmacotherapy treatment which can last from a matter of days to ten years or more. Nonetheless it appears that most treatment episodes occur in GP settings, followed by the treatment provided through the Better Access initiative. In total, a little over 1.6 million episodes/sessions of AOD treatment are provided each year.

In terms of our counting approach, GP treatment and allied health professional treatment provided through the Better Access and ATAPS initiatives account for two-thirds of the services delivered, measured as they are by individual sessions with health professionals. Individual sessions of treatment provided in government-run community health care agencies account for another 9% of services delivered. Episodes of care provided by government-funded specialist AOD agencies, which can run for over a year at a time, account for 10% of services. Hospital services which can run for similar amounts of time account for a further 4% of services and episodes of opioid pharmacotherapy treatment another 5%.

Table 7.12: Summary: Annual amount of treatment provided (episodes/contacts/separations)

Treatment setting	Data source	Number of treatment episodes/contacts	Type
Treatment provided by GPs	BEACH	826,000	Encounters
Treatment provided by government funded specialist AOD agencies	AODTS-NMDS	163,921	Closed treatment episodes
Treatment provided by hospitals	NHMD	69,236	Separations
OST treatment in the community	NOPSAD	87,270	Episodes
AOD treatment provided by agencies	OSR	73,991	Episodes

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[71] Alternatively we could compare the 14,505 AOD use referrals with the 273,639 total referrals, inclusive of referrals where a diagnosis was not recorded ie 5.3%. This could be said to accommodate for the fact that multiple diagnoses were made.

Treatment setting	Data source	Number of treatment episodes/contacts	Type
funded under the Substance Use Program			
Treatment provided in government run community and residential mental health care agencies	CMHC-NMDS RMHC-NMDS	140,125 59	Contacts
Treatment provided by allied health professionals through Better Access scheme	Pirkis, Harris, Buckingham, Whiteford, & Townsend-White (2007) and information provided by authors.	240,356	Consultations
Treatment provided by allied health professionals through ATAPS scheme	Fletcher et al. (2012)	14,756	Sessions of care
		1,615,714	

It is interesting to briefly reflect on this quantum of treatment care. In previous research (Clemens & Ritter, 2008; Ritter, Berends, Clemens, Devaney, Bowen, & Tiffen, 2003) the most commonly referenced data on treatment utilisation is the AODTS-NMDS, and on occasions hospital separations are included (eg, Fischer, Clavarino, & Najman, 2012). Alternately, self-reported rates of treatment seeking (through the NSMHWB) have been used to assess treatment utilisation (eg, Slade, Johnston, Teesson, Whiteford, Burgess, Pirkis, & Saw, 2009b) with attendant limitations. The methodology used here is more comprehensive than either of these approaches, and unsurprisingly it appears that the amount of AOD treatment utilisation may have been underestimated (at least in relation to our count of episodes of care/encounters/separations). It is salutary that, while it is not sensible to add the numbers together (comparing apples and oranges) the total figure is substantially higher than what might have been anticipated. In addition, we should bear in mind the 'hard to count' and 'unrecorded' treatment that we have separately identified by categories (without being able to quantify that amount). See Working Paper # 6 for a discussion.

There are however, two substantial further issues that need to be dealt with in examining treatment utilisation. The quantum of treatment provided, while useful, cannot be compared to prevalence rates (number of people), and requires conversion from episodes/contacts/encounters/separations to numbers of treatment recipients. That conversion is required to account for the possibility that clients have multiples episodes of treatment.

The first step in that conversion is to move from estimating episodes of care/encounters/separations to numbers of people within each data set, and the second step deals with the substantial double counting that occurs when combining multiple datasets. Most of the data collections, designed to measure resource usage, document episodes of care, and do not provide details of unique treatment recipients. Furthermore they tend to use inconsistent approaches to measuring treatment provision. Those that count treatment recipients count over different time periods and episodes of care tend to be measured differently.

Hence, in this exercise we contend with several complications. Firstly the decision of the time period over which we would count treatment recipients / number of people. Our options are point in time measures (a day or a week for example), or over an entire year. The amount of time people spend in treatment ranges from a matter of minutes (brief intervention with a GP) to months (in residential rehabilitation facilities). People do enter various forms of treatment over a year, so a point-in-time estimate (if every data set measured at the same point in time) might be more useful (disregarding the fact that people can be in multiple forms of treatment at the same time). However, we decided

to consider treatment over an entire year because a per annum measure matches the diagnostic window for the prevalence estimation. By far the most complicated task is the conversion from episodes of care to treatment recipients, closely followed by the need to count each treatment recipient only once.

Estimating the number of people in receipt of AOD services in one year

In this section, we report the findings of the first attempt to estimate the numbers of people in receipt of AOD treatment in any one year in Australia. We hope that our work can be built upon by other researchers as we advance the science of this exercise. It is a vitally important exercise because episodes/contacts/separations are meaningless in and of themselves if they cannot be matched to numbers of people. No population rates for treatment can be determined; nor can the relationship between the number of people with the diagnosed disorder (a per annum estimate) be compared to the number of people in receipt of treatment without such conversions.

There are no previously-published conversion rates, and we are working across different datasets, each of which requires its own conversion rate (ie, there is not one metric to use). In addition, there are many ways of thinking about the conversion.

There are four adjustments that need to be done:
1. Convert from quantum of treatment episodes to number of treatment recipients within each dataset
2. Adjust for double-counting of treatment recipients across agencies providing treatment
3. Convert treatment recipient count from a single day (or month) period to an annual figure (only applies to some data)
4. Adjust for double-counting of treatment recipients across datasets.

We do this in two steps. The first step, incorporating adjustments 1, 2 and 3, works within a single dataset. The second step (adjustment 4) deals with the double counting of treatment recipients that occurs across datasets.

In most instances, the episodes of care are annual figures (with the exception of the opioid pharmacotherapy treatment reported in NOPSAD), so we are largely dealing with per annum episodes being converted to per annum numbers of individuals. In several instances the conversion from episodes of treatment to quantum of treatment recipients is unnecessary because the relevant data source also contains information on treatment recipients; ie, for services provided under the Better Access and ATAPS initiatives, for treatment reported in OSR and for opioid pharmacotherapy treatment reported in NOPSAD. For others we need a conversion approach. We attempt to use as many different conversion rates for each dataset as is possible and useful. In this way we derive minimum and maximum ranges of plausible figures for number of individuals.

A summary of the methods is provided in Table 7.13. Working Paper # 8 gives the technical details.

Table 7.13: Summary - Converting from episodes to people

Treatment setting	Data source	Number of episodes, contacts, people	Method for converting from episodes to people	Formulae/conversion rate	Details	Number of people
Treatment provided by GPs	BEACH	826,000 Encounters	a) General population average # of GP visits per annum b) OTP as the multiplier; c) ATOS data as a multiplier	a) divide by 5 b) divide by 4.7 c) divide by 21.6	a) People on opioid pharmacotherapy treatment visit GPs 4.7 times per year. b) Alcohol dependent people visit GPs at the same rate as other Australians c) ATOS estimate of annual GP visits of heroin-dependent people	a) 165,200 b) 175,745 c) 38,240
Treatment provided by government-funded specialist AOD agencies	AODTS-NMDS	163,921 Episodes	a) Pathways as the multiplier; b) AODTS-NMDS c) OSR data d) ATOS and Victorian day-census of AOD treatment	a) divide by: 6.36 for counselling; 0.18 for rehabilitation; 0.69 for withdrawal. b) divide by 1.13 c) divide by: 1.04 for residential treatment, 3.46 for non-residential follow-up and after care, and 2 for withdrawal management and other. d) divide by 4.83	a) Pathways survey contains episodes of treatment in year prior to entering AOD type treatment/interview. b) AODTS-NMDS includes some treatment provider unique person identifiers for some jurisdictions. c) OSR data reports both episodes of care and clients. d) ATOS (Shanahan, Havard, Mills, Williamson, Ross, Teesson, Darke, Ali, Ritter, & Cooke, 2003): in 12 months	a) 33,249 b) 116,811 c) OSR = 61,488 d) 33,938

					following entry to treatment had 2.6 episodes including index; in 12 mths prior had 5 episodes of care on average; average is 3.8. Inflated by 1.25 for concomitant treatment not counted in ATOS and ascertained from Ritter et al. (2003) census.	
Treatment provided by hospitals	NHMD-NMDS	69,236 separations	a) Pathways data b) ATOS data	a) divide by 2.2 b) divide by 2.4	a) Pathways data shows that clients who have hospital admissions have 2.2 on average over a year b) (Shanahan et al., 2003): in month before entry to treatment approx. 0.49 hospital visits/mth = 5.9/yr, 20% of hospital visits are inpatient.	a) 31,470 b) 28,848
OST treatment	NOPSAD	43,365 people on census day	Conversion from day to year required; based on historical NOPSAD data	Multiply by 1.53	Historical NOPSAD data for Western Australia as it transitioned from providing OTP client numbers on an annual basis to a monthly basis	66,762
AOD treatment funded by agencies under the Substance Use Program	OSR	32,565 unique people summed across agencies	No conversion required	1:1	No conversion applied	32,565
Treatment provided in community and residential mental health care	CMHC-NMDS and RMHC-NMDS	140,184 contacts (140,125 +59)	CMHC-NMDS provides conversion rate. No conversion available for RMHC-NMDS	Divide by 20.5	Based on comparison between all contacts and clients reported in CMHC-NMDS. Assume that this relationship holds for AOD treatment.	6,835 + 59 = 6,894
Better Access	Evaluation data	12,684 people	Conversion unnecessary	1:1		53,732
ATAPS	Evaluation data	1,802 people	Conversion unnecessary	1:1		2,516

Notes: ATOS: Australian Treatment Outcome Study

The results are given in Table 7.14. Summing across all data sources the estimated range for the sum of the number of individuals in receipt of AOD treatment in any one year in Australia is: 262,806 (38,240 + 33,249 + 28,848 + 66,762 + 32,565 + 6,894 + 53,732 + 2,516) to 486,495 (175,745 + 116,811 + 31,470 + 66,762 + 32,565 + 6,894 + 53,732 + 2,516). The high level is almost double the low level; with the divergence due to variation in our estimates of GP clients and clients of government-funded AOD treatment agencies. Two of three of the GP client estimates are reasonably close, at the high end. However three of our four estimates for government funded AOD treatment agency clients are closer to the low end of those estimates.

Regardless, some people receive care from multiple providers (between datasets) and hence there is a further adjustment that needs to be made for double-counting between (rather than within) datasets. We turn to this next.

Table 7.14: Plausible ranges of numbers of individuals within each dataset

Treatment setting	Possible ranges for number of unique individuals (within each dataset)
GPs	a) 165,200 b) 175,745 c) 38,240
Government funded specialist AOD agencies	a) 33,249 b) 116,811 c) 61,448 d) 33,938
Hospitals	a) 31,470 b) 28,848
OST treatment	66,762
Agencies funded under the Substance Use Program (OSR)	32,565
Government provided community and residential mental health care	6,835 +59 = 6,894
Better Access	53,732
ATAPS	2,516

Accounting for double counting between data sources

Removal of the double-counting between data sources is a significant challenge. Whilst we know anecdotally that people with AOD problems seek care from multiple settings/services either simultaneously or within the same year, it is very difficult to precisely ascertain the extent of this, especially as it concerns different treatment service systems. The problem is not unique to AOD; in the mental health field endeavours to account for double-counting between different treatment service systems demonstrate the challenges (Harris, Buckingham, Pirkis, Groves, & Whiteford, 2012; Whiteford, Buckingham, Harris, Burgess, Pirkis, Barendregt, & Hall, 2014).

We need to move from an estimate of 262,806– 486,495 people (see above). Here, we count unique treatment recipients across all data sources using the following series of logical steps. We start with a base-line pool of unique AOD treatment recipients included in the AODTS-NMDS data, ranging from 33,249 to 116,811 representing the low estimate and the high estimate respectively. We then move sequentially through the remaining data sources; our assumptions are as described below and set out in more detail in Working Paper # 8. Table 7.15 summarises the steps taken in the calculation process.

1. GP treatment
   Based on the finding of Burgess et al. (2009), the proportion of people with a substance use disorder who received treatment who *only* saw a GP was 22%. Thus we add 22% of the low estimate of GP treatment recipients (8,413) to the low estimate of the base-line pool and 22% of the high estimate of GP treatment recipients (38,666) to the high estimate of the base-line pool.

2. Hospital treatment
   Close to 30% of the Patient Pathways[72] participants had been admitted to hospital in the year prior to their baseline interview. Hence we remove 30% of the AODTS-NMDS clients from the hospital clients. Our estimate of 30% of the AODTS-NMDS clients ranges from 9,975 (low estimate) to 35,043 (high estimate). Recall that the NHMD-NMDS population estimate ranges from 28,848 to 31,470. Hence, for the high estimate of the base-line pool we add no unique hospital treatment recipients. For the low estimate of the base-line pool we add 18,873 – 21,495 unique hospital treatment recipients.

3. Opioid pharmacotherapy treatment
   Approximately one-quarter of entrants to the pharmacotherapy maintenance program in NSW in 2012 had tried a form of treatment that would be counted in the AODTS-NMDS in the year prior to commencing treatment (Chalmers et al., 2013). Without knowing how many of those in the pharmacotherapy maintenance program that had not tried one of those treatments would have been admitted to hospital, or received mental health care through the Better Access, ATAPS, or the state/territory provided mental health care treatment we add the remaining 50,072 people (75%) to both the low and high estimates of the base-line pool.

4. Treatment provided by agencies reporting to the OSR funded under the substance use program.
   We assume that none of the clients receiving treatment from agencies reporting to the OSR are treated by agencies reporting to the AODTS-NMDS. Nor are any counted in NOPSAD or seen by GPs receiving MBS. However some will be treated as in-patients in hospitals. Based on the Patient Pathways finding set out in Step 2, we assume that 30% of clients counted by the OSR would have been treated as an inpatient in a hospital. Hence we assume that 70% of the OSR clients are unique clients and add 22,796 people to both the low and high estimates of the baseline pool.

5. State/territory provided community and residential mental health care.
   We follow the adjustments made by Whiteford et al. (2014) in their measurement of mental health treatment. They did not count residential clients, assuming that they would be counted in the community care data base and/or counted in GP treatment. They assumed that 15% of the community mental health care clients would be assessment only clients who would be referred to MBS funded services. Hence we add 85% of the community health care population (5,810 people) to both the low and high estimates of the baseline pool.

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[72] Department of Health engaged a research team led by Turning Point Alcohol & Drug Centre to undertake the Patient Pathways project. The project team has conducted initial and follow-up interviews with clients that are new to an AOD service. Participants were sampled from the sorts of AOD treatment services reporting to the AODTS-NMDS. We obtained from the research team a set of frequencies, which showed participants' treatment usage in the year preceding their initial interviews.

Our resultant estimate of the number of Australian in receipt of AOD treatment in any one year ranges from 139,213 to 234,153.

We identified one study with which to validate our estimate. Clemens & Ritter (2008) surveyed telephone callers to an AOD telephone counselling and referral helpline in Victoria. They found that of a total of 549 callers, 44% had attended some form of AOD treatment in the last 12 months. Of that 44%, 24.7% had received treatment from publically funded AOD agencies (ie AODTS-NMDS service). This means that AODTS-NMDS clients should represent about 24.7/44 or 56% of all treatment recipients. In our estimate AODTS-NMDS clients represent 24% to 50% of all clients for the low and high estimates of the base-line pool respectively. This suggests that the estimate based on the high estimate of the baseline pool might be more reflective of reality.

Table 7.15: Estimate of the annual number of AOD treatment recipients with duplication removed

Treatment setting and data source	Low estimate	High estimate
Treatment provided by AOD govt funded providers: AODTS-NMDS	33,249	116,811
Step1: Add treatment provided by GPs: BEACH	8,413	38,664
Step 2: Add treatment provided by hospitals: NHMD-NMDS	18,873	0
Step 3: Add pharmacotherapy maintenance treatment: NOPSAD	50,072	50,072
Step 4: Add Aboriginal and Torres Strait Islander AOD treatment: OSR	22,796	22,796
Step 5: Add treatment provided in government operated community and residential mental health care: CMHC-NMDS	5,810	5,810
Total	139,213	234,153

Summary – current treatment utilisation

We estimated that annually AOD treatment comprises over 1.6 million contacts, episodes of care or encounters. This treatment is provided in multiple settings: by GPs, government funded specialist AOD agencies, hospitals, private opioid pharmacotherapy treatment clinics, government community and residential mental health care clinics, psychiatrists and allied health professionals in the mental health sector. Our estimation was built on a series of annual government funded, publicly available data sources which tend to be sourced from administrative data, the goal of which is primarily to document government funded health service activity.

There is little that can be used to benchmark the 1.6 million figure. This estimate is higher than the only previous estimate, by Fischer et al. (2012), which used AODTS-NMDS and NHMD alone – and found 157,959 episodes. Their exclusion of primary care (GP) AOD treatment largely accounts for the discrepancy. Although the various data sources measure treatment provision in unique ways, comparison of the quantum of treatment reveals that 51% of the treatment counts were provided by GP encounters.

Thus we have little way of assessing the validity or consistency of our estimation. We do not know if the estimated figure would have grown or reduced over the last 5 years, nor do we know how it compares to other disorders, for example mental health. (This is because mental health analyses of treatment utilisation are either based on self-report or based on counts of individuals, rather than episodes). We hope future research will build on the analyses presented here so that the amount of care provided for AOD treatment in Australia can be better contextualised.

In relation to the second aim, characteristics of treatment recipients, our analyses confirmed what is well known in the AOD sector; that the majority of treatment sessions were provided to men; the proportions ranging from 52% of GP encounters to 68% of episodes provided by government funded specialist AOD agencies. In the few data sets where principal drug of concern was identified, alcohol tended to be the principal drug of concern for most of the treatment sessions, ranging from 46% of government funded specialist agency provided episodes to 72% of inpatient hospital episodes. Few treatment recipients were younger than 25 years of age – one quarter or less in most data collections. People receiving alcohol treatment were significantly older than those seeking treatment principally for other drugs.

In relation to the third aim, we find that there is no one simple way to convert from episodes of care to people across the multiple datasets. Even in the few data sources that report the number of treatment recipients, it might be a point-in-time count rather than an annual count, or might be the sum of counts of treatment recipients within each treatment agency. Our estimates are based on multiple conversion rates sourced from existing studies of treatment usage. Our first stage estimate added the various estimates of each of the data sets, ranging between 262,806 and 486,495. Without accounting for double-counting between data sources, consideration of the upper estimate reveals that, when measured over a year, each treatment recipient accounts for around four episodes of care, on average.

Our second stage estimate accounted for double-counting between data sources; an even more heroic task. This reduces the number of treatment recipients to between 139,213 and 234,153. The upper estimate shrinks by a little over 50%.

Again, we sought to contextualise or benchmark this figure, but find little to enable a thorough analysis. To take the mental health comparison again, Whiteford et al. (2014) found that there were about 2 million people seen (in 2009/10) with a mental health disorder[73]. Our estimate of the number of people pales into insignificance in that light. However, the population prevalence of mental health disorders is higher than for AOD disorders, accounting for some of the difference.

We can make a comparison of the self-reported treatment rate of people with a substance use disorder using published data from the National Survey of Mental Health and Wellbeing. Slade et al. (2009b, p. 29) estimate that 5.1% of Australians aged 16-85 had a substance use disorder in the 12 months prior to interview. Further, Slade et al. (2009b, p. 33) estimate that 24% of Australians aged 16-85 with a substance use disorder used a health service for a mental health disorder[74] . At June 2012 there were 17.8 million Australians in this age bracket (Australian Bureau of Statistics, 2013). Hence, we can estimate that approximately 218,000 used a service. This figure is close to our estimate, providing a level of confidence in our estimation process.

Finally, we should not forget the 'hard to count' or 'unrecorded' AOD treatment that occurs across Australia. Self-help programs, employee assistance, private services, telephone and internet-based services all should in theory be counted towards the estimate of the number of people who receive AOD treatment in any one year in Australia. Whilst there will no doubt be substantial double-counting to be dealt with, for example many participants in self-help or mutual aid programs also

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[73] We should point out that technically AOD is a mental health disorder under the DSM and ICD classifications systems, and Whiteford et al. (2014) made mention of substance use disorder in the introduction of this article. However, it is clear that they have not included AOD as they used MBS items numbers (for which there are none for AOD) and did not appear to include AODTS in the state/territory mental health service figures.

[74] According to the same report the sorts of services included were general practitioners, psychologists, psychiatrists, mental health nurses and other health professionals working in specialised mental health settings and other health professionals including social workers, counsellors and practitioners of complementary and alternative medicines.

receive specialist AOD treatment within the same year, there will still be a number unaccounted for in the figures reported here.

As we have pointed out, we urge more research in this area. Refinement of the methods used here and development of datasets that contain unique identifiers (to translate from episodes to people, as AIHW is currently undertaking with the AODTS-NMDS) will improve the ease of estimating treatment utilisation and the validity of the estimates. We should care about the number of people who receive AOD in treatment in Australia – not the least because AOD is a significant health and social problem but because knowing more about who receives treatment will inform us about who does not receive treatment, and how much more treatment we should make available. We turn to this next, examining projected demand for treatment.

Conclusions

- For planning purposes we need to know the number of people in AOD treatment. Ours is the first attempt to estimate that number inclusive of generalist as well as specialist treatment.
- Previous chapters have charted the diversity of AOD treatment providers and diversity of treatments.
- No one treatment works for all people and some people try many forms of treatment to find the treatment and the provider that suits them.
- We estimate that approximately 200,000 Australians try some form of treatment over a year. This is an under-estimate because not all treatment is recorded in official datasets.
- On average people who use treatment had approximately 8 episodes of care over the year, with those episodes ranging from a session with a psychologist or a GP visit, to a long-term stay in residential rehabilitation.
- Between one quarter and one half of the people who try treatment are clients of the specialist treatment sector. We have no way of knowing how many clients are unique to that sector.
- Planning needs to acknowledge and accommodate the fact that people legitimately try different modalities of treatment, often provided in different service sectors; and potentially combine those different modalities to create something that works for them.

Chapter 8: Projected demand for treatment: numbers of people and types of gaps

Introduction

The purpose of this chapter is to both quantitatively and qualitatively assess demand for alcohol and other drug treatment in Australia. The quantitative work relies on the use of DA-CCP[75] to estimate overall demand for AOD treatment in any one year, which we then compare to our estimated met demand rate (see Chapter 7). This analysis allows us to estimate the numbers of individuals who would be suitable for, likely to seek and benefit from AOD treatment in any one year but who are not being accommodated in the current service system. The qualitative analysis, however, demonstrates that such numbers, while useful and important, do not shed light on the complexity of demand for treatment. Treatment demand may not be met because there are insufficient services (one of the conclusions drawn from the DA-CCP analysis) but it may also not be met because the structure and type of services are not well-matched to client need, or because the services are not attractive to prospective clients, or because of geography – not enough services in some specific locations. In addition, the qualitative data allows us to identify the types of clients and service types that key informants felt were insufficient (DA-CCP does not differentiate service type, nor include geography).

Importantly, the purpose of this chapter is to assess the extent of unmet demand in Australia in the context of an environment of finite resources. This means that our conclusions are drawn in light of available resources, rather than a 'blue sky' analysis. Secondly, this chapter has been prepared in the context of the Commonwealth government's need to consider the extent of gaps in alcohol and other drug treatment in Australia in relation to its mandate, funding and contribution to Australia's treatment landscape. However, the state/territory governments contribute the majority of the funds (see Chapter 4), so this work is of equal if not more importance to them.

The chapter proceeds as follows: we start with a summary of DA-CCP as the quantitative model used to generate estimates of demand for treatment. We then outline a series of new analyses using DA-CCP which produce ranges of treatment demand. We then bring together the total demand estimates from DA-CCP with the met demand estimates generated elsewhere in the Review (Working Paper # 8; Chapter 7). These are then interpreted in light of previous Australian research, and international benchmarks. We then turn to qualitative assessment of unmet demand for treatment, using data we collected through key informant interviews. Finally, we combine the quantitative and qualitative analyses and draw conclusions.

The Drug and Alcohol Clinical Care & Prevention (DA-CCP) – descriptive overview

There is an extensive existing international literature on quantitative methods and approaches for estimating need for treatment and estimating demand for treatment. This literature was summarised in Working Paper # 1 and # 2, and we have appended a brief review (Appendix C) bringing this together in summary form. There are debates about terminology (such as the difference between 'need' and 'demand') and debates about the best methods to use: epidemiological; social indicators approaches; waiting list analyses; and demand projection. Here we are using the DA-CCP – which is a purpose-built Australian model to estimate total demand (rather than need) for AOD treatment.

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[75] We use the name DA-CCP for ease, however, the revised title is The Drug and Alcohol Service Planning Model for Australia

DA-CCP was developed in order to facilitate planning for alcohol and other drug services in Australia, and provide a basis for national consistency in approaches to planning across all the Australian health jurisdictions. The specific objectives of the DA-CCP project were: to build the first national population based model for drug and alcohol service planning; to estimate the need and demand for treatment; to use clinical evidence and expert consensus to specify optimal care packages; and to calculate the resources needed to provide these care packages. The model followed the principles of population-based planning that were used in the Mental Health Clinical Care and Prevention (MH-CCP) model of 2000 (Centre for Mental Health, 2001; Pirkis et al., 2007). In summary, the model estimated the prevalence of substance use disorders, by drug type, age group, and severity, and then used expert consensus to estimate the proportions of all those who met diagnostic criteria who would be suitable for, likely to seek, and benefit from, treatment in any one year (that is demand for treatment). The demand for treatment was then distributed between service types, referred to as care packages, which represented evidence-based and/or expert judgement regarding care for one year. The model calculates the resources required to deliver that level of care. There are thus five essential components: the epidemiology, severity distribution, treatment rate, care packages, and resource estimation. The model also covers harm reduction services, and contains the functionality to include prevention activities across the whole population.

DA-CCP was an Intergovernmental Committee on Drugs (IGCD) initiative, consistent with the current National Drug Strategy (2010-2015) to "develop planning models for treatment services that anticipate needs". It was funded through the IGCD cost-shared funding model along with significant additional resources provided by the NSW Mental Health and Drug & Alcohol Office, NSW Ministry of Health. DA-CCP commenced development in February, 2010 and was overseen by an Expert Reference Group (chaired by the first author: membership of the Expert Reference Group is provided in Appendix C). It was presented to the IGCD in final form in April, 2013. It was then presented to the Australian Health Minister's Advisory Council (AHMAC). Each jurisdiction now has a copy of the planning tool.

Figure 8.1 provides a conceptual schema for the DA-CCP model. Built in Excel, to ensure a user-friendly platform, the model provides as its final output estimates of the quantum of resources (staff numbers, bed numbers and so) required to meet the predicted demand for AOD treatment for an average population of 100,000.

Figure 8.1: Conceptual schema for DA-CCP
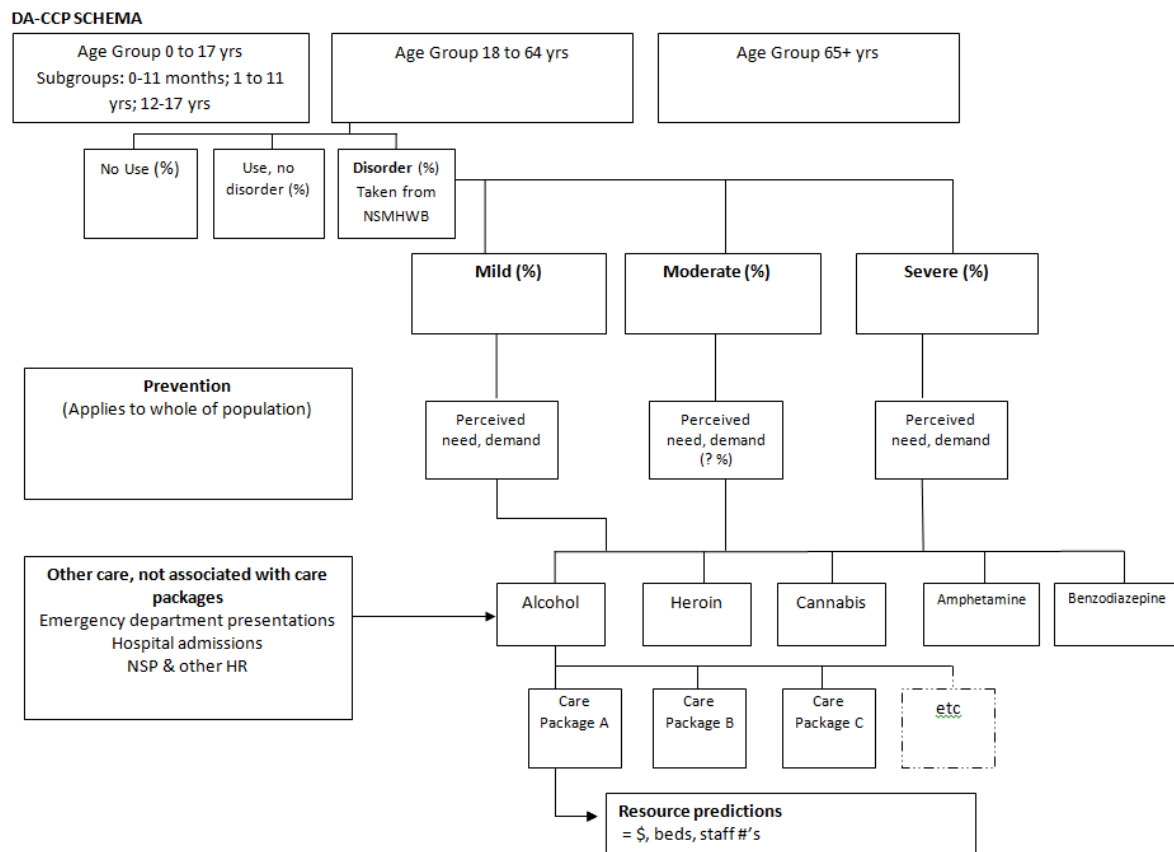
For our purposes here, we are interested in the number of people that DA-CCP predicts as the 'treatment demand population'. DA-CCP also includes other care (such as emergency department presentations and harm reduction interventions) but these are included as resources only, not as people/individuals. The numbers of people that DA-CCP predicts for overall treatment demand relies on three key variables: the epidemiology (that is the prevalence of AOD disorders in the community), the severity distribution (the allocation of all individuals into three disability categories: mild, moderate and severe) and the treatment rates (the proportion of all people who are likely to, willing to, and will seek treatment given the appropriateness of the treatment services available). We take the care packages and the resource estimation as given. However, it should be noted that the majority of the substantial work to develop DA-CCP was in the design and documentation of the care packages. The care packages and resource estimation details are provided in Appendix C.

The epidemiology
The epidemiology for the model was based on the Australian Burden of Disease (AUSBoD) work (Begg et al., 2007) which in turn relied largely on the 1997 National Survey of Mental Health and Wellbeing (NSMHWB) (Australian Bureau of Statistics, 1998; Hall, Teesson, Lynskey, & Degenhardt, 1999). The Composite International Diagnostic Interview (CIDI) was used as the interview tool to establish the rates of ICD-10 diagnoses of dependence[76] and harmful use of alcohol, cannabis,

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[76] ICD-10 defines the dependence syndrome as being a cluster of physiological, behavioural and cognitive symptoms. A diagnosis of dependence is made only if three or more of the following six symptoms have been present together at some time during the previous year: strong desire or sense of compulsion to take the substance; difficulties in controlling

sedatives, opioids, and stimulants. The last two classes (opioids and stimulants) are very low prevalence disorders in the general population, and general population surveys underestimate the prevalence of these drug classes (Degenhardt, Bucello, Calabria, Nelson, Roberts, Hall, Lynskey, Wiessing, group, Mora, Clark, Thomas, Briegleb, & McLaren, 2011; Hall et al., 1999). DA-CCP therefore sought alternate epidemiology for heroin and stimulants (amphetamine). DA-CCP does not account for polydrug diagnoses, and therefore requires adjustment for potential double-counting of demand for treatment by a proportion who are polydrug dependent (we deal with this later).

The prevalence rates used in DA-CCP are provided in Table 8.1.

Table 8.1: Past 12 month prevalence rates applied in DA-CCP, with data source by age group (12 years and over) and drug type.

	12-17 yrs	**18-64 yrs**	**65+ yrs**	**Total Pop.**	**Notes**
Alcohol	1.06%	6.35%	1.42%	8.83%	AUSBoD data from NSMHWB
Amphetamine	0.13%	0.51%	0.01%	0.65%	As reported in AUSBoD – used NMDS-AODT and a (McKetin, McLaren, Kelly, Hall, & Hickman) multiplier – see text
Benzodiazepine	0.01%	0.38%	0.08%	0.47%	AUSBoD data from NSMHWB
Cannabis	0.48%	1.76%	0.05%	2.29%	AUSBoD data from NSMHWB
Opioids	0.03%	0.65%	0.11%	0.79%	(Chalmers, Ritter, Heffernan, & McDonnell, 2009)Chalmers et al. multiplier – see text

For the 12 to 17 year olds, the AUSBoD data gave prevalence rates for ages 15+, but given the DA-CCP model uses the 12-17 year age group, the DA-CCP team calculated prevalence for 12-17 year age group by only taking the AUSBoD prevalence rates for 15, 16 and 17 years, and assuming zero prevalence for 12, 13 and 14 year age groups.

For the 18 to 64 year olds and 65+ year olds, the AUSBoD rates were used based on age-sex-illness-specific prevalence data (See the AUSBoD report Begg et al., 2007, pp. Annex Table 2, p. 210).

For people under the age of twelve, DA-CCP had two categories: those 0-11 months of age; and 1 year to 11 years of age. Neither of these population groups are surveyed for general population rates (the NSMHWB and AUSBoD do not report prevalence rates for these two groups). In addition, the differentiation by drug type is not available for these two sub-categories. In lieu of any other data, the DA-CCP team estimated prevalence of alcohol/drug use disorders for ages 0-11 months and 1-11 years based on actual rates of presentation (the DA-CCP technical manual does not provide any further information about data sources). The numbers in these age ranges totalled 590.

DA-CCP used different sources depending on the drug class. As can be seen in Table 8.1, alcohol, cannabis and benzodiazepines all came from AUSBoD which came from the 1997 NSMHWB with adjustment. For amphetamines, DA-CCP also used AUSBoD but AUSBoD used the AODTS-NMDS and then a multiplier from published research (McKetin et al., 2005) to derive prevalence. For opioids, DA-CCP did not use the AUSBoDs prevalence estimates; rather a revised estimate was calculated by adding the AUSBoD original estimate of the total number for each age group to the age relevant

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substance-taking behaviour; withdrawal; tolerance; neglect of alternative pleasures or interests; persisting with substance use despite clear evidence of overtly harmful consequences
(http://www.who.int/substance_abuse/terminology/definition1/en/).

proportion of the 41,000 Australians "between treatment" for each age group. The between treatment data was taken from Chalmers et al. (2009).

What becomes apparent is that establishing prevalence for five drug classes across the full population spectrum of ages is difficult, and there is not one single data source that can be used. Where population prevalence rates were used, the Australian population upon which the actual numbers were derived was from the Australian Bureau of Statistics (ABS) online publication *3222.0 – Population Projections, Australia, 2006 to 2101*[77]*.* The ABS produces three main series of projections. The ABS Series B population projections were chosen as the primary source for the DA-CCP Model on the basis that it provides a prudent 'middle ground' approach to the assumptions underlying the projection.

The final numbers which were used in DA-CCP for the population prevalence are presented in Table 8.2.

Table 8.2: Prevalence of substance use disorders used in DA-CCP (based on 2006 census)

	0-11mths	**1-11 yrs**	**12-17 yrs**[3]	**18-64 yrs**	**65+ yrs**	**Total Pop.**
Alcohol	-	-	18,300	916,925	48,090	983,315
Amphetamine	-	-	2,190	73,729	271	76,190
Benzodiazepine	-	-	224	54,251	2,570	57,045
Cannabis	-	-	8,348	254,661	1,725	264,734
Opioids	-	-	535	94,506	3,619	98,660
All Drugs	327	263				**1,480,533**

The next step in DA-CCP is to move from a total population prevalence (which may be referred to as 'need') to an estimate of demand for treatment. Clearly not all of the 1,480,533 people will seek, benefit from, or necessarily require, treatment each year (in addition, polydrug use is included in this 1,480,533 population prevalence number).

Severity distribution – Mild, moderate and severe and treatment rate
DA-CCP distinguishes between mild, moderate and severe disability. This distribution was important for DA-CCP, because the type and intensity of the treatment to be provided varies depending on the level of severity of the presentation. For example, someone with a mild alcohol use disorder may only require a single session, whereas someone with severe alcohol dependence may require inpatient withdrawal, counselling, residential rehabilitation and aftercare. The division into mild, moderate and severe was facilitated by the available Australian data on disability weights from AUSBoD (Begg et al., 2007). The proportion of those meeting diagnostic criteria who would fall within the severe disability category, using the AUSBoD disability weights, was calculated first and combined with existing research and expert judgement to divide the remaining numbers between mild and moderate disability.

The ratio of mild to moderate to severe for alcohol was 6:2:1 that is for every 6 people mildly disabled, there are 2 moderately disabled and 1 severely disabled. The same ratio was used for cannabis (6:2:1). For opioids no one was classed as mild or moderate (all were placed in the severe category). For amphetamines, no one was classed as mild, and for every 9 severely disabled, there was one moderately disabled (the ratios were: 0:1:9). Lastly for benzodiazepines, for every 5 people classed as mild, 3 were classed as moderately disabled and 2 as severely disabled (5:3:2). The actual calculation of the disability weights was complex and relied on the original AUSBoD calculation

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[77] Australian Bureau of Statistics (ABS) - 3222.0 – Population Projections, Australia, 2006 to 2101, http://www.abs.gov.au/ausstats/abs@.nsf/mf/3222.0

(which in turn relied on the SF12 measure of functioning). The reason the disability weights and subsequent assignment to mild, moderate or severe disability are important is because these then drive differential treatment rates, and hence are sensitive measures in terms of the model's prediction of demand for treatment.

The table below provides the severity distribution as used in DA-CCP. The same distribution for mild, moderate and severe occurred across the 12-17 years, 18-64 years and 65+ years. For the 0-11 months; and 1-11 years there were no mild, moderate and severe distributions required, as these numbers were simply inserted at the end as numbers treated (327; 263 respectively).

Table 8.3: Mild, moderate and severe distributions in DA-CCP

		Severity distribution
Alcohol		
	Mild	67%
	Moderate	22%
	Severe	11%
Amphetamine		
	Mild	0%
	Moderate	10%
	Severe	90%
Benzodiazepine		
	Mild	50%
	Moderate	30%
	Severe	20%
Cannabis		
	Mild	67%
	Moderate	22%
	Severe	11%
Opioids		
	Mild	0%
	Moderate	0%
	Severe	100%

Treatment rates
The treatment rates for each category of mild, moderate and severe were established for DA-CCP based on existing research and expert judgement. In the 1997 NSMHWB survey (Australian Bureau of Statistics, 1998), 14% of those with substance use disorders had used services. In the later 2007 Australian NSMHWB survey (Slade et al., 2009a), 24% of respondents with substance use disorders used treatment services in the last 12 months. This then informed the absolute minimum treatment rate for DA-CCP. In terms of a maximum, in theory the maximum treatment rate would be 100% – that is we treat everyone with mild, moderate and severe disability who meet diagnostic criteria for substance use disorder. This is unrealistic for several reasons: 1. Spontaneous remission, or natural recovery is not uncommon (a proportion will never require treatment); 2. Some people will seek support for behaviour change through unfunded or informal means (such as mutual aid and so on); 3. Some people will not find the AOD services as an appropriate match for their needs; 4. Some people will simply deny that they need treatment and will be resistant or reluctant to seek care. Therefore, one needs to move from an ideal treatment rate (100%) to an optimal but realistic treatment rate.

The deliberations around this for DA-CCP were informed by earlier research which noted ideal treatment coverage of 51% for alcohol use disorders (70% for harmful use and 30% for dependence, see also Andrews, Issakidis, Sanderson, Corry, & Lapsley, 2004). Subsequent work from the same team adjusted this down to an average of 38% (50% alcohol harmful use and 25% alcohol dependence) (Andrews, Titov, & Team Tolkein, 2006). Expert consensus was used to ascertain the DA-CCP treatment rates in light of the minimum 24% and possible optimal rate of 51%. (It should be noted that there was substantial and sustained debate about the treatment rates in the Expert Reference Group over many meetings). The final treatment rates used in DA-CCP are given in Table 8.4.

Table 8.4: Treatment rates used in DA-CCP

		Treatment rate	Overall treatment rate
Alcohol			
	Mild	20%	35%
	Moderate	50%	35%
	Severe	100%	35%
Amphetamine			
	Mild	0%	36%
	Moderate	50%	37%
	Severe	35%	38%
Benzodiazepine			
	Mild	20%	45%
	Moderate	50%	45%
	Severe	100%	45%
Cannabis			
	Mild	20%	35%
	Moderate	50%	35%
	Severe	100%	35%
Opioids			
	Mild	0%	90%
	Moderate	0%	90%
	Severe	90%	90%

The overall treatment rate column represents the percentage of those diagnosed who are treated, having applied both the severity distribution and the treatment rate.

Despite the sophistication associated with DA-CCP, and the attention to important aspects such as treatment types and levels of care, DA-CCP still relies on prevalence estimation for the underlying population disorder rates (need). The division between mild, moderate and severe disability is also a fundamental feature of the model because this then impacts on final estimates for treatment demand. And the model relies on expert judgement to ascertain demand for treatment – what appropriate rate to use from the total potential number in need of treatment who will seek treatment if the treatment services were appropriate, available and attractive. We therefore undertook sensitivity analyses on the population prevalence, severity distribution and treatment rate, in order to ascertain the extent to which these three variables (solely or in combination) impacted on the final projected/modelled demand for treatment numbers. The next section summarises our work in this regard.

DA-CCP – sensitivity analyses

We sought to examine the three key DA-CCP variables: prevalence rates for the disorders; distribution into mild, moderate and severe (severity distribution); and the treatment rates. Each of these three aspects of DA-CCP is subject to a range of uncertainties, as will have been apparent from the above outline. This therefore means that the predicted demand for treatment (and associated costs) could vary greatly depending on what epidemiology, severity distribution and treatment rates are used. The details of the sensitivity analyses are provided in Appendix C.

In our sensitivity analyses, the prevalence rate revealed a direct, linear relationship to the predicted numbers in treatment. Given this, we have chosen not to vary prevalence in the below analyses. For readers wanting to look at the effect of prevalence changes alone, a simple multiplier can be used on the predicted treated numbers. That is, if you think that alcohol dependence prevalence has increased by 5% simply apply 5% to the final predicted numbers being treated.

Severity and treatment rate however, do not operate in such a linear fashion and therefore we chose to vary these for the main analysis. We examined each of the sensitivity analyses and used those that produced the minimum and maximum change in predicted numbers being treated. We then combined this with our knowledge of AOD treatment and people who seek treatment, such that we did not over- or under-estimate the likely severity or treatment rate (that is, we kept the chosen parameters within the bounds of reasonableness). For example, while the biggest change in the sensitivity analysis for alcohol concerned increasing the mild treatment rate from 20% to 50% (see Appendix C), we do not think this is feasible in practice, as primary care services are simply not geared up to treat that number of people with alcohol use disorders. The full description of the variations we chose is provided in Table 8.5 below.

Table 8.5: DA-CCP sensitivity analyses: summary of variations to be tested

		DA-CCP original severity distribution	SA 1 DA-CCP revised severity distribution – minimum	SA 2 DA-CCP revised severity distribution – maximum	DA-CCP original Treatment rate	SA 3 DA-CCP revised treatment rate – minimum	SA 4 DA-CCP revised treatment rate – maximum
Alcohol							
	Mild	67%	77% [1]	67% [2]	20%	20% [11]	30% [12]
	Mod	22%	12%	12%	50%	30%	60%
	Severe	11%	11%	21%	100%	90%	100%
Amphetamine							
	Mild	0%	0% [3]	0% [4]	0%	0% [13]	0% [14]
	Mod	10%	0%	30%	50%	40%	70%
	Severe	90%	100%	70%	35%	25%	55%
Benzodiazepine							
	Mild	50%	60% [5]	50% [6]	20%	10% [15]	50% [16]
	Mod	30%	20%	20%	50%	40%	50%
	Severe	20%	20%	30%	100%	90%	100%
Cannabis							
	Mild	67%	67% [7]	67% [8]	20%	10% [17]	50% [18]
	Mod	22%	32%	12%	50%	40%	50%
	Severe	11%	1%	21%	100%	100%	90%
Opioids							
	Mild	0%	0% [9]	[10]	0%	0% [19]	[20]
	Mod	0%	30%		0%	0%	

	Severe	100%	70%		100%	80%	

Notes:

Revised severity distribution

1. The minimum alcohol severity was scenario 2: a 10% increase in the number of mild disability, a 10% decrease in the numbers with moderate disability and retaining 11% with severe disability.

2. The maximum alcohol severity was scenario 4: no change to the proportion with mild disability, a 10% decrease in the proportion with moderate disability and a 10% increase in the proportion with severe disability.

3. The minimum amphetamine severity was scenario 2: no mild or moderately severity, with 100% of people severe.

4. The maximum amphetamine severity was scenario 4: retaining 0% as mild disability, but increasing the moderate disability proportion while decreasing the severe disability proportion.

5. The minimum benzodiazepine severity was scenario 2: increasing the proportion with mild disability, and decreasing the proportion with moderate disability.

6. The maximum benzodiazepine severity was scenario 4; a decrease in the proportion mild disability, and an increase in the proportion of severe disability.

7. The minimum cannabis severity was scenario 3: mild disability remained the same, moderate disability increased and severe disability was decreased (to 1%).

8. The maximum cannabis severity was scenario 4: no change to the proportion with mild disability, a 10% decrease in the proportion with moderate disability and a 10% increase in the proportion with severe disability.

9. The minimum opioid severity was scenario 3: no change to the proportion with mild disability, a 30% increase in the proportion with moderate disability and a 30% decrease in the proportion with severe disability.

10. The base case is the maximum for opioid severity.

Revised treatment rate

11. The minimum alcohol treatment rate was scenario 6: the treatment rate for mild stayed at 20%, the moderate treatment rate dropped to 30% and the treatment rate for severe dropped to 90%.

12. The maximum alcohol treatment rate was scenario 8: the proportion of mild who are treated increases by 10% and so does the proportion of moderate (10% increase). Treatment rate for severe stays at 100%.

13. The minimum amphetamine treatment rate was scenario 2: retaining 0% in mild as the treatment rate, decreasing the moderate treatment rate to 40% and decreasing the severe treatment rate to 25%.

14. The maximum amphetamine treatment rate was scenario 3: retaining 0% treated in mild, but increasing the moderate treatment rate to 70% and the severe treatment rate to 55%.

15. The minimum benzodiazepine treatment rate was scenario 5: decreasing the mild treatment rate to 10%, the moderate treatment rate to 40% and the severe treatment rate to 90%.

16. The maximum benzodiazepine treatment rate was scenario 1: increasing the mild treatment rate to 50% (given primary care is the setting for benzodiazepine treatment), and keeping the moderate and severe treatment rates as originally given in DA-CCP.

17. The minimum cannabis treatment rate was scenario 9: decreasing the mild treatment rate to 10%, and the moderate treatment rate, to 40%, and retaining 100% for severe.

18. The maximum cannabis treatment rate was scenario 5: increasing the mild treatment rate to 50%, retaining the moderate treatment rate as it was, and dropping the severe treatment rate to 90% (arguably more realistic).

19. The minimum opioid treatment rate was scenario 5: no change to proportion of mild who are treated, no change to the proportion of moderate who are treated, and decreasing the severe treatment rate by 20%.

20. The base case is the maximum for opioid treatment rate.

Estimating treatment demand from DA-CCP

DA-CCP unadjusted

In the first instance, we take the original DA-CCP estimates, without any adjustment for polydrug use. Table 8.6 provides the predicted treatment numbers (that is total demand for treatment) from the original DA-CCP.

Table 8.6: DA-CCP predicted/modelled number of people receiving treatment in the course of one year

	0-11mths	1-11 yrs	12-17 yrs	18-64 yrs	65+ yrs	Total Treatment numbers
Alcohol			6,478	324,592	17,024	348,094
Amphetamine			800	26,911	99	27,810
Benzodiazepine			101	24,413	1,157	25,671
Cannabis			2,955	90,150	611	93,716
Opioids			535	94,506	3,619	98,660
All Drugs	327	263	10,869	560,572	22,148	**594,541**

Thus, the original DA-CCP predicted that treatment demand would be 594,541 people in Australia over one year. As can be seen, the vast majority are alcohol (348,094: 58.5%) and in the age group 18 to 64 years of age. There is much lower modelled treatment demand for benzodiazepines (25,671) and amphetamines (27,810).

DA-CCP adjusted

We now explore how our sensitivity analyses provide some plausible ranges around the original 594,541 predicted treatment numbers.

As seen in Table 8.5, we chose parameters from the sensitivity analyses that would reflect possible high and low (maximum and minimum) ranges for the predicted treatment numbers. The results are presented in Table 8.7.

Table 8.7: Plausible numbers of people to be treated

	SA 1: Minimum severity distribution (assuming prevalence and treatment rate remain constant)	SA 2: Maximum severity (assuming prevalence and treatment rate remain constant)	SA 3: Minimum treatment rate (assuming prevalence and severity distribution remain constant)	SA 4: Maximum treatment rate (assuming prevalence and severity distribution remain constant)
Alcohol	318,594	397,260	294,012	435,609
Amphetamine	26,667	30,095	20,190	43,047
Benzodiazepine	23,959	28,523	19,966	34,227
Cannabis	80,479	106,953	70,154	144,015
Opioids	69,062	98,659	78,928	98,659
All Drugs	519,351*	662,080*	483,840*	756,147*

*includes 327 (0-11mths) and 263 (1-11 yrs)

Thus we conclude that the predicted number to be treated in Australia may range from a low of 483,840 to a high of 756,148 (with our main estimate being 594,541). The size of the difference in the ranges (in the order of 272,000 people) shows the importance of choosing the severity distribution and treatment rate parameters carefully in DA-CCP. There is no objective evidence base

to support one preferred distribution of severity and treatment rate over another. It relies on making expert judgements.

Having explored the possible range of predicted/modelled numbers for total treatment demand we now turn to the polydrug issue.

DA-CCP adjusted for polydrug use

One of the central issues in estimating current treatment utilisation (see Chapter 7) is the extent of potential double counting of individuals within any one year either because they attend multiple services, or because they attend for different drugs over the course of a year. The same is true for DA-CCP inasmuch as the way the model is built it treats each drug independently, thus someone may have both an alcohol and a cannabis use disorder but will not require nor seek treatment for both of those in one year because they will receive treatment which covers both drug types[78]. This is particularly the case as the way DA-CCP counts people is treatment over the course of one year. Thus DA-CCP potentially double counts individuals who receive a course of care over a year which concerns two different drugs. Hence we need to apply an adjustment to DA-CCP to account for this.

The most parsimonious way to do this is to adjust the prevalence rates – that is, we need to reduce the prevalence numbers by those who are dually (or triply) diagnosed. Given our sensitivity analysis has shown a linear relationship between the population prevalence and the resulting predicted numbers in treatment, we can simply apply a deflator to the DA-CCP output.

In the first instance we need to establish the numbers of people with multiple substance use disorders in any one year. The NSMHWB contains such data, as reported by (Teesson, Hall, Slade, Mills, Grove, Mewton, Baillie, & Haber (2010); Teesson, Slade, Swift, Mills, Memedovic, Mewton, Grove, Newton, & Hall (2012)) and Degenhardt & Hall (2003). The table below provides the statistics available to us, and their sources. Unfortunately it appears that we can adjust for concurrent alcohol and cannabis use disorders, but not other specific drug classes.

Table 8.8: Polydrug diagnostic rates, based on epidemiology population surveys

	Concurrent alcohol use disorder (including abuse and dependence)	Concurrent cannabis use disorder	Concurrent other drug disorder
Alcohol use disorder	na	11.4% (Teesson et al., 2010, table 4, using NSMHWB 2007 data)	4.6% (Teesson et al., 2010, table 4, using NSMHWB 2007 data)
Cannabis use disorder	51.2% (Teesson et al., 2010; Teesson et al., 2012, table 5, NSMHWB 2007 data) 25.9% (Degenhardt & Hall, 2003, using 1997 NSMHWB data)	na	No available data
Other drug use disorder	9.5% (Degenhardt & Hall, 2003 , using 1997	No available data	na

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[78] Most AOD is generic inasmuch as the interventions are tailored across drug presentations, and in any one year of treatment an individual may receive medications for one drug, counselling for another drug, and generic residential rehabilitation which addresses all drugs concurrently. DA-CCP provides treatment over the course of full year across multiple modalities. It is possible that some individuals will receive completely separate treatments for each drug class, but it is still one individual over one year, irrespective of the type of treatments received.

	NSMHWB data)		

We apply these rates of concurrent substance use disorders to the DA-CCP modelled/predicted treatment numbers (reported in Table 8.6) and report the outcome in Table 8.9. (We apply the rates across all age ranges as there are no data about differential rates of concurrent disorder by age group. This is a simplifying assumption).
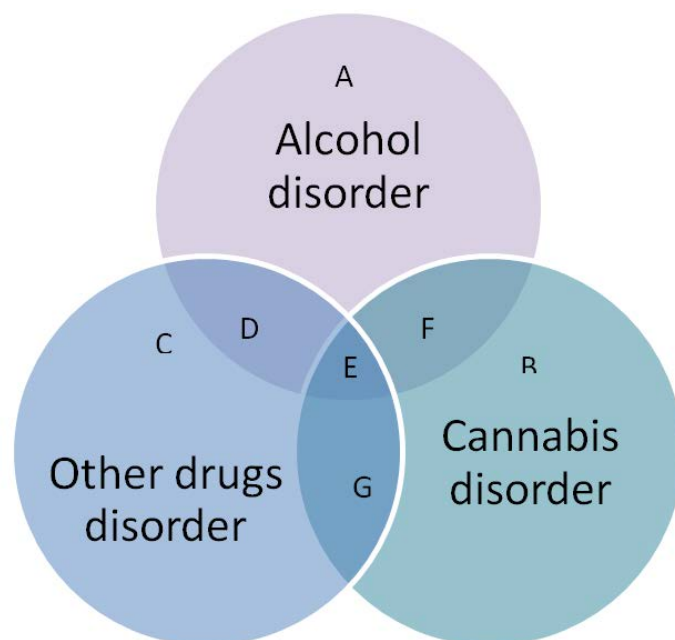
A = Alcohol disorder (Total treatment numbers: 348,094)

B = Cannabis disorder (Total treatment numbers: 93,716)

C = Other drugs disorder (amphetamine, benzodiazepine and opioids) (Total treatment numbers: 152,141

D = Alcohol disorder+ Other drugs disorder (not cannabis) (9.5% Degenhardt & Hall, 2003; 4.6% Teesson et al., 2010)

E = All three drugs (*no available data*)

F = Alcohol disorder + Cannabis disorder (not other drugs) (25.9% Degenhardt & Hall, 2003; 11.4% Teesson et al., 2010; 51.2%Teesson et al., 2012)

G= Cannabis + Other drugs disorder (not alcohol) (*no available data*)

Table 8.9: Impact of concurrent use disorders on DA-CCP predicted treatment numbers

	Total Treatment numbers DA-CCP original	Notes	Results
Alcohol	348,094	[A + D +E + F]	348,094
Cannabis	93,716	[C – F – E – G] [93,716 x 29.5% (average of 11.4%, 51.2% and 25.9%)	27,646
Other drugs (amphetamine & benzodiazepine & opioids)	152,141	[C – D – E – G] [152,141 – (348,094 x 7.5% (average of 9.5% & 4.6%)	127,600
Children	590	No adjustment	590
Total treated	**594,541**		**503,930**

We then also apply the findings from the polydrug analysis to our sensitivity analysis ranges (reported in Table 8.7). This entailed leaving alcohol and cannabis as two separate classes but combining the other drugs into one group, and then applying the respective percentages from Table 8.8.

Table 8.10: Polydrug adjustments to sensitivity analysis ranges

	SA 1:		SA 2:		SA 3:		SA 4:	
	Minimum severity distribution	Polydrug	Maximum severity	Polydrug	Minimum treatment rate	Polydrug	Maximum treatment rate	Polydrug
Alcohol	318,594	318,594	397,260	397,260	294,012	294,012	435,609	435,609
Cannabis	80,479	23,741	106,953	31,551	70,154	20,695	144,015	42,484
Other drugs	119,688	95,793	157,277	127,483	119,084	97,033	175,933	143,262
All Drugs*	519,351	438,719	662,080	556,884	483,840	412,331	756,147	621,946

* All drugs includes 590, 0-11 months, and 1-11 year-olds.

Summary of plausible ranges for predicted numbers in treatment for any one year

Table 8.11 provides all the estimates together. As can be seen, the lowest estimate (from SA 3 polydrug) is 412,331. The highest estimate is 756,147 (SA 4). We describe the parameters for the lowest and highest estimates.

Relative to the main DA-CCP estimate (594,541) the lowest estimate of 412,331 was predicted on modelling a lower treatment rate. This modelled result used the same treatment rate for those with mild alcohol dependence (20%), but a reduced rate of treatment for those with moderate alcohol dependence (instead of treating 50%, it modelled treating 30% of people with moderate dependency), and the treatment rate for severe alcohol dependence was reduced from 100% (ie everybody) to 90%. For amphetamines, only 40% of those with moderate amphetamine dependence were treated (compared to 50% in main estimate), and 25% of severe amphetamine dependence were treated compared to 35% (main estimate). For cannabis, the treatment rate for mild was reduced from 20% to 10%, and the treatment rate for people with a moderate cannabis dependency from 50% to 40%. We retained a 100% treatment rate for those with severe cannabis dependence. For opioids, severe treatment rate was reduced from 100% to 80% and the benzodiazepines treatment rates were also reduced (10% treatment rate for mild benzodiazepine dependence, 40% treatment rate for moderate benzodiazepine dependence and 90% treatment rate for severe benzodiazepine dependence). This low estimate also included the polydrug adjustment, whereby we removed 16% of people from the alcohol treated group, 38.5% from the cannabis group and 9% from all other drugs.

The highest estimate was SA 4, which firstly did not include any polydrug adjustment (ie, we assume that all the modelled people in DA-CCP are uniquely in treatment for their specific drug). In addition, SA 4 had a higher treatment rate across all drug classes. For alcohol, the treatment rate for mild dependence was 30% (instead of 20%). The treatment rate for moderate alcohol dependence was 60% (instead of 50%), and we retained 100% treatment rate for those with severe alcohol dependence. For amphetamines, we retained a 0% treatment rate for mild amphetamine dependence (on the argument that such a condition did not exist), but increased the treatment rate

for moderate amphetamine dependence from 50% to 70%, and the treatment rate for severe amphetamine dependence from 35% to 55% (recalling that amphetamine dependence as modelled in DA-CCP refers to people who inject amphetamines and not to those with stimulant-related disorders, such as ecstasy). For cannabis, the mild cannabis dependence treatment rate was increased to 50% (from 20%) and the moderate rate remained the same (at 50%). The treatment rate for severe cannabis dependence was actually decreased to 90%. For opioid dependence, there was no change to the main estimate. For benzodiazepine dependence, the treatment rate for mild benzodiazepine dependence was increased from 20% to 50% while the treatment rate for those with moderate benzodiazepine dependence remained the same (at 50%) as did the treatment rate for those with severe benzodiazepine dependence (100%).

Table 8.11: Plausible ranges of predicted/modelled number of people to be treated in any one year, nationally

	Plausible numbers to be treated
DA-CCP original	594,541
DA-CCP accounting for polydrug disorders	503,930
Sensitivity analysis 1	519,351
Sensitivity analysis 2	662,080
Sensitivity analysis 3	483,840
Sensitivity analysis 4	756,147
Sensitivity analysis polydrug 1	438,719
Sensitivity analysis polydrug 2	556,884
Sensitivity analysis polydrug 3	412,331
Sensitivity analysis polydrug 4	621,946

Comparison of the DA-CCP findings with estimates of current met demand

If we assume that in any one year there are 200,000 people who receive treatment for their AOD problem (see Working Paper # 8) we can then calculate the extent of met demand, that is the percentage of the predicted/modelled numbers in treatment in any one year from DA-CCP with the estimated number currently in receipt of treatment.

The results are given in Table 8.12. We find that if we assume that 200,000 people receive AOD treatment in any one year, then the proportion of demand currently being met ranges between 26% and 48%. If we translate this into numbers of people, and again assuming we currently have 200,000 people in treatment and given the assumptions behind the DA-CCP modelled estimates, it reveals that the additional number of people to be treated in any one year in Australia to meet predicted demand may be as high as 556,000 more people or as low 212,000 more people. [79]

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[79] Remembering that this is for the whole of Australia, irrespective of drug type or age range, and that funders include the Commonwealth and state/territory governments, where state/territory governments carry the greater responsibility for purchasing AOD services. It also includes primary care interventions (by GPs), not just specialist AOD treatment.

Table 8.12: Extent of potential met demand, Australia AOD treatment

	Plausible numbers to be treated	% met demand, where we assume 200,000 receive AOD treatment in any one year
DA-CCP original	594,541	33.6%
DA-CCP accounting for polydrug disorders	503,930	39.6%
Sensitivity analysis 1	519,351	38.5%
Sensitivity analysis 2	662,079	30.2%
Sensitivity analysis 3	483,840	41.3%
Sensitivity analysis 4	756,147	26.4%
Sensitivity analysis polydrug 1	438,719	45.6%
Sensitivity analysis polydrug 2	556,884	35.9%
Sensitivity analysis polydrug 3	412,331	48.5%
Sensitivity analysis polydrug 4	621,946	32.2%

The predicted additional demand (at between 212,000 and 556,000 additional people) may appear large. The prevalence rates used in DA-CCP are for substance use disorders (that is both abuse and dependence diagnoses are included in the original prevalence (need) estimates). Arguably we should only use dependence diagnosis, but this is counterbalanced by the fact that DA-CCP uses disability weights to allocate all diagnoses into mild, moderate and severe disability. This then goes some way to address the abuse/dependence issue and means DA-CCP does not overinflate the severity and assume that everyone with a positive diagnosis needs, and should access, treatment. At the same time, DA-CCP may underestimate demand for treatment because the proportions in the mild group, especially for alcohol and cannabis may be too high, relative to the moderate and severe groups. In addition, the average treatment rate across the entire model is 35% (excluding opioids). This 35% treatment rate is actually very modest, especially when compared to the current actual treatment rate (as reported in NSMHWB 2007) at 24% (Slade et al., 2009b) [80]. Some may therefore argue that DA-CCP sets the bar too low in relation to its prediction of overall demand.

How do these modelled rates of met demand accord with existing Australian literature? This analysis not only provides some intuition about the use of DA-CCP for estimating unmet demand but also allows us to examine the overall validity of our findings in light of other Australian research.

To date, no one has employed the DA-CCP method, and the existing Australian studies all rely on self-reported estimates of need (through diagnostic criteria) and treatment utilisation based on self-report. Therefore we would expect that the projections generated by DA-CCP would be higher because DA-CCP is predicting overall demand, whereas these Australian studies are estimating actual (current or met) demand. The NSMHWB provides a self-reported rate of service utilisation for those meeting substance use disorder criteria – effectively this is a 'met demand' rate. The NSMHWB asks about "any service use in last twelve months for any mental health disorder" – this means that the self-reported treatment rates are not specific to alcohol or other drug treatment, and it is possible that these estimates are therefore higher than what occurs in reality (that is, they include service use for treatment other than for AOD).

There are four studies that report a met demand rate from the NSMHWB. Andrews et al. (2004) using the 1997 NSMHWB found a met demand rate between 8.1% (harmful) and 13.6% (dependence) for alcohol. In the 2007 NSMHWB analysis, the rate is considerably higher (Slade et al.,

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[80] According to the same report the sorts of services included were general practitioners, psychologists, psychiatrists, mental health nurses and other health professionals working in specialised mental health settings and other health professionals including social workers, counsellors and practitioners of complementary and alternative medicines.

2009b; Teesson et al., 2012), with estimates between 15.5% (harmful alcohol) and 52.4% (any drug dependence). The rates clearly vary by drug class (with alcohol lower than illicit drugs. See Appendix C.

We use these published rates to validate the DA-CCP estimates we generated. We found an overall demand rate (across all drugs) ranging between 26% and 48%. The Slade et al. (2009b) study of the NSMHWB found a current treatment utilisation rate of 24%. This suggests that our low estimate (at 26%) is not unreasonable and at least accords with NSMHWB analysis (notwithstanding the differences in methods). Given this confirmation of the 26% met demand figure, it suggests that unmet demand would be around 500,000 people.

Clemens & Ritter (2008) for Victoria alone compared the prevalence of substance use to the Victorian treatment rate (as measured by the AODTS-NMDS). The Clemens & Ritter (2008) work used a variety of prevalence data (notably need data, not demand data), but only included AODTS-NMDS as the estimate of current utilisation. This work highlights the importance of drug type. There was much higher met demand for opioids (35 to 62%), than for other drugs including alcohol (2.5 to 6.4%) and cannabis (4% to 7%). Likewise Teesson et al. (2012) found a 36% met demand rate for cannabis, and Slade et al. (2009b) reported a 52% met demand rate for any drug dependence. This points to higher met demand for drugs other than alcohol and the importance of dealing with drug classes separately. We examine this later in this chapter (in the first instance we look at international benchmarking).

International benchmarking

Is Australia achieving a higher, lower or similar rate of treatment penetration as that reported in other countries? Table 8.13 provides a summary of the reported rates of met demand in AOD treatment across the globe. It is important to acknowledge the different methods used across studies. Some of the studies reported in Table 8.13 assess met demand based on a population estimate of need. In general these methods produce lower estimates of met demand (because they do not exclude those that will not seek treatment). The higher percentages are found in studies that use a measure of treatment demand as the base population from which to compare actual treatment numbers. (The methods used by the studies are given in Appendix C).

As can be seen in Table 8.13, the rates of met demand vary between a high of 79% and a low of 4.8%. For the higher figures (79%; 55.8%; 26%) each of these three figures applies to drug use (not alcohol) and largely to opioid use. This is not surprising as met demand for opioids is known to be higher than for alcohol in international literature. (The exception here is the Becker, Fiellin, Merrill, Schulman, Finkelstein, Olsen, & Busch (2008) estimate for opioids in the USA at 15.2%). The low rates generally apply to alcohol (and vary between 5.6% and 21.9%). In general the lowest rates were found in studies that took the prevalence of need (from surveys of diagnostic rates) and applied those to either self-reported rates of treatment use or administrative data). That is, these studies do not adjust for the difference between need (meeting diagnostic criteria) and demand (intending to or appropriate for seeking treatment). The DA-CCP estimates are demand projections (not need projections) and hence will be higher than some of those reported in the below table. That being said, it still appears that our results suggest that Australia may have one of the highest met demand treatment rates for alcohol and other drugs.

Table 8.13: Reported "gap" between need/demand and current treatment utilisation (met demand): international benchmarks

Authors	Drug type	Country/region	% met demand
Becker et al. (2008)	Opioids	USA	15.2%
Best, Day, & Campbell (2007)	Drugs	UK	55.8%
Busch, Meara, Huskamp, & Barry (2013)	Substance Use Disorder	USA	12.8% to 30.7%
Chartier & Caetano (2011)	Alcohol	USA	White: 14.01% Black: 17.14% Hispanic: 16.17%
Cohen, Feinn, Arias, & Kranzler (2007)	Alcohol	USA	14.6% alcohol use disorder lifetime 7.5% alcohol abuse 4.8% alcohol dependence 27.9% both alcohol abuse and dependence (lifetime)
Drummond, Oyefeso, Phillips, Cheeta, Deluca, Perryman, Winfield, Jenner, Cobain, & Galea (2004)	Alcohol	England	5.6%
Drummond, Deluca, Oyefeso, Rome, Scrafton, & Rice (2009)	Alcohol	Scotland	8.2%
Edlund, Booth, & Han (2012)	Alcohol	USA	8%
Luckey & Ford (1976) (see also Ford, 1985; Ford & Luckey, 1983)	Alcohol	USA	20%
Kohn, Saxena, Levav, & Saraceno (2004)	Alcohol Use Disorder	Global	21.9%
McAuliffe, Breer, Ahmadifar, & Spino (1991)	Drug abuse	USA – Rhode Island	79% "met demand" 15.8% "met need"
McCollister & French (2002)	Substance Use Disorder	USA	13%
Mojtabai & Crum (2013)	Substance Use Disorder	USA	14.8%
Popova, Rehm, & Fischer (2006)	Opioid use	Canada	26% in Methadone Maintenance Treatment 6% received other outpatient treatment 5% received inpatient abstinence-oriented treatment (eg, detox, withdrawal mgmt.)
Sareen, Henriksen, Stein, Afifi, Lix, & Enns (2013)	Substance Use Disorder	USA	31.4%
Spence (2003)	Substance Use Disorder	USA - Texas	33%
Sung, Mahoney, & Mellow (2011)	Substance Use Disorder	USA	17% (Federal prison inmates[a]) 15% (State prison inmates[a]) 12% (General Public[b]) 30% (Parolees[b])
United States Department of Health and Human Services (2010)	Illicit drugs	USA	19.1%

For the purposes of the following discussion, and given the range of met demand between 26% and 48% of the population in need and appropriate for treatment (see Table 8.12), we use the main figure of 34% as the primary met demand figure in the following discussion (this equates to about an additional 400,000 people). Even though we use this figure henceforth, it should be remembered that there is a plausible range (26% to 48% met demand – that is we are currently treating about one quarter to one half of the pool of people likely to seek and be suitable for AOD treatment).

Examination of individual drug classes in DA-CCP – where are the biggest gaps?

The overall rate of met demand at 34% does not assist with planning other than to suggest that we require more AOD treatment in Australia. We need to drill down further to examine where the largest treatment gaps might be – by drug type, by age group and possibly by treatment type. This is very challenging, as while DA-CCP provides data by drug type and by age group, it does not provide data by treatment type nor by gender. Secondly the met demand data we have available (Chapter 7) does not provide us with information about drug type or age ranges or treatment types pooled across all data sets (it does provide that information for individual datasets).

We need to split the estimated 200,000 people in receipt of treatment between drug classes and ages. Given that the AODTS-NMDS represents the majority of AOD specialist treatment we have chosen to use this as the main data source to conduct such an analysis. The analysis in Chapter 7 shows that the demographic characteristics of clients in different data sets are not substantially different. We divide up the 200,000 estimated met demand figure into the proportions as represented by the AODTS-NMDS data. The results are given in Table 8.14.

Table 8.14: Notional allocations between age and drug classes for the estimated 200,000 people in receipt of treatment, based on the AODTS-NDMS episodes of care divisions.

	0-11 yrs	12-17 yrs	18-64 yrs	65+ yrs	Total
	Actual	Actual	Actual	Actual	
Alcohol	40	4,060	86,060	2,620	92,780
Cannabis	20	6,440	37,980	80	44,520
All other drugs	40	1,640	60,700	320	62,700
All Drugs	100	12,140	184,740	3,020	200,000

In the first instance we compare the drug classes: we use the main DA-CCP estimate of demand (594,541, see Table 8.6).

Table 8.15: Met demand estimate by drug class

	Estimated current met demand (200,000)	DA-CCP predicted demand	% met demand
Alcohol	92,780	348,094	27%
Cannabis	44,520	93,716	48%
All other drugs	62,700	152,141	41%
All Drugs	200,000	594,541	34%

We see that the modelled met demand rate is higher for cannabis and other drugs (41% to 48%) compared to alcohol, which is at 27%. This finding is consistent with the literature, and suggests that one of the major gaps is in relation to alcohol. It also suggests that the smallest treatment gap is in relation to cannabis, where around half of demand is currently being met (given the modelling assumptions).

Can we extend this analysis to age groups? Again, we take the AODTS-NMDS and allocate the notional 200,000 people across the age groups as represented in AODTS-NMDS. (See Table 8.14). We then compare this with the DA-CCP modelled estimates by age group; Table 8.16 gives the result.

Table 8.16: Met demand estimate by age group

	All Drugs – estimated current met demand (200,000)	Predicted demand (DA-CCP main model)	% met demand
0-11 yrs	100	590	17%
12-17 yrs	12,140	10,869	112%
18-64 yrs	184,740	560,572	33%
65+ yrs	3,020	22,510	13%
Total	200,000	594,541	34%

What becomes readily apparent in this analysis is that DA-CCP predicts lower overall demand for the 12-17 year olds than is being met at present. This is invalid. The results for the other age groups appear valid: the largest treatment gap is for older people (65+). The problem for the 12-17 year olds may either be in DA-CCP or in the AODTS-NMDS. DA-CPP used 1997 prevalence rates (AUSBoD adjusted for the younger age groups). As noted earlier, the adjustments to attain prevalence rates for the 12-17 year olds relied only on data available for 15, 16 and 17 year olds. As a result, it is perhaps not surprising that the DA-CCP model is unstable for this age group. We examined whether the problem with the 12-17 year old age group applied across all drugs in that age group. It does not; for alcohol, the predicted total demand for DA-CCP (at 6,478 people) was higher than the AODTS-NMDS modelled current demand (at 4,060 people). The problem appears for cannabis (where DA-CCP predicted total demand at 2,955 people whereas actual met demand based on AODTS-NMDS modelling was 6,440 people). Therefore it seems that the particular problem is for cannabis in the 12-17 year olds. We examined the sensitivity analysis to see if that could shed light. For the 12-17 year olds, the percentage of met demand ranged from 83% (sensitivity analysis involving maximum treatment rate) to 138% (sensitivity analysis involving minimum treatment rates). The sensitivity analysis for minimum severity distribution also resulted in an invalid met demand percentage of 125% for 12-17 year olds. There were no implausible ranges for the other age groups. Finally, we looked at the AODTS-NMDS data where we drew the modelled actual treatment demand. When we examine the 12-17 year olds in the AODTS-NMDS we note that the rate for cannabis is quite high.

These various analyses lead us to conclude that more careful modelling for the 12-17 year old age groups is required (DA-CCP is unstable for this population group), and that the use of AODTS-NMDS to model actual met demand is less than reliable, and should be seen only as an approximation approach. Further research into how to improve the DA-CCP model, and estimates of current met

demand (by unique individuals) is required. Furthermore, these analyses highlight a point already made – that planning requires more than simply a quantitative model to predict demand. The DA-CCP analyses should not be used on their own. Indeed, consistent with all approaches to planning and needs assessment, multiple methods are required in order to gain a full picture of treatment gaps (Eagar et al., 2001). The perspectives and impressions of people working in the field are as important as the mathematical quantifications. We turn to these next.

Key informant perspectives on sector needs and gaps

We conducted interviews with state/territory and Commonwealth government health officials, and with the peak bodies and their Boards representing AOD treatment across Australia. These interviews were conducted between August and November, 2013. We asked key informants to identify areas of unmet demand for treatment.

It is important to provide some context regarding the qualitative data on unmet demand, to clarify underlying influences on the nature and extent of the discussion. First, there is a crossover with other areas of inquiry for the review such as the focus of Commonwealth funding and the role of the Commonwealth in relation to particular services or client groups (for example) as well as planning and decision-making processes regarding funding. We have addressed these issues elsewhere in the report. Second, many key informants were cognisant of the complexities of predicting unmet demand and they emphasised the different approaches to understanding unmet demand (eg, population data sets, service information, waiting lists). Third, in some locations there was a preoccupation with jurisdictional processes of reform and the implications regarding unmet demand, rather than perceptions about existing rates of unmet demand. This is understandable where major changes were forecast or in the throes of being implemented. Examples include the introduction of sustainably-funded and long-term procurement arrangements, or a shift toward providing AOD within a more integrated approach to health and welfare service provision. As suggested by these points and consistent with the first part of this chapter, the issue of unmet demand is complex and multi-layered. Our focus here is on key informant perceptions of unmet demand and the focus is on areas put forward in at least half of the jurisdictions.

Our findings are presented under four headings: general perspectives on unmet demand; priorities for treatment; population groups; and treatment types.

General key informant perspectives on unmet demand

Most key informants noted that there is substantial unmet demand for AOD treatment. They commented that; "needs are not being met", "there are insufficient funds for AOD service provision", "anyone can justify a gap given that resources are so limited", "most organisations report having waiting lists[81]", "there is excess demand for treatment. We have waiting lists. Everyone has them". "There is unmet demand. There aren't enough services".

Data shortcomings were sometimes raised in relation to knowing the amount of unmet demand. While solutions to this concern are complex, key informants from one jurisdiction highlighted some of the issues involved; "[there are] no formal frameworks for the department to be informed by the sector of unmet needs. [The] sector needs to keep statistics on who we don't service for capacity reasons or when the service they want is unavailable."

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[81] The use of waiting lists to estimate unmet demand is problematic, as detailed in Working Paper # 1.

There was a keen understanding of the complexities involved in identifying, and interpreting information from indicators of unmet demand. For example, one key informant suggested that: "In thinking about unmet demand there are a number of issues; capacity, whether [the] service is appropriate to needs, and an understanding that treatment places (eg, beds) have to be empty at times to meet demand. Many services are not meeting the demand of clients trying to access services, (though they may be meeting the demand of the funding agreement) and utilise a waiting list. Whilst the client is on the waiting list it may be difficult, due to staff shortages and lack of funding specific to engagement, to keep the client engaged with the provider in other ways. This leads to the client disengaging from the service, with lost opportunity for recovery or engagement".

Another key informant highlighted some issues that may impact rates of demand, as follows: "Rural/remote? How do you know what unmet demand there is? How do you establish a need when the service may not be provided consistently? In [geographic area] the [AOD service] doesn't dispense opioid pharmacotherapy treatment. Does this artificially restrict demand? There is some evidence of over-capacity in terms of empty places in services, but what does that mean? Sometimes inpatient withdrawal isn't at full capacity because people would have to travel out of [the] area and there are no options on discharge. There are plans in the [geographic area] to do more in the community". These comments reinforce the understanding that unmet demand is not simply driven by lack of treatment places, but also by perceptions of the services, and their location. As noted by one: ". Are the numbers on [opioid maintenance treatment] stable because people find it difficult to access treatment/ find treatment provided unattractive, or is there no unmet demand? [The] same question could be asked in relation to [AOD] withdrawal services. Is [the AOD] withdrawal service not getting referrals because people find it difficult to access and GPs are no longer keen to refer (most are self-referrals)?"

As reflected above, the discussion on unmet demand was not restricted to the number of service places, but included perspectives on the range of, and capacity within, existing services. This was particularly the case for discussions involving key informants from peak boards and services. For example, key informants from one sector felt that, "there is an insufficient *range* of services", and a key informant from another jurisdiction noted that, "many service gaps exist *within* services (eg, services needing to become more culturally secure, more LBGTI friendly)".

While the discussion coalesced around substantial unmet demand, two contrasting points were raised. First, key informants from the Northern Territory noted that, "the addition of 200 beds through mandatory treatment will meet need". Second, in one jurisdiction that is undergoing reform, some key informants felt that, "expressed demand for AOD treatment is being addressed. There is an opportunity to segment the population and divert some clients through on-line and self-directed care opportunities". Further, their colleagues (in separate consultations) felt that, "while there is not an over-supply of some services currently, we are moving into a new era via the reform process. We are trying to design a system that meets the range of service needs that clients have (a holistic model)".

Rurality and remoteness

Service availability in rural and remote areas was a significant focus of key informant discussions. This involved services in general as well as particular service types. Key informants commented that, "services are concentrated in more densely-populated areas. [This] places some areas at risk."

There was some variation in the discussion according to characteristics of the jurisdictions. Where remoteness was a major feature, concerns were about both service availability and sustainability. For example, "meeting needs of particular groups outside [the] metro area is particularly difficult –

more vulnerable to single service providers in each area; not good at providing for all", "there is a need across regional [areas]", and "the [district] does not have many services".

There was also some discussion on the need for modified service models to allow for remoteness. (See also Working Paper # 2). This may involve particular relationships with primary health and include embedding programs in community health. It may include providing community development as part of / alongside the AOD programs.

Good working relationships between different parts of health were particularly important in managing demand in rural and remote settings. For example, one key informant noted an arrangement, where "GPs know there is excess demand for [AOD] treatment so they carry clients a bit longer before referring them into the treatment system". In another jurisdiction, a key informant described the 'Remote AOD Worker Program', which employs local community members (in the main) who are provided with clinical supervision, education and training, as well as ongoing, co-ordinated management and support. The program operates within "a best practice model for operations and engages in constant reflection to maintain the model". The workers operate from primary health centres and Aboriginal Medical Services. Reported advantages include their links with the local community, program sustainability (as each worker operates as part of a conglomerate of community services rather than in isolation), and the possibilities regarding access to housing (which is a major challenge for remote worker programs in many locations). These models highlight the diversity of settings in which AOD is delivered and the importance of flexibility and diversity in service models, to support reach and sustainability.

Some key informants commented on the need for service models appropriate to Aboriginal and Torres Strait Islander communities (generally with respect to rural and remote areas), in terms of strategies for engagement, community support, and the development of pathways between different services. As noted above, community development was regarded as an integral strategy for programs; with one informant suggesting a dedicated workforce is required.

In some jurisdictions, the difficulties in providing a service to remote communities were expressed in relation to particular settlement types. This includes farming areas, mining settlements and towns where fly in fly out recreational visits occur (ie, mining workers are in town for a short period). For example, "farming areas may be a problem. Low density of people, and low density of GPs with relatively few skills in AOD treatment. Including cultural barriers associated with overseas born doctors".

Population groups with high need

Some key informants noted that severity of need and risk to oneself would be important in deciding on priorities for treatment. Comments from a sample of key informants (from different jurisdictions) illustrate this point, "priority to the vulnerable and disadvantaged", "people with severe drug problems", "[prioritise] by level of risk to the person", and "an important priority is the immediate health risk". These comments reinforce the need for a specialist sector that can provide an appropriate response for clients with serious problems associated with their drug dependence. In deliberations about treatment investment, priority should be given to those most in need.

Given the high rates of unmet demand, it is unsurprising that additional treatment places were identified for a wide range of population groups. In at least half of the jurisdictions, there was commentary on six groups, described in detail below.

1. Young people: Key informants perceived a general shortage of appropriate services for young people. Some comments pertained to intervening when drug use was risky rather than entrenched, for example providing for "youth (getting in early)", and "youth programs as a deterrent for VSA (volatile substance abuse)".

A number of key informants spoke about increasing rates of demand for treatment from young people. "There has been more demand, 'across the board', for 18-20 year olds", "[there is a] gap emerging for 16-18 year olds. CAMHS [Child and Adolescent Mental Health Services] is only dealing with people younger than 16". "We know from child protection and youth justice that there is a need for AOD treatment in the 'youth space'".

Services for young people are quite underdeveloped in some locations, for example, "in the youth area there are enormous gaps. There has been no expansion. It is dismal". In addition, there was some commentary on the need for tailored service models, including "tools for young people" and interventions targeting particular sub-groups, such as those in regional areas, "youth in remote settings is an unmet need". Some key informants reflected on the need for a holistic approach toward young people in need of AOD treatment, with the view that, "we need youth workers that operate across AOD, mental health, and community development".

There was also some commentary on the timing and nature of AOD responses for young people with multiple problems. Comments include; "at what point does specialist AOD come into the picture", "[it is important to] note that services are often housed in youth services (not Headspace) and operate as part of a holistic model", and "our [youth] service reaches [young] people not otherwise engaged with services". Our findings suggest the need for discrete services for young people with multiple concerns (including AOD problems) who may not access mainstream models.

2. Families, parents/carers with children, and women: Some key informants noted that the needs of families and parents/carers with children (usually identified as mothers) were not being met. Their comments were about the absence of appropriate services. For example, "gaps include a family-centred approach, [and] services for women and children", and, "there are no facilities for families with children".

The need for residential services was a common theme in these discussions, particularly for rural and remote locations. For example, in reference to one remote area it was noted that, "providing for women with children is a service gap [in the district], where is there is no residential family program". And in another, "the closure of [the residential service] has generated a greater gap in the ability to provide adequate services for family AOD recovery. Adult services are not resourced to look at family".

There was also some discussion about women that was separate from their possible role as parents with dependents. This discussion generally referred to the need for women specific services and, in two locations, this incorporated a recognition of the particular issues that may be encountered by women in need of drug treatment, including, "holistic services by need, e.g., financial counselling, child and family support, family violence support", and "all services for women (including transitional support between interventions)".

One key informant commented about the need for interventions that target different levels of community; "services not only for individuals, but family and community. Working at all levels to build supports for positive change".

3. Offenders and prisoners: There was substantial discussion on the need to do more for people with drug problems who are in contact with the criminal justice system. This includes young people in juvenile detention and people in prison or post-release, as well as community offenders. Key informants felt that the investment in diversion programs have been a valuable initiative that increases access by these groups. They noted that diversion funding "has meant a unique contribution [in terms of client access]" and "'Justice re-investment is a very good idea". Further, a key informant from one location said that, "if there is no diversion, there wouldn't be much funding for AOD in the state".

Prisoners were identified as a vulnerable group with substantial rates of drug use problems. One aspect of their incarceration is the opportunity to provide interventions and achieve real change. "There is substantial need as well as an opportunity while people are incarcerated", however some key informants noted that it seems that "prisoners are not a priority in terms of treatment and this is a concern, with an increased focus on punishment and prisons as a 'warehouse for AOD problems' resulting in increased treatment demand over time" and "AOD services [for prisoners] are very underdeveloped".

Some key informants saw the elevated risk of harm from overdose and relapse into drug use post-release as a particular area of need for intervention. They noted that, "there are a growing number of deaths in the immediate period (first couple of days) after release from detention. This is often related to drug overdose due to the lack of tolerance after a period of incarceration. There seems to be a lack of formal pre-release discharge programming", and "post-release support programs are needed".

There were some calls for planning to clarify future directions for services involving these clients groups. For example: "The forensic area is very fragmented and of growing significance. Government needs to rationalise how it is supported – which channels are involved. There are multiple funding streams and an intersection with brokerage agencies. Courts are involved in providing referrals."

Particular groups were identified as in need of tailored approaches. This includes "services for CALD in criminal justice system are under-resourced; [we] need to acknowledge trauma issues", and "more meaningful diversionary activity on APY (Anangu Pitjantjatjara Yankunytjatjara) lands".

4. Individuals with co-morbid AOD and mental health problems: Clients with co-morbid AOD and mental health concerns were highlighted as a group where more treatment capacity is required. Key informants noted that, "mental health struggle with co-morbid clients", "mental health and AOD integrated services" are needed, and "[it] comes back to the layers of government issue – which level of government looks after mental health and AOD – how to create links? [It] also comes back to [the] continuity of care issue – care across the spectrum". Moreover, it has been "difficult to engage the mental health sector in AOD issues at a time when co-morbidity is an increasing presentation".

Alongside this commentary, many key informants noted that substantial progress has been made regarding AOD service capacity to respond to those with co-morbid AOD and mental health concerns. The ISI was often raised in these discussions. One key informant spoke about the need to maintain the gains that have been made, suggesting that an ongoing commitment is needed: "There is an appreciation of co-morbidity in AOD, but not a lot of funding to enable staff to deal with these issues, staff turnover means this capacity has not been sustained.

In one jurisdiction, key informants raised the need for services catering for "youth with anxiety/depression and substance misuse".

5. Aboriginal and Torres Strait Islander people: In many jurisdictions, key informants commented on the need for more services for Aboriginal and Torres Strait Islander Australians – consistent with the perspective that those most in need should be prioritised. They felt that, "Aboriginal AOD should remain a priority", and "more needs to be done to increase Aboriginal people's access to services". There was discussion about the need for a residential program for Aboriginal and Torres Strait Islander women and the need to "explore Indigenous appropriate models" and consider "cultural understandings of binge drinking".

Key informants in one group spoke about the lack of "models for doing good assessments for Indigenous people – particularly youth. The tools aren't there and it is dangerous to pathologise, this is a concern involving Torres Strait Islander young women in particular". Another group commented that, "[there are] 12+ Aboriginal and CALD from northern suburbs who aren't accessing treatment. Might be approachability rather than accessibility".

The complexity of the issue is illustrated by this comment: "Rural and remote and Aboriginal – residential rehabilitation may appear to be in over supply, but there is [a] mismatch of supply and demand, with people having to travel too far and [the] service not being culturally appropriate. Many Aboriginal people are unable, due to family relationship, language and culture, to attend the current residential rehabilitation centres".

6. Culturally and linguistically diverse groups: As reflected in the text above, CALD groups were raised a number of times, in discussions about young people, offenders and prisoners, and service accessibility. In some jurisdictions there was a call for CALD services, or at least attention to the appropriateness of existing service models for these groups. One key informant group noted there are "no CALD services but no sense [or understanding] of need" and another group mentioned that "[there is] nothing specifically targeting CALD".

Service types
Key informants also identified gaps in relation to specific treatment types. We have organised these comments according to the focus on residential services or outpatient care, and including pharmacotherapies. There was also some discussion on related topics, including capacity building, integrated models, and client accommodation.

1. Residential rehabilitation: Many key informants commented about residential rehabilitation, including the need for additional treatment places and possibilities regarding alternative residential programs. At national level, it was noted that, "[there is a] commitment to this model (RR)" consistent with the "area of greatest need [and in recognition that it is] the most expensive form of treatment". Further, "residential rehabilitation for Aboriginal people 'is funded because this is where the gaps are and because this is the preferred service type for ATSI".

At jurisdictional level, most of the discussion on residential rehabilitation focused on the extent of unmet demand. In one location, it was suggested that residential rehabilitation "is underfunded and needs support'. In other jurisdictions, key informants reported waiting times between 21-105 days (assessment only), and they commented that, "[there is a] shortage of residential rehabilitation beds, with a 12-week waiting period", or noted that, "residential rehabilitation beds are limited". Tangentially, in another jurisdiction, it was noted that, "[the] review found no strong evidence to increase [the] number of residential rehabilitation beds".

In some jurisdictions, key informants commented on unmet demand for particular client groups, including Aboriginal and Torres Strait Islander people and youth. For example, "[the state] needs more residential rehabilitation – more Aboriginal-specific residential rehabilitation in non-metro

areas". There is "no service in this space, 10-16 years [of age], [and] very few other services for this age group. Government hasn't recognised that users are becoming younger".

A number of key informants called for variations on the traditional therapeutic community model, suggesting that "other [residential] models should also be explored", and there is "need for more variation" in the service model. In addition, "enhancements to retain clients and in-reach by other services and systems [are needed]". Other examples concerned family services: "there is no funding for family counselling attached to residential care", "family needs to be engaged" and suggesting "support for families of those in residential rehabilitation".

2. Residential withdrawal: Access to withdrawal beds is limited according to the key informants, who commented on "[the] lack of detox beds", and that "[access to] resi detox is appalling, clients are expected to travel long distances", "there is nothing in the north". This issue applies particularly to regional areas, with key informants reporting that, "there are no detox beds regionally", "access to residential withdrawal beds is difficult for regional areas", and "there are no detox beds regionally and no allocated beds in hospitals for withdrawal".

The need for youth-specific withdrawal services was identified in one location, while in another location key informants explained that access is good for those with alcohol problems but difficult for those using pharmacotherapies.

3. Pharmacotherapies: The shortage of community prescribers was highlighted in discussions about unmet demand for opioid pharmacotherapy maintenance, while stakeholders in two locations described initiatives designed to build expertise and support for service provision and community prescribers. Key informants noted that, "[we] still have large unmet need", "[there is] limited access to opioid pharmacotherapies [it is] lacking in community service", "[we] still have large unmet need", and "[we] need more GPs in [location] for opioid substitution". Conversely, in one location it was reported that there are, "no waiting lists and [we are] not exceeding the state cap".
Some key informants spoke about potential changes to the PBS which may assist in alleviating the unmet demand for pharmacotherapy maintenance, as follows: "PBS to cover dispensing fees, support to integrate pharmacotherapy into primary area, account for additional time involved in GP visits when clients have complex issues. A new Tier 2 class titled 'Addiction Medicine' to be established for 2014-15 in the Tier medical classes".

4. Counselling and other outpatient services: The substantial unmet demand for outpatient treatment, particularly counselling, was a major focus of discussion. Key informants commented that, "many services have waiting periods and this is particularly challenging at points of transition", "[there are] substantial waiting lists (6 weeks)", and "[service name] has increased group work to expand its supply of services by over 100%, but is still not meeting demand".

Key informants from one location commented specifically on case management. They noted that, "the multiple unmet needs of complex clients weigh on staff. They have to work with multiple departments and multiple challenges". Their comments extended to the need for appropriate models for particular groups; "there is a gap in the delivery of intensive outpatient services to the 'hard end' of the client group. These clients don't have what it takes to navigate their way around the system".

Some key informants spoke about the potential from day programs; for example one key informant described steps taken to increase sector capacity in this area. They said, "there is a need to adapt services, and some of this requires resourcing to do so – eg, the recent move to develop day programs so as to make drug treatment more accessible to different people … service gaps had been

identified regarding access to non-residential structured day programs". In another location a key informant spoke about the short term nature of support for developing day programs and the limited sustainability possible in this context; "'we put lots of energy into day programs but this has lost momentum".

Service capacity to provide counselling was in focus in one location, where problems had been experienced with sole worker programs. Counselling outreach in remote areas was seen as important and needing an appropriate level of resourcing to avoid a sole worker program, which involves "too much pressure on staff". There was also a call for a more continuous program of care for those experiencing withdrawal, involving "case management for clients pre and post detox".

5. Integrated models: Collaboration, continuity of care, and holistic approaches were highlighted as areas needing development. This includes working across different parts of health. Key informants commented on the need for "collaboration across services to increase access", and some felt there should be "holistic [services], to improve overall outcomes".

One further area was raised in discussions about treatment gaps and unmet demand. There was recognition of accommodation problems faced by clients and the fundamentally important nature of secure housing to enable and advance treatment outcomes. Key informants felt that, "the housing shortage is an issue", and "clients need stable housing and employment to be able to then address profound AOD issues". Transitional housing and accommodation post treatment were also regarded as important, for example in the provision of aftercare and post residential rehabilitation.

Summary: key informants perspectives on gaps and unmet demand

In summary, these findings accord with our quantitative analysis. In particular,
- Unmet demand is substantial
- It is difficult to measure
- Existing data have significant shortcomings.

Further, the qualitative data highlight that:
- Key informants have a keen awareness of the importance of and complexities in pursuing a better understanding regarding unmet demand.
- Sector capacity to provide for client needs must be considered when thinking about unmet demand.
- Underlying factors (such as service availability and visibility) may impact treatment seeking and reduce visible demand.
- In some areas, particularly involving remote communities, tailored service models are required to enable service access and inform understandings of unmet demand.

In more than half the jurisdictions, the following gaps were identified:
- Population groups with high need
  - *Young people*
  - *Families, parents/carers with children, and women*
  - *Offenders and prisoners*
  - *Individuals with co-morbid AOD and mental health problems*
  - *Aboriginal and Torres Strait Islander people*
  - *Culturally and linguistically diverse groups*
- Service types
  - *Residential rehabilitation*
  - *Residential withdrawal*

   o *Pharmacotherapies*
   o *Counselling and other outpatient services*
   o *Integrated models.*

Other areas of unmet demand or priority areas where gaps existed, which were raised in less than half of the jurisdictions include: GLBTQI, people in the contemplative phase, alcohol, aging population of opiate users, benzodiazepines, after-hours services, aftercare, amphetamine-type stimulants, steroids, and volatile substances. Key informants also spoke about the need for sector capacity building, so that services are able to provide an appropriate response. For example, in one jurisdiction where participants had outlined a list of groups and services pertaining to unmet demand they explained that each group 'needs its own Improved Services Initiative' (ISI).

Conclusions

- It is clear that at present, Australia provides comprehensive alcohol and other drug treatment services, across a range of client groups, treatment types and locations.
- There is a greater demand for services than current supply.
- We estimate that between 200,000 and 500,000 more people would be in treatment if demand were to be fully met. [82] This means that current met demand may vary between 26% and 48% of all people who will seek, and are appropriate for, AOD treatment.
- No service system can meet 100% of demand – and indeed, when examined in comparison to international figures, Australia is doing well. International benchmarking of our findings suggests that Australia has a relatively high rate of treatment utilisation and possibly one of the lowest rates of unmet demand in the world.
- There are some readily identifiable gaps. The first is in relation to alcohol treatment – our quantitative estimates of demand suggest that we need more alcohol treatment services.
- Other areas of unmet demand include services for young people; families and women with children; and Aboriginal and Torres Strait Islander people (we note that DA-CCP does not at present include the kinds of treatments appropriate for Aboriginal and Torres Strait Islander people. A specifically designed Aboriginal and Torres Strait Islander DA-CCP is in development).
- Service types that were identified as not meeting current demand were residential rehabilitation, residential withdrawal, pharmacotherapies and counselling. Perhaps this is not a surprise as these categories reflect the core service types across Australia. This accords with the overall extent of unmet demand predicted by the DA-CCP model.
- Increasing the overall amount of AOD treatment provided is important, but given resource constraints, choosing the areas of greatest unmet demand is vital. Responsibility for increasing met demand rests with all the AOD treatment purchasers – both Commonwealth and state/territory governments.

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[82] By fully meeting demand, recall that this is based on a DA-CCP treatment rate of 35% - ie full demand is the equivalent of only treating 35% of all people who meet diagnostic criteria.

Chapter 9: Planning

This chapter concerns approaches to planning alcohol and other drug (AOD) treatment. It is strongly connected to the preceding chapters on measuring met and unmet demand, but takes us beyond estimating the amount and type of services to examine planning processes.

The chapter starts with introductory comments about planning, its importance, and the goals of planning. A distinction is drawn between 'strategic' and 'technical' planning and these two types or levels of planning are then described in detail. It is through an examination of strategic and technical planning that the potential role of the Commonwealth and state/territory governments comes to the fore. The next section discusses joined-up planning in the context of two levels of government. We then consider important stakeholders to planning other than government. The literature and key informants reinforce the important role that a number of stakeholders including service providers and clients have in planning processes. This leads us to then consider another question — the most appropriate focus for planning (a focus on national, state or local planning). The chapter concludes with a description of current planning processes for AOD treatment in Australia.

There has been much written about planning, and healthcare planning. Planning is "a coordinated and comprehensive mechanism […] for the efficient allocation of resources to meet a specific goal or goals" (Thomas, 2003, p. 2). Planning has also been described as, "the process of preparing a set of decisions for action in the future, directed at achieving goals by preferable means" (Dror, 1973, p.330, cited in Eagar et al., 2001). It is an explicit process, directed towards the goal of healthcare resource allocation (Fazekas, Ettelt, Newbould, & Nolte, 2010).

Planning must take context into account. As Duckett & Willcox (2011) note, there is no objective assessment of healthcare need, rather any assessment of need or demand exists within a social and political context. In addition, the very ways in which need or demand are defined and operationalised matter (see Working Paper # 1).

Healthcare planning should be considered alongside other public policy decision-making. "Broad political goals, such as ensuring economic sustainability, have to be considered and weighed against the goals of healthcare planning" (Fazekas et al., 2010, p. xiv). The World Health Organization notes: "it is now widely understood that national health policies, strategies and plans have to extend beyond health-care delivery and cover the broad public health agenda […] and that they have to go beyond the boundaries of health systems, encompassing action on the social determinants of health and the interaction between the health sector and other sectors in society" (World Health Organization, 2010, p. 1).

Planning is not value-neutral, and its goal is to allow resources to be directed. Therefore clarity about the values underpinning planning and the goals of planning are centrally important. Eagar et al. (2001) argue that the intention of planning is to achieve resource distribution that is equitable, efficient and ensures effective delivery. Eagar et al. (2001) identify the following goals of a healthcare plan:
- Equity — of access to health care services or of outcome
- Accessibility — including geographic, physical, cultural/linguistic
- Acceptability of services — to the client group and the community
- Affordability of services — to the client group and to the community
- Efficiency of services — including technical (maximum output, minimum input), allocative (appropriate distribution of benefits, service mix), and dynamic efficiency (adaptability)
- Effectiveness and quality of services.

The goals of planning for AOD services have been articulated by Babor, Stenius, & Romelsjo (2008). They argue that there are three goals:

- Equity — such that there is equitable access to AOD services
- Efficiency — the most appropriate mix of AOD services
- Economy — the most cost-effective AOD services.

The above goals are consistent with the principles we articulated in Chapter 1: effectiveness, efficiency and equity.

Is planning important? Certainly the existing literature (which is considerable) takes as a given that healthcare requires planning, and that good planning produces benefits aligned to the goals – that is to improve healthcare outcomes, equity, accessibility, efficiency and so on (Eagar et al., 2001). Likewise, key informants reinforced the fundamental importance of planning: "We need better planning – what do we want; and who are the populations we should service?" Key informants commented on the absence of effective planning processes, assessment of need, unmet need, and gap analysis. This applied nationally and at state level (notwithstanding that some jurisdictions engage in more comprehensive planning processes than others): "AOD funding has never been fully worked out in terms of planning".

Key informants were also readily able to identify some of the consequences of poor planning. For example, "it is hard to prioritise without information on need and on what else is being funded, which means resources are not easily redistributed". In particular the challenge of having two funders (Commonwealth and state/territory) in the absence of shared planning was identified as a major concern for the judicious distribution of resources. For example, key informants perceived that some Commonwealth investments resulted in poor value for money because the program was thought to be ill-suited to state/territory needs or plans.

Perhaps it is not surprising that planning may be inadequate, when one considers the literature on the kinds of data and methods required for good planning. The kinds of data that are likely to be required for comprehensive planning include:

- Socio-demographic data, population count, age, sex, education, occupational status, socioeconomic status, Aboriginal and Torres Strait Islander status, Culturally and Linguistically Diverse status, income distribution, poverty, etc (Eagar et al., 2001).
- Geographical information about where people with needs reside, service locations (Russell, Humphreys, Ward, Chisolm, Buykx, McGrail, & Wakerman, 2013).
- Epidemiological data about the nature of the disorder, ill-health of the population, including prevalence, incidence, mortality and morbidity data, illness severity, years of life lost, disablity-adusted life years, quality-adusted life years, and statistical modelling (Best et al., 2007; Harris et al., 2012; Whiteford, Harris, & Diminic, 2013b).
- Systematic reviews of the evidence for treatment effectiveness and cost-effectiveness, randomised and controlled studies, other types of research studies, health systems research, clinical guidelines, treatment models (Robinson, 1999).
- Information on services: what exists, location, specification of activities etc (Green, 2007; Harris et al., 2012; Whiteford et al., 2013a).
- Data on current treatment utilisation and trends, including activity measures such as admissions and separations (Best et al., 2007; Harris et al., 2012; Whiteford et al., 2013b).
- Use of planning benchmarks from Australia and other countries (Harris et al., 2012).
- Surveys, focus groups, consultative groups and in-depth interviews of stakeholders, document analysis, continuing consultation (Best, O'Grady, Charalampous, & Gordon, 2005;

Fuller & Edwards, 2004; Sutton, Maybery, & Moore, 2011; Weiner, Amick, Lund, Lee, & Hoff, 2011).

- Various potential dialogue methods: nominal group technique, Delphi expert panel and so on, see Eagar et al. (2001) and McDonald, Bammer, & Deane (2009).
- Public opinion, including for example community forums/public meetings (Maddock, Daley, & Moss, 1988; Robinson, 1999).
- Consensus forecasting; scenario planning (Eagar et al., 2001).
- Political records and information from ministries, agencies, institutions etc (Green, 2007; Robinson, 1999; Whiteford et al., 2013b).
- Expert opinion, clinician opinion (Best et al., 2005; Robinson, 1999).
- Casemix information — illness severity, numbers and types of treatment, classification of care packages, cost weightings, diagnosis-related groups (Duckett & Willcox, 2011; Eagar et al., 2013).
- Economic data, such as cost benefit, cost effectiveness, cost utility, program budgeting and marginal analysis, current resource allocation, costings of eg, staffing, information on payment systems (Robinson, 1999; Whiteford et al., 2013b).
- Resource availability — personnel, equipment, buildings, transport etc (Green, 2007).
- Information on clients' and potential clients' views on services, accessibility, affordability, needs and levels of satisfaction, barriers to treatment etc (Best et al., 2005; Digiusto & Treloar, 2007; Eagar et al., 2001; Mitton, Smith, Peacock, Evoy, & Abelson, 2009; Treloar, Newland, Rance, & Hopwood, 2010).

The above list is extensive and makes the point that data are essential for planning. Key informants were aware of the importance of adequate data to inform planning but noted the poor connection in AOD between the data collection/collation and its use in planning: "[We] don't currently use available administrative datasets for gap analysis (eg NMDS)". Similarly, we were told of instances where reports and information are given to government and the information is then perceived as not being used to inform planning.

Aside from poor current data utilisation, a number of key informants pointed to gaps in AOD planning data — including both population health measures and specific treatment data: "There is no good data on unmet need". (We can attest to this in our work for the Review). In other examples, some states/territories do not have confidence in the existing data. For some of the smaller jurisdictions, as noted in consultations, administrative data (such as the AODTS-NMDS) are likely to be less robust and may need to be supplemented with other sources of information.

The importance of using multiple methods is highlighted by Fazekas et al. (2010) who argue that key informant interviews assist to "understand the complex, informal and tacit aspects of the planning process which are not well captured in published accounts or in official descriptions of how systems operate" (p. 3). In the national Mental Health Roadmap, the Council of Australian Governments states: "We will build and learn from qualitative and quantitative evidence to ensure we make the best of investment and provide the right models of care" (Council of Australian Governments, 2012, p. 3).

Multiple methods are required for planning because different tools focus on different aspects of the system: no one approach or tool will suffice; triangulation of data increases its likely validity; and expert knowledge is not readily tapped through any one method. See Working Paper # 9 for more details about planning, and an outline of the key components in healthcare planning.

In summary, the need for a coordinated and planned approach to planning has been highlighted: "A systematic planning process is required" (key informant). Good planning attends to goals and makes

explicit the values and how trade-offs will be managed. Planning also requires skills and data. Multiple types of data and use of multiple approaches are preferred over a single approach or tool for planning. We now turn to the kinds of planning that may be required in relation to AOD treatment services in Australia – strategic planning and technical planning.

Strategic planning and technical planning

The literature draws what we see as a helpful distinction between two different levels or types of planning: strategic or higher level planning, and technical or operational planning.

'Strategic planning' refers to high level, policy planning, where the goal is to set the vision, direction and objectives to be achieved. As noted in Eagar et al. (2001), strategic planning involves determining the goals and general direction of healthcare delivery and the development of the overall framework and principles. This is distinguished from technical planning, or operational planning, which refers to the translation of strategic objectives into a concrete sequence of activities, involving the allocation of budgets and resources, the provision of facilities, equipment and staff and the organisation of services (Eagar et al., 2001; Ettelt, Nolte, Thomson, & Mays, 2008). Technical planning is also referred to as 'allocative planning' with the explicit goal of allocating resources (Green, 2007)[83].

We use these two terms as an organising framework to think about AOD planning in Australia. First we examine 'strategic' planning.

Strategic Planning

Planning can occur at the strategic or policy level, where national goals and objectives for healthcare (or other public goods) are developed and agreed. These national strategies need to articulate down to the technical level of planning. As the World Health Organization notes:

> "National policies, strategies and plans must be linked to regional or district-level operational plans. The extent of linkage depends on the level of detail in the national strategic plan and the degree of autonomy at decentralized level. […] Many countries link the national strategic plan with operational plans through rolling medium-term plans and expenditure frameworks" (World Health Organization, 2010, p. 3).

Having an agreed vision which encapsulates the goals and objectives provides the framework and context for more detailed planning. It also provides the long-term perspective (Fazekas et al., 2010). As noted earlier, goal conflict can occur — for example the trade-off between cost containment and quality of care. It is at the strategic level that these goal conflicts can be resolved. The higher level strategy also considers leadership and governance, and the regulatory and legal frameworks (World Health Organization, 2010).

The Commonwealth has a natural role to provide leadership in national strategic planning for AOD treatment. As our key informants (across government and service provider levels) noted: "The Commonwealth's role is providing a national approach — this is where we can add value"; a "national coordinating layer" is required.

This leadership role in developing a national AOD treatment strategy is consistent with the perspective that the Commonwealth's roles in healthcare are: financing, regulation, research and monitoring and leadership through national strategies (Eagar et al., 2001).

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[83] Planning can also be a political process. While some literature identifies strategic planning as more 'political' (Eagar et al., 2001) and by association, implies that technical planning is outside the political, the reality is that political processes can impact on both strategic and technical planning.

One final note about strategic planning before we turn to technical planning: a formal governance structure around planning is required. Key informants gave examples where informal communications resulted in better planning, but noted that this relies on accident or on particular individuals. There was strong agreement that a structured formal set of planning processes was required: "[we] need a governance structure around planning with Commonwealth and State working together"' "More structured processes are needed for this to occur".

Technical planning

'Technical planning' in healthcare is often a synonym for health needs assessment. Health needs assessment refers to a systematic approach to the distribution of scarce healthcare resources, based on client need, and treatment effectiveness. In the seminal paper on healthcare needs assessment, Wright, Williams, & Wilkinson (1998) provide the following summary:

> "Health needs assessment is the systematic approach to ensuring that the health service uses its resources to improve the health of the population in the most efficient way.
> It involves epidemiological, qualitative, and comparative methods to describe health problems of a population; identify inequalities in health and access to services; and determine priorities for the most effective use of resources. Health needs are those that can benefit from health care or from wider social and environmental changes. Successful health needs assessments require a practical understanding of what is involved, the time and resources necessary to undertake assessments, and sufficient integration of the results into planning and commissioning of local services" (Wright et al., 1998, p. 1310).

Put simply, needs assessment identifies the gap between current service utilisation and optimal service utilisation, and community attitudes towards priorities and targets for intervention. There is an extensive literature defining terms such as 'need' and 'demand' (see Working Paper # 1 Andersen & Newman, 2005; Bradshaw, 1994; Stevens & Raftery, 1994). Definitions and conceptualisations of need are important because when used in planning, they can have significant implications for resource distribution. Thus any technical planning must clarify and define the scope of 'need' and 'demand'. (For example, see Chapter 8, where DA-CCP is outlined. In DA-CCP need is defined as the population prevalence of AOD disorders and demand is defined as a proportion of that total prevalence, based on expert judgement — generally at around 35%).

There is a reasonably large literature on technical planning for AOD treatment. In a series of early papers, Ford and colleagues (1985, 1997; 1983; 1983) describe a variety of treatment planning approaches for AOD which they term "demand-based projections". The approaches all start with existing treatment utilisation (hence 'demand-based') with the underlying assumption that past demand predicts future demand and that past demand reflects client needs[84]. Combining demand projections with other indicators (such as hospitalisation rate, total population size, mortality and arrest rate) can facilitate prediction of bed capacity (at a state level). These forecasting models can be used to "compare a present system with a normative experience…[and] demonstrate areas of shortage or oversupply" (Ford, 1985, p. 250).

There has been extensive research which has used social indicators to predict the need for alcohol and/or drug treatment services at the local level (AEDS, 1982; Beshai, 1984; Gregoire, 2002; Sherman, Gillespie, & Diaz, 1996). In Beshai's (1984) work, for example, the indicators included number of alcohol outlets, mortality rates, alcohol-related traffic offences and measure of housing cost and overcrowding. In Mammo & French (1998) the indicators were drink-driving arrests, alcohol-related mortality, domestic violence arrests and alcohol retail outlets. More recently

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[84] Ford notes that both of these underlying assumptions are open to criticism.

McAuliffe & Dunn (2004) have used a social indicators approach to develop alcohol and drug need indexes for each USA state; and McAuliffe, Woodworth, Zhang, & Dunn (2002) for specific towns.

Since the early work in the USA, researchers have moved to epidemiological models to plan for services (rather than demand-based models: see for example, McAuliffe, LaBrie, Woodworth, Zhang, & Dunn (2003). A number of papers describe epidemiological estimates of demand for treatment. For example Rush & Urbanoski (2007) for cannabis users in Canada; Schultz, Arndt, & Liesveld (2003) for older substance abuse clients; Mojtabai & Crum (2013) for substance use treatment in the USA; Kip, Peters, & Morrison-Rodriguez (2002) on the limitations of national epidemiologic data for needs assessment. Clemens & Ritter (2008) used a multiplier technique to estimate the need for alcohol treatment in Victoria. There is debate about the application of national epidemiologic data to state- or county-based needs assessment (see Epstein, Hourani, & Heller, 2004; McAuliffe & Dunn, 2004; McAuliffe, LaBrie, Lomuto, Betjemann, & Fournier, 1999) which links to the discussion about the most appropriate level for planning.

To summarise: the advantage of social indicator methods is that they rely on existing administrative datasets. The advantage of the epidemiological methods is that they rely on estimating the actual number of people with alcohol or drug problems. The advantage of the demand-based projections is that they take into account treatment seeking behaviour. (See Dewit & Rush, 1996 for a comprehensive review of various ways of assessing need for treatment, including epidemiological and social indicator models). Debate continues about the extent to which epidemiological models, social indicator approaches or demand-based projections are preferred (see Epstein et al., 2004; McAuliffe, 2004; Simeone, Frank, & Aryan, 1993). It is likely that combinations of these approaches, coupled with qualitative data and dialogue processes will produce the most robust planning estimates.

The Drug and Alcohol Service Planning Model for Australia (2013) [formerly DA-CCP[85]] is a technical planning tool that uses demand-based projections built from epidemiology of the prevalence of substance use disorders (see Working Paper # 1; and Chapter 8). DA-CCP has been the first attempt to develop a decision-support tool for planning which provides a nationally-consistent approach.

There was broad agreement from key informants that needs-based planning models would be useful: "A model that can identify gaps systematically is required". "Demographic needs based planning is required which lends itself well to the use of quantitative tools, such as DA-CCP". Key informants were broadly positive about DA-CCP:
- **"**DA-CCP is a possible mechanism for planning; for determining service need".
- "It would be helpful to adopt the DA-CCP or some other population-based planning tool agreed at national level. We don't have a model that articulates service provision by region".
- "DA-CCP and population modelling would probably show that we needed more treatment".
- "It is a tool you can use, it provides parameters to work with; a good starting point".
- "DA-CCP could be a useful tool".

It was also noted by key informants that a significant amount of work would be required to generate the necessary capacity in the sector for the effective use of DA-CCP. Furthermore, appropriately, key informants were mindful of its limitations ("any tool has its limitations" key informant). This view is consistent with the need for good planning to embrace multiple tools and approaches, as noted earlier.

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[85] Although DA-CCP has been renamed, we continue to use the acronym here for simplicity.

Despite the significance of DA-CCP in generating estimates of demand for treatment for the first time in Australia, more is required in relation to planning. Three key points are made here: firstly the importance of predictive tools for demand for treatment being married to what is actually happening and the extent of current service utilisation; secondly the importance of geography (which is not dealt with in tools such as DA-CCP), and thirdly, the evaluation of effective planning.

DA-CCP only predicts what 'should' be and does not provide any estimate of what is currently provided. In order to use DA-CCP, we need Australian estimates of current service utilisation. Chapter 8 provides our first attempt at this. Spence (2003) noted the importance of a technical planning tool being able to specify the required operational units of service to meet demand. In his work, it was interesting to note that his allocative model revealed that there was a greater amount of intensive residential treatment provided than predicted by the model[86]. (Our findings for DA-CCP are not dissimilar in relation to cannabis treatment for young people — see Chapter 8). This highlights the potential value but also limitation of using a single quantitative planning tool. Dialogue amongst stakeholders about the tool results, and the best mix of services to meet needs, is then also required.

As reviewed in Working Paper # 2 there are few planning frameworks that take into account geography, or the spatial dimensions of access to services. As noted in Working Paper # 2, spatial analysis for the purposes of planning healthcare services is a "recent development" (p.27). Nonetheless the authors argue that the methods reviewed, such as gravity-based methods [87], are likely to have applicability for AOD treatment services in rural and remote areas of Australia.

Finally, what is perhaps notable in the existing literature on AOD treatment planning is that there were almost no identified articles which describe the planning method, its subsequent implementation, and then evaluation of the treatment system or healthcare outcomes as a consequence of the application of planning tools. In the one exception, McAuliffe et al. (1991) described a comprehensive needs assessment for drug treatment in Rhode Island, including estimates of met and unmet demand, treatment type considerations and resources. They concluded "[t]he RI Department of Health […] adopted our overall recommendation for tripling the drug treatment system" and "the orderly expansion of treatment services in Rhode Island testifies to the effectiveness of the needs estimation methods used in the present study" (McAuliffe et al., 1991, pp. 365, 367). It is difficult to conclude from one example that technical planning in AOD produces better treatment service systems, or lower alcohol or drug-related harm or consumption, but this is its purpose.

The distinction between strategic and technical planning begs the question about the appropriate roles of different levels of government in planning. We turn to this next.

Two levels of government and 'joined-up' planning

One of the most commonly discussed issues amongst key informants was the two levels of government purchasing of AOD treatment, and the need to consider planning in this light.

All the people we spoke with argued for 'joined-up' planning processes. By 'joined up' we mean coordination and collaboration between the state/territory and Commonwealth funders of AOD

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[86] Only 9% of people were estimated to need intensive residential treatment, but actual admissions to intensive residential treatment accounted for 29% (Spence, 2003).

[87] With the advent of sophisticated mapping technologies (ie, Geographic Information Systems), methods which take into account small area variation have recently become possible. Most promising among these are 'gravity-based' methods, which take into account not only service provider supply and population demand, but also travel time or distance between the two (See Working Paper # 2).

treatment[88]: "The optimal approach would involve the state and Commonwealth meeting and agreeing on what to fund". This succinct quote echoes what we heard from almost everyone who spoke about planning across levels of government.

There was a sense from the key informants that planning had been better coordinated in the past — at least as much as planning entailed funding decisions. We heard from a number of people about Commonwealth funding rounds prior to 2011/12 where a more consultative collaborative process was undertaken around funding decisions. For example: "originally there was a state advisory committee that involved national leaders […] and included state government input. This helped with prioritising projects for funding". We do not want to suggest that collaborative funding decisions at a particular point in time replace 'planning' per se, but are indicative of the potential for more joined-up planning (and the apparent worth of collaborative planning across levels of government).

We were also told of positive experiences when funding decisions were able to be collaborative. In at least two jurisdictions it appears that there was co-operation between the Commonwealth (STO offices) and state/territory governments in relation to sharing information about services, planning and funding (although both examples seem to be predominantly the state sharing data, rather than a fully reciprocal process). The impression we received was that these examples largely arose out of goodwill and effective individual interpersonal relationships between key players. Formal planning processes would remove the reliance on happenstance and effective interpersonal relationships, and formalise what appears to only occur between certain individuals.

Clearly, the two funders – Commonwealth and state/territory – are vital to any planning process. The key informants argued for both funders to participate in planning together. We note that this should apply irrespective of who is the lead purchaser — that is the states/territories collaborate with the Commonwealth when they are leading a planning process with a view to their own purchasing and vice versa. We received a number of examples where state/territory governments felt that if planning was undertaken jointly between the two levels of government, better outcomes could be achieved:

> "If the Commonwealth wants good returns to its investment they should cooperate with the state and peaks".
> "Ideally it would be a partnership where the Commonwealth listens and works together with the states and territories in decision making".
> "It is problematic that the Commonwealth and state don't come together to plan".
> "The Commonwealth and states don't seem to talk to each other, which would be useful if they could. They have some contact, but not in terms of what is happening on the ground".

Given that some states/territories are moving towards planning reform, it was suggested that there may be an opportunity for the Commonwealth to ride the back of this wave: "In moving to a new system, gaps will be identified by catchment. Perhaps this can inform Commonwealth funding, if it is being looked at by geographic location".

There is a sensible rationale for joined-up planning:
- It potentially improves the likelihood that value for money from any one funder will be maximised
- It potentially avoids duplication of funding
- It increases the chances of cohesive treatment service systems

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[88] There was some speculation about the causes of the poor joined up planning processes and lack of cohesion across Australia. The cessation of the Ministerial Council on Drug Strategy, and the Intergovernmental Committee on Drugs working in isolation from the sector, were posed as possible reasons for the apparent lack of coordination and communication between levels of government.

- It potentially reduces the likelihood of gaps being created
- It is cost efficient (that is good planning requires resources, which can be shared).

Despite the obviousness of joint planning, it is not without its difficulties:
- The most appropriate focus and geographical area (or unit) of planning needs consideration
- It requires a governance structure ("there is no obvious governance structure in place to facilitate joint planning")
- It needs to attend to probity — that is, planning needs to occur distinctly separate from the process of funding decision-making.

Consultation, engagement of multiple stakeholders

The above section has canvassed issues around two levels of government engaged in planning together, however the literature extends beyond the role of the purchasers in planning, and argues for engagement of the whole community in planning. Almost all the literature on planning identifies the need for multiple stakeholder input. For example:

> "Thus, it will be important to understand the role and power of actors as powerful stakeholder interests are likely to undermine effective planning if there are no mechanisms in place that allow for consensus building" (Fazekas et al., 2010, p. 9).

Eagar et al. (2001) argue that there is an expectation that government will involve the community to help decision-making, and to ensure government is accountable and responsible. They identify multiple stakeholders including community members. Eagar et al. (2001) note that engagement and consultation may be avoided by governments because of concerns regarding it being time consuming, unpredictable, uncontrollable, confronting or embarrassing, but they argue that the substantial benefits outweigh these issues. One compelling reason for consultative planning processes is that planning involves difficult decision-making about the allocation of scarce resources. There is value in having broad engagement and consensus in this situation because stakeholder views can diverge from economic rationality (Robinson, 1999).

As noted by key informants: "Ideally there would be cooperative planning between Commonwealth, state and NGO sector"; "Commonwealth/state/NGO sector should all be at the table". The two quotes reflect a prevailing view that it should not just be the funders (Commonwealth and state/territory) but also the service providers that are engaged in planning. The importance of including clinicians and service providers was highlighted across a number of interviews: "meaningful consultation with the sector".

Consumer involvement in planning was raised in key informant interviews in most jurisdictions as an area for improved AOD practice. Consumer involvement is lacking in service planning at present, notwithstanding the challenges associated with effective engagement, training and support for consumer involvement. ("Consumer participation needs proper design and training"). There appeared to be a commitment to building this area and ensuring meaningful consumer engagement and representation. (From one jurisdiction: "we are undertaking work to explore effective ways of obtaining consumer input — recognising that more needs to be done and there is a need for direction regarding how").

The health planning literature identifies the involvement of clients in planning and delivering health services, and it is recommended as a means of improving the quality of services. A systematic review on consumer involvement concluded that "involving patients has contributed to changes in service provision, but the effects of these on quality of care have not been reported" (Crawford, Rutter, Manley, Weaver, Bhui, Fulop, & Tyrer, 2002). The engagement of consumers in the planning of drug

treatment services in Australia has been the subject of a comprehensive project (Bryant, Saxton, Madden, Bath, & Robinson, 2008). Noting that consumer participation is now a standard part of healthcare, Bryant et al.'s review of consumer participation in drug treatment services revealed that consumer participation at the service level was "not uncommon" (p. 130), but engagement in decision-making and planning processes was largely absent.

Aside from the stakeholders discussed above, some key informants reminded us that effective planning needs to move beyond the boundaries of the traditional AOD specialist treatment system because of the strong intersections between AOD clients' needs and other health and welfare services. Some key informants argued that there should also be input from other departments including housing, child protection, childcare and family services, primary health, and community health. These departments are also supporting the AOD treatment client group and vice versa ("we are supporting their clients") and in some cases are funders of AOD services. In some jurisdictions, planning across government portfolios already occurs. It was also noted that individual services should also consider the broader range of stakeholders in their own planning processes. With the complexity of the target group for AOD services it is likely that clients are, or need to be, accessing other services and systems. This requires some level of integration across these systems in the provision of a multi-faceted care model. Careful planning strategies can enable this through the establishment of shared goals, actions, measures, and, in particular, planned communication channels to support effective care provision.

The issue of localism - national, state or local planning?

One of the implicit debates throughout the literature on planning is the most appropriate focus or level for planning, and the extent to which local planning is superior to regional or national planning. There is no doubt that any planning needs to be linked/articulated across levels (as noted earlier). That aside, there is a very real question about the respective role of local versus state versus national planning; and its relationship to strategic and technical planning.

Strategic planning is most likely undertaken at a national level, although it is also important at a state level. As noted earlier, strategic planning sets the goals, principles and priority areas. Strategic planning does not operationalise. It is at the technical planning level where specification of the allocation decisions occurs (eg: number of beds, amount of treatment places for sub-groups within the population). So the question to consider here is the focus for technical planning. Can one engage in technical planning at a national level? Or is this better undertaken at a state, regional or local area? In general, the literature indicates the latter.

The UK has championed local level planning and resource distribution. DrugScope wrote a summary of the UK changes for the AOD sector (Roberts & Simpson, 2013): Directors of Public Health will be responsible for the distribution of AOD treatment funds, with local Health and Wellbeing Boards. These Boards will be informed by "Joint Strategic Needs Assessments", which in turn will link with the National Public Health Outcomes Framework[89]. DrugScope notes how complicated the arrangements are (and difficult to describe succinctly). What is clear is the commitment to local action led by local government. They also note that "the challenge for services will be to find the capacity to influence decision-making at local level" (Roberts & Simpson, 2013, p. 6).

In a research report produced for the National Institute for Health on 'Decentralisation and Performance: Autonomy and Incentives in Local Health Economies' (Exworthy, Frosini, Jones, Peckham, Powell, Greener, Anand, & Holloway, 2010) the authors conclude that decentralisation

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[89] The National Public Health Outcomes Framework has 66 indicators, of which 3 are for alcohol/drugs (DrugScope & The Royal Society for the encouragement of the Arts Manufactures and Commerce, 2013, p. 7).

does not necessary enhance organisational performance, and there is evidence of continued centralisation ("Regulation and performance management (forms of centralisation) are required to ensure that system-wide objectives are met"). Decentralisation should be seen as a "means to an end" rather than an end in itself and clarity of policy objectives is required (Exworthy et al., 2010).

Fragmentation of the healthcare system can occur under decentralisation, and the success and impact of decentralisation varies depending on the local health context. There seems uncertainty that UK localism will achieve its goals (Allen, 2006)[90]. For our purposes, it seems important to disentangle policies of decentralisation from those of planning, although they are clearly intertwined. Here we want to consider the extent to which planning at a local level is an important requirement of effective resource distribution (which can be considered independently from the actual resource distribution — which is the point of decentralisation)[91].

Best et al. (2007) describe a local planning process for AOD treatment in the UK. This approach firstly involved collation of local data on epidemiological of drug use and numbers in treatment, followed by a local expert group with a variety of stakeholders to review the quantitative data. Then a local "treatment map" (configuration of services, services linkages and client flows) was developed and the expert group were then able, using all the data, to identify gaps and needs. Like Babor et al. (2008), Best et al. (2007, p. 274) point out that "little thought has been given to the concept of a drugs treatment system"). They argue that "the method enables treatment need and availability to be systematically assessed in order to inform the treatment commissioning process "(Best et al., 2005, p. 263). Other examples in the literature include Dietze, Rumbold, Cvetkovski, Hanlin, Laslett, & Jonas (2000) and Dietze, Jolley, & Cvetkovski (2003).

In Australian healthcare, Eagar et al. (2001) argue that area health organisations are an appropriate level of focus for planning. The advantages pointed out by Eagar et al. (2001) include greater capacity for technical efficiency (by pooling resources), and encouragement of greater equitable resource use. In addition local planning facilitates innovation and flexibility and the opportunity to shift between priorities in response to local conditions (Eagar et al., 2001). However, a relevant exception for AOD, noted by Eagar et al. (2001), are highly specialised services, which need to be planned at the state or national level (Eagar et al., 2001).

Medicare Locals have had a particular mandate for local planning (noting however that the boundaries to some Medicare Local areas are consistent with state/territory jurisdictional boundaries ie ACT and Tasmania). The case example below describes some of the approaches to needs assessment and healthcare planning which have been undertaken by Medicare Locals.

Case example: Healthcare planning approaches undertaken by Medicare Locals
(The full details can be found in Chapter 17).

A key role for Medicare Locals has been "undertaking local health planning, identifying gaps in services at the local level, examining opportunities for better targeting of services and establishing formal and informal linkages with the acute and aged care sectors" (http://www.ascmo.org.au/ind/Medicare-Locals.pdf p.4). Planning processes were described in the first of the five nominated objectives for Medicare Locals —

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[90] Wolstenholme, Drummond, Deluca, Davey, Elzerbi, Gual, Robles, Goos, Strizek, Godfrey, Mann, Zois, Hoffman, Gmel, Kuendig, Scafato, Gandin, Coulton, & Kaner (2013), in estimating the gap between need and access to specialist AOD treatment across Europe, noted that the devolution of health systems has meant that data collection and meaningful comparisons between areas is now limited.

[91] There is a comment pertaining to this in the key informant data: "Either they should plan together or their combined money should go to one or the other. It is a waste of money to each operate separate pools of money". This suggests that where planning is linked up, resource distribution can occur at different levels, but where planning is not linked up, then separate resource distribution becomes problematic.

"Identification of the health needs of local areas and development of locally focused and responsive services" (p.5). Guidelines for planning and needs assessment were also provided under the Medicare Locals Accreditation Standards. The objective of 'Standard 6: Analysis and Planning' has been: "A planned approach to service delivery informed by adequate and appropriate research, analysis and consultation". (http://www.medicarelocals.gov.au/internet/medicarelocals/publishing.nsf/Content/ML-accreditation-standards~standard6#.Uncqtb9rZvU). It would appear that each individual Medicare Local has approached planning and needs assessment processes slightly differently. However, two key aspects seem to have broadly applied to many, these being (i) partnerships and community consultation and (ii) data input into planning. The Medicare Locals appear to demonstrate commitment to local planning.

Planning Tool

The Australian Medicare Local Alliance has hosted information on their website about the Medicare Local Planning Tool (http://www.amlalliance.com.au/policy-and-advocacy/medicare-local-health-planning-tool). The tool has been described as "a simple, online map-based tool that has been designed to help Medicare Locals with their service planning and the maintenance of local health service information. It provides access to a range of validated national population health data sets as well as health services information from the National Health Services Directory (NHSD). It is a tool that will evolve and expand as more data sets are added and underlying health service information is improved and integrated." This tool has been available to Medicare Locals as a service without charge[92]. The tool has been said to assist with planning in the following ways:

"It is a practical, visual tool that will help you to identify and visualise the health and social characteristics of your region - and Australia more broadly, assisting you in your needs assessments and subsequent service planning

It will act as an easy platform with which you can update and maintain health service information as part of the National Health Services Directory

It provides a framework to support health program development and analysis

It draws on national information and data sets including:

Education, household, community and economic data

Population distributions and projections

Indigenous health

Mortality

Maternal, children, family, countries of birth

Prevention, chronic disease, MBS, aged care".

Such a tool (depending upon whether appropriate data input is available) may also be relevant for assisting with the planning and provision of AOD treatment, although we note that AOD treatment has not been a priority area to date.

One example of planning processes can be seen in the ACT Medicare Local. The ACT Medicare Local has launched a 'Population Health Commissioning Atlas' (http://www.actml.com.au/Uploads/Documents/ACTMLPopulationHealthCommissioningAtlas_web.pdf). On the ACT Medicare Local's 'Health Needs Assessment and Planning' website, it is said that "The Atlas' findings about health status and variation in the ACT will drive how we focus our activities and programs over the next year as we continue to improve the health of Canberrans and keep them well and out of hospital" (http://www.actml.com.au/about-us/health-needs-assessment-and-planning). The 'Needs Assessment Overview' describes the processes and approach to needs assessment, and the key inputs into the 2013 Needs Assessment Report (http://www.actml.com.au/Uploads/Documents/ACTMLOverviewPopulationHealthCommissioningAtlas.pdf). Major inputs into the 2013 Needs Assessment Report included (p.2):

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[92] The planning tool is only accessible with a Medicare Local password, however this presentation provides slides of screen shots which demonstrate the visual aspects of the tool, and how various services can be displayed using interactive maps (Drug and Alcohol is one of the categories listed):
http://www.amlalliance.com.au/__data/assets/pdf_file/0020/45236/20120905_prs_Gabe-Gossage_-National-Health-Services-Directory.pdf

"A Population Health Commissioning Atlas containing information about the ACT population including demographic and socio economic status from sources such as the ABS; health service use from Medicare and hospitals; estimates of prevalence of illnesses and disease; and comparative results in areas such as immunisation and screening

A Local Supplement which examines the determinants of health across Canberra's suburbs such as public transport utilisation and the extent to which residents can easily work to civic services such as health care, shops and schools

A Consultation Report containing key findings from interviews with over 70 organisations representing community agencies, peak bodies, government services, private sector and primary care professionals in the ACT. They were asked if they thought there any gaps in services, unmet need in the community and where improvements could be made to primary health care."

The distinction between local, regional and national planning creates an interesting tension: it seems obvious that the most effective planning unit is a small, geographically defined one. Yet the most recent research focuses on national (or state) planning (DA-CCP). One possible explanation is that as our quantitative, mathematical and epidemiological science has advanced, new quantitative modelling involving advanced statistics have been developed and forecasting models drawn which require substantial technology and resources. Thus, these are done at a state or national level, as a local community would not have the resources to plan using these kinds of tools. Indeed, as pointed out in Working Paper # 2 there are considerable data and technological requirements for local area planning in rural and remote areas. This appears to be the nub of the problem. Hence we find that technical planning is currently largely undertaken at national or state level, despite the literature focusing on the importance of local planning. In addition the reliance on epidemiological and quantitative modelling tools (due to their advancement) occurs despite the literature demonstrating that consultative processes and engagement with communities is essential.

A number of key informants noted the importance of local state/territory context, which raises the question about whether national treatment planning can inform specific state/territory funding decisions (irrespective of whether the funder is the Commonwealth or the state/territory). The view was expressed that sometimes national priorities do not meet state/territory needs: "If there were national priorities, what meaning do they have for a state like [X] …. Planning needs to take account of where the state/territory is at". It is likely that there will be different priorities for different jurisdictions. In this sense, treatment planning needs to be conducted on a scale such that the needs, gaps and context are taken into account. This is where the distinction between strategic planning and technical planning may be helpful.

There is a further complexity though – the argument for local or region-specific planning. As key informants noted, health departments are moving towards "local communities having responsibility for planning, based on the premise that local communities know their own needs". We were provided with examples of regional/local planning in mental health. Regional AOD treatment planning is occurring in both Victoria and Western Australia where some significant reforms in AOD treatment have been underway.

It appears that key informants supported local/regional planning focus but reminded us that this can only work well when "appropriate structures and resources exist". Statewide services (eg residential rehabilitation) need to be configured into any local planning process. In addition, our client group can seek treatment from across regional boundaries: "We recognise that clients are transient and do not limit service provision by location. People can move across boundaries". This needs to be taken into consideration in discussion of the appropriate level of planning (and applies equally between state/territory planning).

One final level of planning is that which occurs at the individual service provider level. Service planning should occur as a routine part of agency activities (and links to the Quality Framework requirement for services to be active data collectors/evaluators). We note that in the 2012 Commonwealth AOD treatment funding round, services were required to identify how their proposal met the needs of their population (see Working Paper # 4). In the SMSDGF guidelines for the open rounds, applicants needed to demonstrate "identified need". In this sense the Commonwealth relied on the applicants' own needs assessment processes. This is a possibility to consider, although no key informant argued that service level planning would be sufficient by itself.

Current planning for AOD in Australia
It should be noted that while the extent of planning as described below, may seem minimal there are actually very few areas of healthcare that engage in comprehensive planning.

National AOD treatment planning

Strategic planning around AOD treatment in Australia is arguably achieved through the National Drug Strategy. Some key informants noted the National Drug Strategy as an overarching strategic plan, and noted that we "need national oversight and consistency". The current National Drug Strategy 2010-2015 (NDS) is built on three pillars, the first of which, demand reduction, pertains to both prevention and treatment: "demand reduction to prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol and the use of tobacco and other drugs in the community; and support people to recover from dependence and reintegrate with the community" (Ministerial Council on Drug Strategy, 2011, p. x). "Planning and quality frameworks for treatment services" was identified as a structural priority for the NDS 2010-2015 (there were 4 structural priorities: the internet, data collection, and links and coordination with mental health services were the other three). There are specific actions under each of the pillars. The actions of relevance for treatment planning per se as specified in the NDS 2010-2015 are:

- Develop planning models for treatment services that anticipate needs.
- Develop new evidence-based national planning tools to help jurisdictions better estimate the need and demand for alcohol and other drug health services across Australia. This should include the full spectrum of services from prevention and early intervention to the most intensive forms of care, and a range of services across the life span (Ministerial Council on Drug Strategy, 2011).

We examine the extent to which the current NDS provides a strategic plan for AOD treatment in Australia in Chapter 13.

For technical planning, the development of DA-CCP has been the first attempt to develop a decision-support tool for planning which provides a nationally consistent approach. DA-CCP can model the potential quantity and type of AOD services required, along with the resources required to deliver such services. Chapter 8 covers this in some detail. In order to plan for how much AOD service to provide, an estimate of the current treatment utilisation is required (Chapter 7) which is then compared to the national treatment utilisation under an ideal system (Chapter 8). We used DA-CCP to generate estimates of the ideal or optimal amount of services at a national level (see Chapter 8). DA-CCP models the potential demand (number of people) who could be in receipt of treatment in any one year, nationally. As seen in Chapter 8, this may amount to 400,000 to 500,000 more people than currently receive treatment. Despite the significance of DA-CCP in generating these estimates for the first time in Australia, more is required in relation to planning, because of inherent limitations in any one approach (such as DA-CCP). As noted above, multiple methods are required, which then triangulate the information across sources.

DA-CCP was not used as a planning tool in the last Commonwealth funding round. The priorities for the two funds (NGOTGP and SMSDGF) were determined on the basis of history. No changes were made to the priorities for the NGOTGP 2012 funding round; the SMSDGF priorities were determined from the original fund sources (see Working Paper # 4).

State/territory AOD treatment planning

There are a variety of processes in AOD treatment planning in jurisdictions across Australia. For our purposes, we focus here on planning for the provision of AOD treatment, rather than the planning that occurs in relation to overall AOD policy (eg state/territory drug strategy documents), although we note that in most jurisdictions, treatment planning articulates up to higher-level strategy documents (including AOD policy, but also other policy planning documents). The data reported below come from our interviews with state/territory health departments and AOD peak bodies. It does not represent a systematic review of all planning processes across each jurisdiction, but rather the perceptions of planning processes, from those we spoke with. The information presented below has not been cross-checked with each jurisdiction. (This information is also summarised in Chapter 11, along with purchasing and contracting arrangements for each jurisdiction).

In the NT, according to our key informants, planning is limited. There have been many consultations and mapping exercises over the years, but it appears that these are not necessarily then linked to plan the rollout of services.

Planning structures and processes are evolving in Queensland, following the disaggregation of planning and government services funding and provision from a central to catchment-based arrangement (HHS), although AOD services are yet to be fully devolved to the HHS. Queensland is undertaking AOD NGO treatment commissioning at present, although details of planning processes associated with this were not reported to us.

In Victoria, until recently planning was ad hoc and not always integrated, according to our key informants. The AOD reform process underway at present seeks to address the fragmentation. The reform includes a catchment-based planning function which will assist in configuring local responses and contribute to system planning. Demand modelling is informing statewide planning. The consultation and planning process for the reform involved key stakeholders.

WA has undertaken a comprehensive planning process, including the use of DA-CCP as one planning tool. A 10-year plan is being developed, involving a sector framework. Development is happening collaboratively between the sector and the Drug and Alcohol Office. There was a workshop for the sector in October 2013 where the framework for the plan was introduced and discussed. The goal was to have developed a plan by end of December 2013, and the details by April 2014. Engagement of stakeholders and regular meetings and consultations are being held. The planning framework is said to have identified gaps and interventions.

In South Australia a major planning process was undertaken for the 2011/2012 funding round, commencing with the internal review of treatment services in 2009 which provided an environmental scan and considered the evidence-base. More recently annual forums between SA Health and the non-government sector have included Drug and Alcohol Services South Australia (DASSA) preparing maps of all AOD services and accredited GP prescribers. DASSA has also trialled DA-CCP as one decision-support tool.

In Tasmania, our key informants noted the absence of robust needs analysis. A five-year plan was developed, with significant consultation which identified service gaps, and where capacity building

was required. This informed Tasmanian government purchasing of both government and NGO services.

In NSW, we were advised that the Local Hospital Networks are responsible for planning and decision-making about AOD priorities for the government services. The role of the central ministry is in assisting these planning processes, for example the development of models of care for detoxification. Evaluations are used to inform decisions about treatment services. For the NGO services, planning is undertaken on a very small, local scale if at all. There is currently no endorsed NSW Health AOD Plan (it is under development at present).

In the ACT, we were advised that the government uses evaluation data and expert reviews to assess the service system and plan for treatment services. There is documentation regarding the current priorities. One-off planning processes are also undertaken. The ACT conducted a review of treatment service needs. This review included stakeholder consultation. The overarching strategy to help inform treatment planning is the ACT ATOD Strategy (whole of government and community approach).

Conclusions

Key points from the review of the literature, key informant data and our own analysis:
- AOD treatment planning facilitates an understanding of the needs of a population in relation to AOD treatment and provides a coordinated and comprehensive mechanism for the efficient allocation of resources to meet a specific goal or goals.
- There is strong commitment to effective AOD treatment planning in Australia.
- The consensus appears to be that planning processes need input from the two primary funders — Commonwealth and state/territory governments; in a 'joined up' fashion.
- There is also consensus that service providers and consumers (current and future clients) be engaged in AOD treatment planning in Australia.
- A useful distinction can be drawn between strategic planning and technical planning.
- Strategic planning involves high-level agreement on values, goals and priority areas, and is a good fit with a leadership role for the Commonwealth.
- Technical planning involves specifications of the service types and populations in need of treatment and the required array of services to meet needs, usually best undertaken for defined geographical areas (eg, jurisdictions).
- Planning is a difficult and complex undertaking that can be resource intensive.
- Australia has a national quantitative technical planning tool, DA-CCP that provides national (and state/territory) estimates of the amount of treatment, types of treatment and resources required to meet demand. This information shows, at a national level, the extent of unmet demand for treatment, but this alone does not enable purchasing decisions.
- DA-CCP is silent on who the purchaser should be (and who the provider should be).
- Gaps remain in our planning tools and data: inclusion of geography and special needs groups are but two examples, along with the need for good consultative processes over and above any quantitative tool
- At present, there are no formal planning methods used for the NGOTGP and SMSDGF, nor the use of pre-defined formulae for funds distribution (eg, per capita distribution across states/territories).
- Challenges for planning include balancing specificity with flexibility, ensuring innovation is not stifled and marrying local needs assessment with regional, state and national needs assessments.
- The respective roles of national, state and local planning processes are currently unclear.

Chapter 10: Accountability: Contract management, performance and financial monitoring

Introduction

The purpose of this chapter is to document and assess the mechanisms by which the Commonwealth demonstrates public accountability for AOD treatment funding through contract (or agreement) management, the ongoing relationship with grant recipients, performance and financial monitoring. The chapter connects with preceding chapters on the existing funding mechanisms and what is being purchased.

The chapter commences with a discussion of accountability for public funding in these domains and what we know of NGO contracting in Australia, before summarising the current departmental reform process in this area. It then describes the accountability mechanisms, beginning with the funding agreement, focusing on the funded organisations' obligations around acquitting grants. It discusses the importance of performance monitoring, and the performance measures that could be used. Subsequently we discuss the ways in which the Commonwealth engages with funded agencies in the process of contract management, and finally examine data on a particular issue of concern to the NGO sector, namely the length of contracts.

The Productivity Commission (2010), p.129 explains that the financial, governance and performance information that is required to acquit/obtain funds (through grants for example) is but one of four types of reporting to government agencies undertaken by the not-for-profit sector. The remaining three include; corporate and financial reporting associated with the legal structure under which agencies are incorporated, requirements of fundraising legislation, and information required for endorsement for concessional tax treatment. The Productivity Commission noted that the requirements vary, often significantly, between the four reporting mechanisms and stressed the capacity to "scope for greater consistency in reporting requirements and for sharing of information across agencies". For the purpose of this chapter, however, our focus remains on the accountability mechanisms attached to the Commonwealth's AOD treatment funds.

Our qualitative analysis is based on data collected from key informant interviews undertaken as part of the rapid assessments, as well as analysis of formal documentation, including funding agreements and publicly-available information on government websites.

At the outset it is important to acknowledge that the Commonwealth's grant management practices have been under reform over the life of this review. The establishment of the Grant Services Division (GSD) in October 2013 saw the Commonwealth centralise many aspects of its grant enabling processes (including aspects of tendering and contract management and performance monitoring) with the goal of streamlining and increasing the consistency of its practices, and reducing red-tape[93]. The GSD has subsumed a number of responsibilities from the state/territory offices of the Commonwealth (STOs) and the policy areas within the Policy Programme Division that are linked with the NGOTGP and SMSDGF P1 granting schemes. Before the establishment of the GSD the STOs operated as 'satellites' in relation to the Central Office. They were not part of any Division. At the time that we interviewed STO staff the STOs had responsibility for all aspects of contract management, performance and financial monitoring. STOs have now been subsumed into the GSD;

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[93] http://www.health.gov.au/internet/main/publishing.nsf/Content/GSD-Grant-Services-Division

they comprise the Regional Service Grants Branch. We discuss the reform process in more detail below.

Accountability for Commonwealth funding

The Commonwealth Grant Guidelines[94] (Department of Finance and Deregulation, 2013) (the Guidelines) establish the policy framework for grants administration. They are part of the financial management framework that assists government to work with the non-government sector. This framework is intended to ensure that Commonwealth resources are used efficiently, effectively, economically and ethically to achieve Commonwealth policies[95]. According to the Productivity Commission (2010, p. 321), frameworks such as this "should provide an appropriate basis for government agencies to weigh up the costs and benefits of alternative approaches to meeting their requirements".
The Guidelines (p. 52, 12.1) state that "granting activities … should be underpinned by solid governance structures and clear accountability for all parties involved in grants administration". They advise that grant agreements should:

> clearly document the expectations of all parties in relation to the grant; including a clear understanding between the parties on required outcomes, prior to the commencement of grant funding; appropriate accountability for public money, which is informed by risk analysis; agreed terms and conditions in regards to the use of the grant, including any access requirements; and the performance information and other data that the recipient may be required to collect as well as the criteria that will be used to evaluate the grant, the grant recipient's compliance and performance (p. 54, 12.8).

Furthermore, the Guidelines recommend that "grant agreements are supported by ongoing communication, active grants management and performance monitoring requirements, which are proportional to the risks involved." (p. 56, 12.2). As the public management literature observes, accountability in this context is generally described as a power relationship where an accountability holder, in this case the Commonwealth, has the right to information, auditing, and scrutiny of the actions of an accountability giver, the funded agencies providing treatment services (Mulgan, 2002). More recently, researchers have recognised that the relationship may not be so simple. Non-government organisations have multiple accountability relationships; for example with communities, funders and professionals (Tenbensel, Dwyer, & Lavoie, 2013), each of which needs to be balanced against the other. The funded agency will not necessarily regard their accountability to the funder as the most important accountability relationship or the relationship that must take priority in day-to-day operations (Dwyer, 2004).

This tension between accountability relationships was echoed in the comments from key informants from the Boards of peak agencies representing the NGO sector. And yet, as one key informant from the NGO sector acknowledged in relation to Commonwealth funding, "we do need accountability measures. If we say we're going to do something we need to show we did it."

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[94] The Commonwealth Grant Guidelines (CGGs) are a legislative instrument issued by the Finance Minister under section 64 of the FMA Act and FMA Regulation 7A. Regulation 7A requires staff members to act in accordance with the CGGs when performing duties in relation to grants administration.
[95] See section 44 and Regulation 9 of the Financial Management and Accountability Act 1997. From 1 July 2014 the Public Governance, Performance and Accountability Act 2013 will come into effect in Australia. It will replace the Financial Management and Accountability Act 1997 and Commonwealth Authorities and Companies Act 1997. Under the Act Australian public service entities must: cause records to be kept that properly record and explain the entity's performance in achieving its purposes; measure and assess the performance of the entity in achieving its purposes and prepare annual performance statements for the entity, provide information about the entity's performance in achieving its purposes.

Commonwealth contracting of not-for-profits in Australia

Since 1995 there have been seven major reviews of the not-for-profit sector, culminating with the Productivity Commission Research Report on the Contribution of the Not-for-Profit (NFP) Sector released in 2010. This report was commissioned by the Rudd Labor government, as part of its agenda to mend the fraught relationship between the Howard government and the NFP sector involved in human service delivery (see Butcher, 2013 for a discussion). The Productivity Commission (2010), which canvassed the views of the sector and government on a range of issues including those pertinent to this chapter, received a clear message from the sector that government tendering, contracting and reporting requirements "impose a significant compliance burden and constraint on efficiency and effectiveness of service delivery". The sector was frustrated that these requirements did not seem to improve service delivery outcomes for clients; rather they limited the ability of funded agencies to innovate and respond. The Productivity Commission also highlighted the gulf between how governments and the NFP sector perceived their relationship. In the delivery of human services, around 80% of government agencies saw their engagement as a 'partnership' whereas the NFP sector saw government agencies having the upper hand (Productivity Commission, 2010). According to Butcher (2013), these concerns have been echoed in a number of state government reports (Auditor General Western Australia, 2000; PAEC, 2002; QAO, 2007; VAGO, 2010; in Butcher (2013) and studies from 'think tanks' and university-affiliated research centres (Edgar, 2008; Maddison et al., 2004; Melville, 2003; in Butcher (2013).

The findings of the Productivity Commission are thought to have been integral to the Rudd and Gillard Labor governments' reform package, which was intended to mend relationships and enhance partnerships between the NFP sector and government. As part of the flow of reforms, the Labor government established the National Compact (a policy framework designed to establish new rules of engagement between government and the not-for-profit sector), the National Office for the Not-for-Profit Sector in the Department of Prime Minister and Cabinet and, subsequently, the Australian Charities and Not-for-Profits Commission (ACNC) as the independent national regulator of charities. One of the objectives of the ACNC is to work with state/territory and federal governments and agencies to develop a 'report-once, use-often' reporting framework for charities[96]. With the advent of the Abbott Liberal government, the National Office for the Not-for-Profit Sector has been disbanded and not-for-profit and volunteering functions transferred to the Department of Social Services. The process of disbanding the ACNC is also in train (Butcher, 2013). The Senate referred the Australian Charities and Not-for-profits Commission (Repeal) (No. 1) Bill 2014 to the Senate Standing Committees on Economics, and a report was tabled on 16 June 2014. The committee recommended that the bill be passed, on the basis that it would relieve the regulatory burden faced by many charities[97].

Regardless, the Productivity Commission's (2010) findings foreground our information gathering. They have established a framing for discussion about contract management in Australia and it is perhaps unsurprising that many of the findings were echoed in the data we collected. A disappointing aspect of the Productivity Commission report was that it made no clear recommendations as to how the problems of contract management could be alleviated.

Here we summarise the key Productivity Commission (2010) findings pertinent to this chapter.
- Government efforts at tighter control and measurement through funding agreements and reporting requirements have become more detailed and prescriptive. The administrative

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[96] http://www.acnc.gov.au/ACNC/About_ACNC/ACNC_role/ACNC/Edu/ACNC_role.aspx?hkey=88635892-3c89-421b-896d-d01add82f4fe.
[97] http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Economics/ACNC/Report/index.

load favours larger, bureaucratically-sophisticated organisations, which is contributing to a loss of diversity in the sector.

- More detailed, more uniform, reporting mechanisms lead to a reduction in local autonomy and a decreased ability to harness local knowledge.
- Service contracting is largely driven by measuring outputs rather than the quality of the services being delivered.
- The NFP sector believes that the imposition of more complex contractual and reporting requirements (commonly known as 'red-tape'), has been driven by government departments and agencies seeking to reduce risk by transferring it to the NFP sector, rather than managing the risk themselves.
- There is also a suggestion that poor risk management may result in an inappropriate transfer of risk to the NFP sector; which is not compensated for taking that risk.
- There is a sense that the burden of contractual and reporting requirements is often disproportionate to the government funding that organisations receive and the risks involved. Nor do they lead to improved outcomes for clients.
- Intriguingly, while on the one hand the increased reporting requirements are seen to transfer risk to the NFP sector, there are those in the sector that doubt whether the information they provide is used. The sector would like to see the data used and analysed, and provided back to the sector to help providers modify service delivery for client benefits.
- The NFP sector bemoans the lack of consistency in contracting and reporting within government departments and between government departments at both jurisdictional levels. With multiple sources of funding this increases the administrative burden.
- Some in the NFP sector are concerned that the government has been inappropriately using contract management as a way to "probe into the management, operating methods and broader community activities" of agencies.
- There was also concern that the micro management reduced the ability of the NFP sector to respond to changes in client needs and changing conditions.

The establishment of the Grant Services Division (GSD) of DoH in October 2013; and the move to streamline and increase the consistency of its practices, and so reduce the red-tape faced by funded agencies, can be seen as a response to some of the issues of concern identified by the Productivity Commission. We outline what has taken place, based on data from key informants from the Commonwealth, below. Before that, however it is important to restate the seven Commonwealth Grant Guidelines principles of better practice grants administration outlined in Chapter 1: robust planning and design; collaboration and partnership; proportionality; an outcomes orientation; achieving value with public money; governance and accountability; probity and transparency.

Reform in Commonwealth contract management and performance and financial monitoring

A key informant from the Commonwealth identified two principles from the Guidelines as key to the recent reform; specifically – proportionality and an outcomes focus. The proportionality principle states that the Commonwealth should design a granting activity so that it is commensurate with the scale, nature, complexity and risks involved in that activity. The outcomes orientation principle reminds the Commonwealth to design and implement granting activities that encourage grant recipients to focus on achieving the outcomes that government policy requires while seeking the most efficient and effective use of inputs.

According to the GSD website, its key role is to "support the Australian Government's commitment to ensuring ethical, economical, effective and efficient use and delivery of funds for services through a sustainable and consistent approach to grant administration". Its goals are to: i) create rigorous, systematic and consistent ways of managing the business of the Commonwealth; ii) promote and

continue to strive for better practice in grant administration, including reduction of red tape for grant recipients; and iii) provide quality grant administration services to all grant recipients and the department's policy and program areas[98].

As part of the reform process, standardised funding agreements were introduced in 2013 and it is intended that there will be changes to performance monitoring to reduce the burden on funded agencies where possible through the adoption of a risk-based approach to grants management. The risk-based approach consists of risk assessment and management at the grants program design, service provider selection and management of funding agreement stages. The five areas to be assessed for risk are: the provider's ability to deliver the services to the required standards; the provider's ability to manage the agreed service delivery activities to agreed standards; the provider's policies and processes associated with service delivery (quality assurance processes, complaints handling); the provider's ability to remain viable over the life of the funding agreement; and the provider's ability to manage grant funding (financial management)[99]. We were informed that a 'Risk Rating Process' is still under development. The intent is that during the establishment of the contract with funded agencies the "risk at program level and at provider level" will be determined. Once a risk level (low, medium, high) is assigned to a project, projects of similar risk will be managed in consistent ways. Consistent with the proportionality principle, contract management of low risk projects could be considerably less intensive than is currently the case. Agencies funded for low risk projects will be required to do less reporting as well.

There are five branches within the GSD. The National Programs Branch has responsibility for the grant assessment process (selection of agencies to be funded), and ensuring legal compliance with contract conditions for grant programs like NGOTGP and SMSDGFP1. Whereas previously the grant assessment process was embedded in policy areas; aspects of it have been centralised. The policy areas retain policy development and control the grant scheme budget. They still make the final decisions on where the money goes. Centralisation ensures that approaches are not radically different, but there will continue to be recognition that the Commonwealth funds diverse organisations for diverse services. The Commonwealth is mindful of the particularities of the various funding schemes and services purchased. It is intended that the GSD will liaise with the policy areas related to the funding scheme; the policy areas will provide relevant policy and technical support. The grants officers based in the STOs will continue to manage the relationships with grant recipients (the day-to-day administration), assessing performance, compliance and whether deliverables are being met.

Contract deliverables

Romzek & Johnston (2005) stress the importance for accountability effectiveness of the contract, specifying "clear and mutually understood specification of each party's contract obligations and how the contractor's performance will be assessed".

Clarity of obligations
Each funded organisation contracted by the Commonwealth under the NGOTGP or SMSDGFP1 schemes has one contract, known as a funding agreement, regardless of the number of projects/programs funded by DoH. The funding agreement contains a deed and individual schedules for each funded program/project/grant. On 22 November 2012, the Department of Health released a new Standard Funding Agreement (SFA) for the majority of its grants. The intent of the SFA was to eliminate multiple individual funding agreements being offered to service providers by using a single,

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[98] http://www.health.gov.au/internet/main/publishing.nsf/Content/GSD-Grant-Services-Division
[99] http://www.health.gov.au/internet/main/publishing.nsf/Content/gps-risk-management

consistent set of Terms and Conditions for most of its programs. In some instances, the SFA will include program specific Supplementary Conditions[100].

It is not our intention to consider all obligations spelled out in the funding agreements. Our primary concern is with the obligations around the Commonwealth's payment of grant funds and performance monitoring. As explained in Chapter 6, agencies are block funded. The Commonwealth distributes tranches of funding or payment to funded agencies when they meet certain performance obligations. According to Section 4 in the Deed the Commonwealth may, at its discretion defer, reduce or not make a payment if the funded agency has not met its obligations or it underspends.

A Schedule is created for each funded project/program. For NGOTGP and SMSDGF P1 grants there are standard schedules for each organisation and project. An Action Plan forms the basis of the Schedule.

The deed contains requirements for the funded agency around the performance of the project including the obligation for funded agencies to submit an Action Plan and to undertake what is set out in that Action Plan, once it has been agreed on by the Commonwealth. The Action Plan includes Strategies, Key Activities, Outcomes, Performance Indicators, the Budget, and Timeframes (where appropriate) against objectives in line with the template to be provided by the Commonwealth. It also includes reporting requirements (when to report, who to report to, and what to report). It is the responsibility of the STO to assess the Project Plan against the Project Aims and Objectives from the grant application.

The budget can include line items for salaries, on-costs, service delivery costs (operating including line items for motor vehicle, consumables etc); and administration costs (insurance, utilities, rent). Funded agencies are required to spend funding "in accordance with the proportion shown" in the Schedule, although NGOS can vary total expenditure for each line item by up to 10% of line item or $10,000, whichever is greater, as long as total Budget is not increased.

The Schedule states that the Commonwealth:
- Can request changes to the Action Plan or Budget, and if it does the NGO must consider and respond in good faith and take the best endeavours to make that change to the Commonwealth's satisfaction
- Can approve, or not approve, an Action Plan/Budget and resubmissions of same in its absolute discretion
- Can request an Agreed Action Plan or Budget be updated or changed and Participant must consider and respond in good faith.

Specifically, agencies receive a tranche of money on execution of the funding agreement. They are given a month or two to establish the Project Plan for the life of the funded project and receive a further tranche of funds once the Commonwealth accepts the Project Plan. Subsequent tranches of funding are paid to the funded agency subject to it submitting six-monthly Progress Reports against the Project Plan (known as Annual Reports at the 12 month marks) and six-monthly statements of income and expenditure, as well as annual audited financial statements.

Organisations receiving funding under the NGOTGP are also contracted to provide data on all closed treatment episodes in a financial year for the Australian Institute of Health and Welfare (AIHW)-managed Alcohol and Other Drug Treatment Services-National Minimum Dataset (AODTS-NMDS). Each annual report is to be based on the template provided by the Commonwealth. All publicly-

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[100] http://www.health.gov.au/internet/main/publishing.nsf/Content/gps-standard-funding-agreement

funded treatment agencies, whether the treatment provider is a government organisation or a non-government organisation, are required to report to the AODTS-NMDS. A treatment episode is considered closed when:

- the treatment is completed or has ceased
- there has been no contact between the client and treatment provider for 3 months
- there is a change in the main treatment type, principal drug of concern or delivery setting.

There is no consistency in the method of reporting NGOTGP funded activities across the states/territories or even within some states/territories. In the ACT for example, the data are provided to the ACT health department, which then submits it direct to the AIHW. In NSW, there is quite some confusion as to reporting. NGO members of the Network of Alcohol and Drug Agencies (NADA) in NSW provide their data to NADA which provides the compiled data to the NSW health department and thence on to the AIHW. Organisations that are not members of NADA provide their data direct to the NSW health department. In Victoria the data are provided to AIHW via the Alcohol and Drug Information Service, whereas in Tasmania the funded organisations seem to provide the data direct to the AIHW.

In any case, if the funded organisation receives funding from both the Commonwealth and State/Territory the organisation is required to collect data and provide it to the state/territory health department. The state/territory health department provides the data to the AIHW.
It is clear that neither STOs, nor the Commonwealth have access to the data at the individual funded organisation or project level. It is also clear that the data are not used to monitor the performance of funded projects, nor of the grant programs as a whole. The data do not include the performance indicator information reported in Progress Reports; based, as they, are on completed episodes of care. The NGO treatment sector also has concerns with the data collection, in terms of its representation of treatment activity. For example, data on comorbidity treatment are not collected. Progress reports must contain a description of performance against the Project Plan, including information on the whether project's aim is being achieved and reasons for not performing to plan, if that is the case.

Annual reports must use the template provided by Commonwealth and contain:
- An assessment of the project's performance against objectives, strategies and key activities in the approved project plan
- An outline of the key strategic partnerships and register of communication and consultation with relevant service providers
- An outline of the continuous quality improvement activities undertaken
- For Commonwealth-only-funded services, confirmation that the obligations in regard to AODTS-NMDS reporting (for example) have been met, or a copy of the data collected over reporting period.

The progress reports are read by STO staff and it appears that the STO staff's approval of the progress reports trigger the payments. We were advised that the implication of not "meeting the reporting requirement" is for funding payments to be delayed. We heard of few instances when funding payments were delayed. However, the meaning of "meeting the reporting requirements" is unclear, as is the way in which the reporting assessments are undertaken and feed into payment decisions. Some STO key informants explained the process in terms of assessment against the performance measures, which we discuss in a later section. Nonetheless, according to another STO key informant the role of the contract manager is to mediate and to minimise events like this happening rather than delay payment. Other STOs reported that payment was automatic on the funded organisation delivering their progress report.

A Commonwealth central office key informant explained the current process, "once grant officers are satisfied that the funded organisation has undertaken what it said it would in the Project Plan; that the budget is on track, and the performance measures achieved, or that steps are in place to get back on track; they OK the payment". Furthermore, we heard that, in future, as part of the Commonwealth's reform process, while progress reports will still be required ("to see how funded organisations are travelling"); the milestone payment and deliverables will potentially be delinked. We were told that payments for a funded helpline, for example, could be more or less automatic, whereas if a funded project is designed to proceed in stages, payment for subsequent stages would depend on successful completion of preceding stages.

Some key informants representing the NGO sector expressed their uncertainty about how the information they provide to the STOs was used. Some regarded the delivery of the progress reports and financial reporting as 'a tick on a page' to get funding. In the opinion of one key informant reports for SMSDGF P1 and NGOTGP funding were not read by the STO. It was only reports for SMSDGF P2 funding, funding for Aboriginal and Torres Strait Islander services, that were read. Yet, most key informants were concerned that the activities of funded agencies were monitored against their Project Plans and they took seriously the potential consequences of not meeting their stated actions.

Just as the Productivity Commission found, we heard from key informants representing the NGO sector that:

- Contract management and reporting could be quite onerous and involved a substantial cost to agencies, especially to small agencies.
- Some larger NGOs have invested in administrative systems to deal with the burden of reporting.
- It would be good to see the State and Commonwealth working together to develop consistent approaches in reporting. As one key informant explained, meeting the reporting demands can have implications for service delivery "with multiple funding sources, which have different timeframes for reporting, and different reporting and data requirements, it is hard to maintain a rhythm of service delivery".
- It could be more useful to report at the organisational level than at the individual project/program level.

Case example: Organisation A
(See Part 3 for full details)

Over time the organisation has built up a single client and contract management system. This has streamlined reporting, particularly when clients are engaged in multiple programs across the organisation's activities. The system has been developed such that reports can be generated in different formats for different departments and funders. The management system also has a grants management component, whereby all the deliverables of a funding contract are logged into the system, so every time an acquittal report is due it can be managed and deliverables can be easily tracked. Given that the organisation is applying to over 100 trusts and foundations every year, and having 20-40 of those requests successfully funded, it was noted that it was essential to have systems for managing all these funding contracts at different stages. In one participants' opinion, the system makes managing the multiple funding environments possible.

Despite the sophistication and integration of the system developed by the organisation, it was noted by several participants that it would be beneficial for government departments to streamline funding reports and systems across the whole of government because reporting against multiple contracts with multiple government departments becomes "a nightmare". It was noted with frustration that every government department has a different standard contract format ("it is a waste of time"). It was suggested that the core part of government contracts should be the same, and only the schedule should change. There was the

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perception that there are a lot of inefficiencies that could be improved with the government contracting. Participants also noted with frustration that rarely do the funder's contract managers stay in their role for very long. Personnel changeover is disruptive, time-consuming and problematic for the continuity of relationships with funders.

A Commonwealth key informant explained that the Commonwealth had recognised the potential for reporting burden and had made deliberate steps to reduce that burden in the last funding round by ensuring that all organisations had the same templates for progress reports for each funded project. The key informant also noted the promise of the introduction of the risk-based approach to contract management to further reduce the cost of contract management and reporting on those projects judged to be low risk.

The double burden felt by organisations funded by both the Commonwealth and state/territory governments is discussed later in the chapter.

Establishing suitable deliverables and performance measures for accountability

Accountability effectiveness depends crucially on setting realistic and suitable performance measures and deliverables (Romzek & Johnston, 2005). In this section we consider what sort of deliverables should be included within a contract for SMSDGF and NGOTGP funding and the role of performance measurement in those deliverables.

Tenbensel et al. (2013) describe four forms of accountability:
- Input accountability, which covers the situation where funding is attached to paying staff, buying materials, and renting office space
- Process accountability represents the situation where accountability is defined in terms of procedural requirements (such as timeliness of service satisfactory completion of reporting)
- Output accountability, where funded agencies provide services that can be counted
- Outcome accountability, where the tangible impact on the community/clientele is monitored.

Alternatively, accountability can be conceptualised in terms of performance measures, which have been categorised into three types by Hall & Rimmer (1994). Activity indicators relate to output accountability and measure the work undertaken (eg, the number of patients treated). Efficiency measures consider the relationship between inputs and outputs (e.g. the unit cost of providing a service). Pertaining to outcome accountability, effectiveness indicators are concerned with the extent to which objectives have been achieved through consideration of outcomes, such as change in treatment recipients' behaviour.

There is significant debate both internationally and in Australia about the advantages and disadvantages of using the various performance measures.
The performance measure should marry with what the government is purchasing. Most commentators argue that, in theory, outcomes should be the preferred focus on the basis that governments want to purchase health outcomes, and should not be concerned with how those outcomes are achieved (as this is the provenance of the professional service providers). However, output and process accountability remain the norm because outputs and processes are things that the provider is more unambiguously able to control and measure (whether they are meaningful or not for client outcomes Tenbensel et al., 2013). The reality is that, for many health services including AOD treatment, it is simply not possible to specify a causal pathway between a specific intervention and an outcome. In an ideal world, performance measures should concentrate on what is being

purchased: quality of care, cost savings, innovation and continuous improvement. Goldsmith & Eggers (2004) note how hard this can be.

It is also salutary to note that the Australian health care system more generally does not pay for outcomes: activity-based funding is output-based funding (not outcome-based funding); Medicare is also output-based funding (see Chapter 6)[101]. As Epstein (2013) argues, the choice to try to define specific performance metrics or outcome-based goals is problematic in and of itself. Service providers will work to comply with the requirements of the contract, but will ignore other elements of service quality or adherence to broader program goals.

Having said this, we should note the distinction between paying by outcome (setting outcomes as deliverables) and performance monitoring on outcomes. Performance monitoring can be undertaken on outcomes without need for the payment to be contingent on achievement of the outcomes. There are reasons for the Commonwealth to consider outcome-based performance monitoring. It needs to show that the grant funds are achieving 'value for money'. One of the Commonwealth Grant Guidelines principles states that funded agencies should focus on achieving government policy outcomes (Department of Finance and Deregulation, 2013). Granting activities should be designed and implemented so that grant recipients focus on outcomes for beneficiaries while seeking the most efficient and effective use of inputs. As we outline below, there were many amongst the key informants who voiced a preference for measuring outcomes over activity/output for knowing what the funded project achieved..

In our judgement, based on key informant data, the performance indicators associated with the NGOTGP and SMSDGF P1 projects are a hybrid – they are primarily output based (eg, number of clients entering the program, retention rate, bed occupancy rate), although some outcome measures may also be included (eg, number of clients reporting reduced primary drug use, number of clients engaged in training/employment at end of program and three months later). There is limited recourse to clients to determine the effectiveness of a treatment program (eg, client satisfaction with program, client perspective on success in treatment). Quality of service provision performance measures include the funded organisation's accreditation status, staff training, and evidence that staff are using relevant evidence based treatment guidelines.

The funded organisations help develop the list of performance indicators for their own projects under both schemes. In establishing the project plan they are required to propose a list of performance indicators. The NSW STO provided us with the 2012-2015 Project Plan template that the Commonwealth provided to funded organisations to assist in that process. The template outlines the objectives of the NGOTGP and SMSDGFP1 schemes and provides the following five shared project goals:
1. Deliver drug and alcohol treatment services and reduce drug-related harm for individuals, families and communities
2. Provide a high quality alcohol and drug treatment service, including maintaining existing capacity within your organisation
3. Ensure your service meets the specific needs of target groups (such as women, youth, families with children, and Aboriginal and Torres Strait Islander people)
4. Support clients through the treatment journey through internal services and referral pathways/linkages (such as legal, employment, medical, child and family care, housing etc)
5. Enhance service capacity to deliver appropriate services and treatment to clients with complex health and social needs including mental illness.

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[101] This reinforces the important distinction between a method of payment to service providers (Chapter 6) and monitoring and accountability against goals. These are two separate things, and while Chapter 6 finds the payment methods linked to outcomes is not evidence-based, here outcomes monitoring may form an important part of accountability.

Funded organisations are asked to list for each of these five goals:
- Examples of the associated strategies
- Key activities relating to those strategies
- Timeframes for activities
- Associated outputs/outcomes and performance measures.

We were advised by the NSW STO that projects do not need to address all five goals – some small projects only address two goals. Exemplifying consideration of proportionality in contract management; the NSW STO, for example, has encouraged NGOs with multiple projects to only report on the goal of providing a high-quality drug and alcohol treatment service once.

Although not a widespread concern, some key informants told us that the national nature of programs means that templates and guidelines are overly generic and broad. There is a tension between allowing enough flexibility to create performance indicators relevant to a project and funded treatment provider and providing the Commonwealth with information adequate for judging performance. As a key informant from the NGO sector explained, there cannot be standardised measures across the sector, because services and modes of treatment are so different and there is no way to make a comparison. "Even within counselling there are different models of treatment and different target groups".

Yet, reliance on the funded agencies to develop the performance measures comes with its own challenges. As noted by a key informant from an STO, "it takes real skills to develop good performance measures". In that key informant's experience, NGOs have varying degrees of ability in this area. We learned that Project Plans that STOs received were not always well described and that they vary considerably between NGOs, even between NGOs providing the same service. Some NGOs use a narrative approach while others propose quantifiable measures. In making assessments against the Project Plans one STO key informant noted that the performance measures are not always demonstrable against project objectives.

With regards to the question of what performance measures would best assist Commonwealth efforts to understand the value for money of projects, possible options were canvassed. Key informants from some of the STOs expressed a preference for an outcomes-focused approach, rather than the activity- or output-based approach inherent in the current system. Key informants pointed to developments in the ways that state/territory governments were funding treatment. It was felt that, in Victoria for example, a move towards outcome-based performance measurement would occur in tandem with sector reform.

An NGO key informant used the example of counselling to illustrate the preference for outcome monitoring over output or activity monitoring. "Say we offer 12 sessions over 12 weeks, but if after 4-5 sessions there's improvement and the client leaves treatment we have no way of reporting that success back to the Commonwealth". Yet, we were told, there is tension in defining appropriate outcome measures if the focus is on drug use. "For example, a client can stay on program for 12 weeks and have no change in drug use but could have achieved great outcomes in terms of getting a job, and pulling the family back together. Building on those outcomes the client could well go on to give up drugs. At the completion of treatment, we would not be able to report those more holistic outcomes".

Notwithstanding this, the difficulties in operationalisation were acknowledged, and not just the differing abilities of funded organisations to furnish data. Ideally, for example, treatment recipients would be followed up after they left a program/service to capture the long-term effect on their drug use.

With this focus on performance 'measurement', attention tends to be focused on quantitative measures, to the detriment of qualitative reporting; which both the NGO sector and STOs found valuable. As an STO key informant explained, "narrative content provided in service reports gives context to the services provided and often of local AOD/ service/ regional issues".

Key informants from the NGO sector, as well as some STOs expressed the opinion that reporting should be valuable to the NGO and its Board as well as to the funder. In an ideal world, it was felt, the Commonwealth would work with the NGOs to develop a better system of reporting – to ensure mutual benefit from the process.

A key informant representing the NGO sector expressed the opinion that the Commonwealth's recent funding for suicide prevention "worked well" in comparison to the Commonwealth's funding of AOD treatment. The request for tender material asked "How would you measure success?" According to the informant, this "forced us to get qualitative and quantitative domains (including housing and economic outcomes) and translate these to the funding agreement".

There may be lessons to be learned from the approaches taken by state/territory health departments in monitoring their own treatment provision, as well as NGO treatment provision that they have purchased. As outlined below, both South Australia and Tasmania use output-based indicators in performance monitoring of NGO treatment provision, but both are in the process of developing a set of clinical outcomes for treatment provision provided directly by government.

The South Australian health department uses block grant funding to purchase AOD treatment from the NGO sector. It prescribes what evidence-based treatment is to be purchased before going to tender and purchases agreed quantities of treatment provision from a funded organisation. The organisations are required to report on a quarterly basis on sets of performance indicators and outputs as part of performance monitoring. Drug and Alcohol Services South Australia (DASSA) provides funded organisations with reporting templates specific to each service type (residential rehabilitation, counselling etc). The indicators used by DASSA are output, rather than outcome, based:

- Number of available beds (sobering up and residential rehabilitation)
- Number of admissions
- Number of service contacts
- Number of individuals
- Number of individuals commencing treatment
- Number of episodes
- Number of programs /training courses provided
- Proportion of completed episodes
- Bed occupancy ratio
- Mobile Assistance Patrol Indicators
- PDDI service provision and supporting data.

Funded organisations are also required to report on qualitative information (eg, significant events in the period including achievement of work plans, summary comments on the statistics, any issues causing concern). They also provide financial statements. On an annual basis, if DASSA judges that an organisation is underperforming they meet with that organisation to plan how to resolve the issues.

DASSA is working on defining a set of clinical outcomes (which should be in place by the end of 2014) for its own clients and service provision, eg level of substance use, level of mental distress, injecting risk, self-report quality of life.

Tasmania also uses block grant funding. The contract between Tasmania's health department and the funded organisations are informed by the Tasmanian Department of Health and Human Services (DHHS) guidelines around service agreements[102]. Consistent with the Commonwealth approach, DHHS has introduced consistency in the front end of the agreements; each service agreement is the same and Schedules can differ.

Funded organisations must report against performance indicators and the DHHS provides guidelines about how to establish the indicators. Unlike South Australia and Victoria, Tasmania does not stipulate the construct of the treatment it is purchasing. Hence its purchase approach is more akin to that of the Commonwealth.

According to key informants in Tasmania, the indicators have not been benchmarked and can vary markedly between projects. The indicators for a project are primarily established by the Alcohol and Drug Service (Tasmania DHHS), with some consultation with the funded agency. The Alcohol and Drug Service told us of its intent to reform these measures once it has established an effective monitoring mechanism for its own service provision. It recently developed a set of performance indicators for the services it provides.

In the opinion of key informants representing the NGO sector in Tasmania, the agencies report on throughputs, client numbers, completed episodes of care, and other output measures. Furthermore, it was felt that these measures do not relate to the purpose of the funding. There is little consistency in the quality of the service agreements and in what is contracted and reported on. There can be a long list of performance indicators, even for small amounts of funding, requiring substantial investment of time in reporting that is out of proportion to the level of funding involved.

Funded organisations also report against their budgets and, it was felt by some in the Tasmania Alcohol and Drug Service (DHHS), that they would benefit from receiving information on clinical and organisational governance from the organisations to ensure quality of care.

In relation to reporting to the Tasmania Alcohol and Drug Service (DHHS), NGOs do not receive feedback on what they report. That being said, over the past 3 years the department has increased its efforts to engage with agencies; conferring about how the program is progressing, whether there are issues of concern and so on.

Performance monitoring and co-funded projects

The Commonwealth funds a significant number of organisations that are also funded by the state/territory government (see Chapter 5). In these circumstances it can be difficult for funded organisations to tease apart the cause and effect for that part of the project funded by a single level of government. For example, take the situation (described to us during the rapid assessments), where the Commonwealth funds an intake worker who works on a project funded by the state/territory. To provide the Commonwealth with evidence of the intake worker's impact firstly requires an understanding of the impact of the entire project. Then, one approach is for the organisation to estimate which clients, activities, or outcomes (for example), would not have eventuated without the worker's input. Were that possible, the organisation needs to be mindful that the intake worker is attached to a project; the establishment and ongoing viability of which is contingent on state/territory funding. The worker would have no impact without the state/territory funding.

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[102] https://www.dhhs.tas.gov.au/about_the_department/business/community_sector_relations_unit/grants_management

When funded organisations report to the AODTS-NMDS on dually-funded projects we heard of some instances where the organisation apportions episodes of care to the two levels of government in the same ratio as the relative funding split. If, say the Commonwealth contributes 40% of funding, then the organisation will report 40% of the episodes to the Commonwealth. In some instances, we heard that organisations that receive joint funding simply expand the funded service, which adds valence to this approach. However, even in the knowledge that there is excess demand for treatment at an Australia-wide level, this approach does not allow for the possibility (for example) that service provision expands to the point where it more than meets demand for treatment in its catchment area. In that case, the final 40% of funding would not have as much of an impact as the first 60% of funding.

Yet an STO key informant, speaking from the perspective of someone with responsibility for monitoring services delivered by individual projects, thought it would be more useful to learn about the overall outcome of a project, rather than the percentage that the Commonwealth funds. In their opinion, "I'd rather know how the overall service is going, not the 10% we fund".

Even so, the Commonwealth needs to ensure the 'value for money' of its own funding, so the extent to which one funder can or should 'claim' the outcome from a funded project is of vital importance. This speaks to consideration of variants of the Activity-Based Funding model as the Commonwealth's payment mechanism (Chapter 6). In the case of a payment mechanism built around Activity-Based Funding, the ability to apportion outcomes to each level of government would probably come down to the relative proportion of funding.

The implications for funded agencies need also to be acknowledged. As we explained in the introduction to this chapter, the NGO sector has to manage multiple accountability relationships. With more cooperative planning (as discussed in Chapter 9) alignment between jurisdictional expectations of funded projects will be better assured, reducing the potential for conflict in the jurisdictional objectives of funded projects. Where there is overlay in funding (for example the joint jurisdictional funding allows a worker to extend their working hours; or the funded service to extend its opening hours) key informants from the NGO sector also see value in having a single contract to reduce their contract management and reporting obligations.

At the very least, measures could be put in place to reduce the double-reporting requirements. There is support for the need to work with other funders to agree on a single report from the STOs but, as we were told "this is something that needs to be negotiated at higher levels". A Commonwealth key informant from the central office explained that where the state/territory government is investing the majority of government funding to the project the Commonwealth is willing to accept the same type of information that is reported to the state/territory government for its progress report. For example if the agency reports the number of attendances at the agency for a particular project to the state/territory, the Commonwealth will accept this in lieu of another performance indicator that may have been agreed upon in the Action Plan for the Commonwealth. (Duplication is covered in Chapter 12).

Intersection of deliverables and performance measures with purchasing framework

At this stage it is important to understand how the accountability framework and performance-based monitoring intersects with the funding framework. Is it the case that the purchasing framework limits the choice of deliverables and approach to performance monitoring? In Chapter 6 we concluded that there were two feasible funding mechanisms for the Commonwealth; the current block grant funding approach, and a unit cost/fixed price approach – both of which apply when the

Commonwealth directly purchases services. (The Activity Based Funding payment methods apply where the Commonwealth transfers purchasing to states/territories)..

So to characterise the current system for the Commonwealth: funded under block grants, agencies receive their agreed funds over the life of the project contingent on i) the establishment of a Project Plan for the funded project which sets out, amongst other things, performance monitoring measures and ii) subsequent reporting on progress against that Project Plan and financial monitoring. The extent to which the Commonwealth's release of project funds is contingent on an agency's report of achievement against the performance measures (including activity-based and outcome measures) is contested. Regardless, the performance measures have the potential to be used to measure and record the impacts of the Commonwealth's investment; and may ultimately contribute to showing that the grant fund overall is "value for money". We now turn to some state experiences for insight.

Contract management relationships

STO performance monitoring for organisations funded under NGOTGP and SMSDGF P1 revolves around the physical reports provided by the organisations, that is, the 6-monthly progress reports (performance reports and financial reports) and annual reports (where performance is assessed against objectives/approved action plan and audited financial reports). Contract managers within the STOs assess whether the funded project is meeting its activity plan (including performance indicators). The STOs also carry out a financial assessment. According to key informants from one STO, if an organisation is experiencing problems meeting its targets for a project it is required to identify the reasons and develop a plan to remedy the situation.

Goldsmith & Eggers (2004) point out that the management of effective partnerships between government and providers requires a different skill set from the traditional public service roles. It requires highly skilled and knowledgeable contract managers who are given "ample discretion". They state the skill set required is "more like symphony conductors than drill sergeants" (p.158), and conclude "governments do not have enough of these kinds of men and women" (p.155). The Australian Institute of Grant Management's (2011, p. 3) *Grantmaking manifesto* notes that "a good grantmaker brings to the task a specific set of skills and a considerable body of knowledge". Key informants from the NGO sector reiterated these views, in view of the potential role of contract managers in supporting organisations that may be having difficulties establishing or running the funded service. (See also WA case example on the partnerships approach, Chapter 11).

It is clear that there is not consistency across the states/territories in the approaches to grants management. In the Tasmanian STO, for example, one person manages all the funding sources for an organisation; whereas in some STOs contract managers are specific to funding programmes. The Tasmanian STO reports that they have found benefits from this approach: the funded organisation finds it easier to maintain one relationship and it gives the STO corporate memory. This observation has salience in light of Productivity Commission (2010) findings about the inherent difficulties of multiple funding relationships. Yet we learnt from the NGO sector the importance of AOD-sector-specific knowledge to good grant management.

There is also flexibility in the way that STOs manage the risks of poor performance. For example, a key informant from one of the STOs explained that it was their policy, when particularly concerned about a service, to use a range of monitoring strategies that includes visiting them bi-monthly. Using this approach the STO had managed to "progress the NGO during a difficult period".

We heard from a few STO key informants of the feedback they gave to NGOs subsequent to assessing the progress reports and there was a range of perspectives from the NGO sector. While

some in the NGO sector were concerned about insufficient feedback from the STOs, others commended the STO for their feedback.

Key informants from the NGO sector valued good relationships with contract managers and some considered face-to-face contact with STO staff as integral to valuable performance monitoring. The sector also values assistance when a project is staring up. The South Australian Network of Drug and Alcohol Services has established a network of NGO AOD treatment services' project managers, and encouraged government contract managers from both the STO and DASSA to attend.

While the flexibility of contract management practices was no doubt valued by the NGO sector it also leads to concerns about "inconsistent treatment". According to central office key informants, the centralisation reform ensures that there will not be radically different approaches in the future; but there will be continued recognition of the need for flexibility in contract management approaches given the diversity in what and who is being funded. Managing the line between complete consistency and flexibility is not easy.

Case example: Organisation A
(See Part 3 for full details)

It was said that having real relationships with contract managers is important, and that it was especially beneficial if contract managers can visit the program site so that they have a real understanding of what it is the program does so organisations and contract managers can work together to resolve any issues that may arise during the contract period.

In the same vein, concern was expressed by some key informants, both from within STOs and within the NGO sector about staff turnover within STOs leading to changes in contract managers. The potential for inconsistency in contract management has negative ramifications for both parties. As we heard from an STO key informant; once the Action Plan is set by one contract manager it is fixed, even if the next contract manager would like to see it revised. What might be acceptable as an assessment measure for one contract manager might not be perceived as useful to another. On the other hand, some NGO key informants bemoaned the frequency of change in reporting requirements, suggesting that in some cases the assessment measures might not be fixed over the life of the contract.

Case example Organisation B
(See Part 3 for full details)

Participants noted that their state government funders give very little feedback on reports and the limited feedback had been received sometimes over 12 months later. Participants said they were very happy with the more detailed feedback they receive from the Commonwealth (which was regarded as "very thorough"). If sometimes the organisation does not agree with feedback, then there is room to discuss and resolve misunderstandings with the Commonwealth.

It was noted that reports are the primary way contracts are monitored (including financial reporting and audited accounts). Participants were pleased that the Commonwealth is open to rolling over small amounts of surplus funds; however the state funders do not permit this. Participants also said they were happy with their contract arrangements with the Commonwealth, and that local staff/project officers have always been "incredibly supportive". Although there had been some personnel change in local office (and some staff were better than others), on the whole the relationship is positive.

According to an STO key informant, the reports give NGOs time for reflection. The STO is able to identify trends in some regions by analysing information from across the reports, depending on the extent of their funded presence in that region. STO key informants rued the DoH decision to centralise contract management, considered by some to be "moving to a light touch approach". In their opinion it "would be a shame" to discontinue site visits and to cease providing feedback. It is not clear that this will be an outcome of the centralisation process.

Performance measurement to assess accountability of the funding program

In terms of the Commonwealth's responsibility for monitoring the effectiveness of overall program funds – the 'value for money' of programs – a Commonwealth key informant stressed the importance of "monitoring the success of the whole grants scheme". The clear message from key informants was that performance measurement should be from the population-level perspective. The summation of the individual project level measures of outcomes has little meaning. According to McDavid, Huse, & Hawthorn (2013, p. 405), "It is fallacious to assume that knowledge of performance at one level implies knowledge of performance at other levels". As key informants reminded us, the outcomes achieved by their clients are cumulative over their treatment experience. They cannot be considered in isolation of the effects of the treatment that came before; just as the long-term effect of a specific intervention may not be realised for some time. This interplay between the outcomes achieved by the various interventions within the treatment sector is best viewed from the lens of the sector as a whole, in terms of its contribution to reducing the harms of AOD use.

But, as the Commonwealth key informant acknowledged, measures of grants-scheme level outcomes are "difficult to nail". The National Commission of Audit (2014: http://www.ncoa.gov.au/) notes that the change in the Budget reporting framework in 2009-2010 required departments to report achievements against objectives at a program level. In this regard, it expressed concern that the Commonwealth's portfolio budget statements did not detail for Programme 1.3 – Drug Strategy (which includes NGOTGP and SMSDGF P1), the types of activities undertaken and individual performance of the components. While it acknowledged that "some programmes suit the development of straightforward key performance indicators more than others" it felt "that more meaningful and measureable key performance indicators should be developed and maintained" (Appendix Volume 3: 53).

The objectives of the NGOTGP, as outlined in the 2012-2015 Project Plan Template (on which the project level measures of outcome build) are:
- Improve drug and alcohol treatment service outcomes, increase the number of treatment places available, and reduce drug-related harm for individuals, families and communities;
- Increase access to a greater range of high-quality drug and alcohol treatment services and strengthen the capacity of NGOs to achieve improved alcohol and drug treatment service outcomes;
- Fill geographic and target group gaps in treatment provision (e.g. women, youth, families with children, and Aboriginal and Torres Strait Islander people);
- Increase access to a greater range of high-quality alcohol and drug treatment services;
- Support both psychological and physiological health.

Although it is possible that measures associated with these objectives could be developed at the population level; it would be difficult to attribute the impact of the Commonwealth's investment alone, when the NGO AOD treatment sector has myriad sources of funding.

Performance measurement of the SMSDGF P1 in relation to the stated objectives in the 2012-2015 Project Plan Template would be built around supporting AOD treatment services to, for example, develop partnerships with the broader health sector and build capacity to effectively identify and treat coinciding mental illness and substance misuse. These objectives do not lend themselves to measurement in a conventional sense, although it is possible to identify appropriate indicators, by working with management and staff to map tangible outcomes sought by activities undertaken and associated sources of data. This approach would be best undertaken as part of an integrated review process on program effectiveness.

Length of contracts

The length of contracts is a sensitive issue. The NFP sector in general considers that the length of contracts with government is too short; they are inconsistent with the length of time it takes interventions in disadvantaged communities to effect improvement in client outcomes. Short-term and /or irregular funding is not conductive to establishing and maintaining long-term approaches (Productivity Commission, 2010). The Productivity Commission recommended that governments "align the length of the contract with the period required to achieve agreed outcomes" (Productivity Commission, 2010, p. xxiv). There is an argument that this recommendation is of little relevance for the AOD sector, considering that AOD dependence is a chronic relapsing condition which would suggest that contracts should run for substantial periods of time.

The NGOTGP and SMSDGF P1 contracts are of three years in length. Whereas one NGO treatment sector key informant explained that a three-year contract "isn't too bad when organisations have yearly (sometimes 6-monthly) rollovers in other areas like mental health" this was not the case for new services. The NGO treatment sector feels that that contracts need to be of sufficient duration to allow program establishment and routinisation. While capacity building initiatives might be achievable in fewer than three years, a three-year contract for treatment delivery does not acknowledge the start-up time; the time to build expertise, establish policies and procedures, and to recruit appropriate personnel. In the 3-year cycle, a key informant explained, the first year is devoted to implementation and establishment of practices, which leaves 18 months to demonstrate effectiveness before the tender process begins again. For example, one agency had to custom design an IT package for a new program.

Most of the NGO key informants who ventured an opinion were not in favour of rolling over funding for treatment projects indefinitely because of the perception that "people can get slack" if they know the funding is coming in. Without the need to reapply for funds they felt that a sense of complacency may permeate some services as there was "no incentive to look at your practice". Nonetheless the majority view was for timely and appropriate review and renewal options for further funding. It was felt that this approach would support service sustainability while encouraging a culture of ongoing reflection and improvement. It would also allow for changes in community need and associated adjustments to project funding arrangements (eg to account for trends in dominant primary drugs of concern among the treatment population).

WA is instituting a long-term funding arrangement that includes regular review, involving 3+1+1 years. The review occurs in a timely manner (ie, well before the three years is up) and it is not onerous. If a service is doing well then the likelihood is that funding will continue.

A key informant from the South Australian health department explained that they likewise offered 3-year contracts, in line with forward estimates from Treasury which were driven by the 3-year length of the Health Care agreement. They acknowledged that recruitment of staff and the establishment of standards/systems takes time, but also pointed out the advantage of a 3-year contract is that "we

can respond to emerging issues". Tasmania is moving towards standardising their contract length to 3years. The NSW state government cycle is for 4 years.

NGO key informants also spoke about the implications for their staff of government funders regularly going to market, and their organisation's ability to attract and keep quality employees. The negative repercussions for non-profit sector employees of the era of new public management and government contracting have been well documented. Short-term employment contracts and project contracts have become the norm (Evans, Richmond, & Shields, 2005). There has been some recognition that a market-driven approach is not suitable when dealing with complex social issues. Collaborative endeavours are more likely to maintain and build on community resources (eg, long standing programs and expertise) and result in cohesive responses to these concerns.

If three years is too short, what length of contract is suggested by the principles of better practice grants administration? Funding for core treatment is intrinsically long-term; however due process requires a cycle of review and renewal. Four to 5 years was nominated by a number of informants. This timeframe, we heard, which would better allow agencies to plan and deliver long-term treatment, would reduce staff turnover and so on. Funded agencies are better able to ensure efficient and effective use of government money if funding is assured. It is also more consistent with the shift toward longer term planning for AOD treatment sectors (eg 10-year plans for WA and Victoria).

In this vein, key informants favoured rolling over contracts contingent on meeting performance targets, rather than repeatedly going to tender; and interim reviews with scope for modification to address changes in demand and improvement in service delivery. As one key informant asked, "Why do we need to re-tender if our service has been going for some time and is still doing well?" At the extreme end, someone suggested that the initial 3-year contract be followed up by another two sets of 3 years. Another suggested model was a minimum of 4-years contract, with a built in review at 2 years and, for ongoing service delivery the opportunity to roll-over the contract for a further four years contingent on performance.

The SACOSS position for health and community services is 5-years contracts; 3 year + 2 year ongoing/renewal rather than re-tender. Puplick, Bailey, Brassil, Peters, & Pierce (2012, p. 51), in their review of grants management practises for the NSW Ministry of Health recommend that where contracts are awarded initially for 3 years,

> that at an appropriate mid-point in the contract they are subject to an evaluation which, if positive, would allow the contract to be extended automatically at the end of the three years for a further period of two years. This 3+2 (or 3+3) model would be available only where there has been an evaluation which confirms both the need for the continuity of the service and the capacity of the organisation to continue providing it at an appropriate level. (Puplick et al., 2012, p. 51)

As well as reducing pressures on the Commonwealth with re-tendering, they argued that this would allow the provider to provide continuity of service and improve staff development.

> **Case example Organisation A and B**
> (See Part 3 for full details)
>
> Organisation A
> Ideally, participants said that 3 or 4 years would be an ideal length for contracts. Anything less than 3 years was not regarded as enough time (it was said that 2 years is hardly even enough time to collect or document the learnings from the program and for 1-year contracts the focus becomes recruitment and then looking for future funding straight away). That said, participants said that contract length was an important accountability mechanism and that they would not like to see a poorly performing organisations funded for longer than 4 years. However, this depends on the monitoring systems throughout contract.
>
> Organisation B
> In discussing contract length, it was noted that although the 3-year funding model is relatively workable, a 5-year model would be better and a "bit more substantial". Participants suggested that this is what has happened with the specialist homeless services which have just had funding roll over annually since 2010. In these participants' opinion, a competitive tendering process every 5 years would encourage good practice.

Conclusions

Key points from the review of literature, key informant data and our own analysis:

- The Commonwealth's contract management, performance and financial monitoring practices are under reform, along with other aspects of the Commonwealth's grant enabling processes. The reforms are intended, amongst other things, to increase consistency in contract management and monitoring practices across all Commonwealth funding and reduce the contract management and monitoring burden on funded organisations, in line with the principle of proportionality.
- The contribution of ongoing relationships between STO contract managers and funded NGOs to the success of the funded projects should not be underestimated. However, there is variability in the approaches taken by STOs and the ability of the STO staff to undertake these responsibilities.
- NGOTGP and SMSDGFP1 projects are block funded. The Commonwealth distributes tranches of the agreed funding amount to funded organisations. The delivery of those tranches is contingent on the funded organisation meeting obligations, primarily the provision of progress reports against an agreed upon Project Plan and associated financial reports at 6-monthly intervals over the life of the grant. There has been variation in the extent to which the STOs assess the submitted progress and financial reports before funding is delivered. In some cases it is automatic. In other instances funding was delayed on account of inadequate progress reporting. The extent to which the performance measures included in the Project Plans are considered as deliverables is contested.
- Organisations funded under the NGOTGP and SMSDGF (treatment services) are also contracted to report against the AODTS-NMDS or OSR. There is no consistent approach to the process of reporting in each jurisdiction, and it is not clear whether all treatment funded by government is recorded. The Commonwealth does not use these data to assess the value for money of individual projects. Nor are the data considered useful to assess the value for money of the NGOTGP or SMSDGF as a whole. Some key informants from the NGO sector were concerned about the burden of work undertaken by NGOs to meet their contract obligations, particularly smaller organisations. This has salience in view of our finding that the NGO sector does not have a clear understanding of how the Commonwealth uses its Progress Reports. The Commonwealth's grant management reform process, , particularly the establishment of a 'Risk Rating Process', is intended to substantially reduce reporting

requirements for low risk organisations and projects, and to establish consistent contract management and reporting approaches for organisations and projects with a similar risk rating..

- The Commonwealth's assurance that funded projects provide 'value for money' is implied through its monitoring of an organisation's progress against the project plan. Yet, there is some concern amongst STO key informants that their ability to monitor value for money is hampered by this approach. The performance measures tend to be output/activity based, and there was a groundswell of support amongst key informants from all sectors for outcome-based reporting; although the consensus view is that the development of suitable measures was fraught. There is movement towards developing outcome measures in several states.

- The Commonwealth funds a significant number of organisations that are also funded by the state/territory government. There are inherent difficulties in apportioning outcomes to particular sources of funding within a project, or even particular sources of funding within an agency. There is an argument that funded agencies having to report to both jurisdictions is not consistent with the proportionality principle.

- The Commonwealth is concerned to assess value for money of the grant programs as a whole, but has yet to develop an approach. The National Commission of Audit highlighted the fact that the Commonwealth's Budget Reports have not to date reported on the activities and associated performance measures undertaken as Drug Strategy programs (which includes NGOTGP and SMSDGF P1).

- Three-year contracts for AOD treatment service delivery that do not include interim reviews and the option for renewal / extension are problematic for service establishment, routinisation, and sustainability.

Chapter 11: Part 1 Summary

Here we provide a summary of the preceding chapters. Before we move to Part 2 of the report, where we consider options, we recognise that irrespective of the choices about planning, purchasing and accountability, it must be underpinned by good processes. In order to attain the principles we identified in Chapter 1, it is essential that there are good processes. Indeed, it may be true that it matters less what choices are made about planning, purchasing and accountability as long as there are good processes. In WA there has been substantial reform which has been built on a 'partnerships' approach. We were impressed with what we heard about WA, because it seems that they have achieved a real and meaningful partnership between all the stakeholders, which has facilitated new procedures for planning and purchasing. This chapter concludes with the WA as a case example of good processes.

Summary of findings

Context (Chapter 2)
- Alcohol and other drug treatment in Australia is provided by both government and non-government organisations
- The investment in AOD treatment represents value-for-money. For every dollar invested in treatment, the community saves seven dollars.
- Treatment produces positive health outcomes: reduced consumption of alcohol and other drugs; improved health status; reduced criminal behaviour, improved psychological wellbeing; and improved participation in community.
- Research has shown that the way in which governments purchase AOD treatment has an impact on treatment outcomes.
- With two levels of government engaged in AOD treatment funding, and the shift to purchasing from non-government organisations, attention is now being focused on communication, co-operation and collaboration in the 'co-creation of public value'.
- By working cooperatively and collaboratively, there is increased scope to identify and implement meaningful change for AOD treatment sector development and support for sector sustainability. This is the responsibility of not just the Commonwealth government but also state/territory governments, service providers and other stakeholders to the Australian AOD treatment system.

Funding flows (Chapter 3)
- AOD treatment is provided by a range of service providers in a range of locations
- There are multiple funders of AOD treatment services; including both Commonwealth and state/territory governments, philanthropists and the clients themselves
- Commonwealth funds go to all the service providers that we identified; and state/territory funds are also directed to many of those service providers, illustrating the importance of federalism in AOD funding
- Funding is not only delivered directly to service providers, via grant funding of treatment services and Medicare for example, but indirectly through intermediaries via often convoluted pathways. For example, Commonwealth funding is delivered to hospitals via the National Health Funding Pool, and can travel to service providers through state/territory governments via National Partnership payment, and via other intermediaries such as Medicare Locals and Local Hospital Networks.
- NGOs providing AOD treatment rely on multiple sources of funds at the same time; for example a number of departments in both levels of government, philanthropy, clients and fund raising.

- The combination of multiple sources of funds and both direct and indirect funding pathways can result in NGOs having multiple funding relationships at the same time with multiple agencies.

Amount of treatment funding (Chapter 4)
- Compared to the prevalence rate of AOD problems in Australia and the extent of the burden of disease from AOD problems, the investment in AOD treatment appears small.
- The overall expenditure on AOD treatment in Australia, inclusive of both specialist and generalist AOD treatment was estimated at $1.261 billion.
- From this total, the Commonwealth's contribution is 31%; state/territory governments' contribution is 49% and private contributions is 20%.
- If we remove the private contribution (philanthropy and client co-payments), the Commonwealth contribution is 39% and the state/territory contribution is 61%, and the total expenditure is $1,007,977,579.
- Examining just government funding ($1 billion), 55% of all government funding is in specialist AOD treatment and 45% is in generalist AOD treatment.
- The Commonwealth plays a vital role in funding the specialist sector – their contribution represents 21% of all specialist AOD treatment funding in Australia (the states/territories 79%).

Current Commonwealth grants schemes (NGOTGP and SMSDGF) (Chapter 5)
- Through the NGOTGP, in 2012/13 the Commonwealth's total funding amount was approximately $49 million for that year.
- NGOTGP grants were spread across all Australian jurisdictions. All grants were competitively tendered. There was no change to the priority areas for the NGOTGP in the 2012 round relative to earlier rounds.
- As a flexible fund, the SMSDGF can use multiple mechanisms for purchasing: open competitive grant rounds, targeted grant rounds, one-off funding, and procurement. The SMSDGF has six priority areas, of which four directly relate to alcohol and other drug treatment.
- In 2012/13, the SMSDGF had grants totalling about $80 million for that year.
- Approximately 70% of the SMSDGF funds were for Aboriginal and Torres Strait Islander services in 2012/2013. The remaining 30%, which were subject to competitive tendering, were largely capacity building projects and counselling services in the 2012 round. All jurisdictions received SMSDGF grants in 2012/13.
- The Commonwealth purchases core AOD treatment, supporting treatment functions and capacity building with the NGOTGP and SMSDGF grants schemes.
- Within 'treatment' we identified 'core AOD treatment': withdrawal, residential rehabilitation, psycho-social therapy (counselling), and maintenance pharmacotherapy; and supporting treatment functions
- Within 'capacity building', we proposed three streams:
  - Client/priority topic
  - Organisational / institutional
  - Intra- and inter-sectoral systems of care.
- The current Commonwealth investment is 84% in treatment and 16% in capacity building (when the quantum of funds is used as the metric).
- When the NGOTGP and SMSDGF funds are considered together (and excluding Priority 2 & 3), the Commonwealth invests predominantly in counselling (37% of funds), followed by residential rehabilitation (28% of funds).

- This investment is not inconsistent with states/territories investment. While we do not know the quantum of funds, the most common service type is counselling.
- The Commonwealth purchases core service types that align with the states/territories purchasing.
- Based on the data available, there is no evidence of 'duplication' to the extent that unmet demand is high, and organisations use Commonwealth funds to deliver more or better care.
- In terms of the total funds to Aboriginal and Torres Strait Islander AOD services, the SMSDGF allocated $56,312,052 under Priorities 2 & 3 for the year 2012/2013. The funds within the NGOTGP that went to Aboriginal and Torres Strait Islander AOD services amounted to $6,564,532. This means that of the total $130 million in NGOTGP and SMSDGF for the year 2012/2013, 48% was allocated to Aboriginal and Torres Strait Islander AOD services.

Current purchasing mechanisms (Chapter 6)
- Multiple purchasing mechanisms are in play at present. For example, the Commonwealth currently purchases AOD treatment through four mechanisms: competitive processes (grants schemes), fee-for-service (Medicare), activity-based funding (hospital services), and transfers to states/territories (special purpose payments).
- The way in which AOD treatment is currently purchased by the Commonwealth and states/territories through the NGO sector is predicated on models that exist for social welfare services, not those for health. Thus, governments purchase social welfare services, such as employment services, and homelessness services, largely through competitive grant schemes. Arguably, alcohol and other drug treatment services have simply been subject to these social welfare processes because the providers are NGOs. However, if one considers AOD treatment as a health service, then the usual mechanisms for health funding (such as ABF or fee-for-service) would be more appropriate.
- It is useful to distinguish the mechanism by which the provider is chosen (eg: competitive selection, historical or negotiated, preferred-provider, or via accreditation/registration processes) from the mechanism by which the payment occurs (block grant, activity/episode-based, capitation and outcome-based).
- Each of these has advantages and disadvantages. Existing literature and key informants to the Review have informed our analysis of the relative strengths and limitations.
- Competitive processes to select the providers of AOD treatment are widely used. These approaches have a number of general advantages, particularly transparency and fairness. There is also a perception that competition is a driver of quality and may involve reduced price. However, there are a number of disadvantages that apply to AOD. A limited number of potential providers exist. Funders risk undermining sector viability through processes that do not account for a) organisational characteristics (eg, size and capacity to write proposals) and b) the vulnerability of organisations to uncertain funding arrangements.
- The competitive process, if effective, needs to be designed with consideration of the pool of potential providers and it should be well-resourced. Assessment panels need to include experts with a sound understanding of service delivery and clinical excellence. A selective process, possibly focused on a pool of preferred providers is worth consideration.
- Individually-negotiated processes to select the provider are common for government service provision. In some cases, individually-negotiated selection of providers occurs with NGOs. The key criticism of this process is the lack of transparency and fairness.
- Transfer of funds to states/territories is the way in which healthcare in Australia has evolved through special purpose payments and the National Health Funding Pool (NHFP). The advantages of such an approach are the reduced administrative costs to the Commonwealth, and the increased potential for coordinated planning and purchasing. The key disadvantages are the risk of loss of funds, and the lack of checks and balances provided by the two levels of government.

- Accreditation of approved providers who can then submit invoices for services rendered (ie the Medicare model) is unlikely to be feasible for AOD treatment that is funded by the Commonwealth. This model increases the amount of services provided but operates in a largely uncapped budget environment.
- The use of block grants (whether with or without specifications of activity within the contract) is a common mechanism for funding flows – and is the one currently used by the Commonwealth for the NGOTGP and SMSDGF. The advantages are its simplicity and flexibility. The disadvantages include potential inconsistency in funding between agencies (no fixed or unit price), limited incentives for efficiency, and potential limitations on the specificity regarding what is sought and delivered (depending on the nature of the agreement).
- Price per episode is becoming the prevailing model for funding healthcare in Australia. The hospital funding through ABF and the Victorian AOD ABF are important developments for consideration. ABF models provide clarity about what is being funded, can promote efficiency and increase budget control (assuming funding is capped), and provide benchmarks for service pricing. One way in which the Commonwealth can use an ABF model is to specify its funding contribution to AOD treatment (which is then managed by the states/territories). However, establishing high quality ABF systems can be expensive, prices need to be set correctly, and infrastructure established to adjust prices over time.
- Capitation, a price per population, is a model widely-used in US healthcare. It has not yet been fully implemented in Australia. It is unlikely to be the solution to funding Australian AOD treatment services.
- The use of outcome-based payments has not shown the necessary positive results to make it a viable model for implementation at this time.
- In considering all the options, it is important to bear in mind that:
  - Mixed models are most common (for example an ABF and a block funding approach for the same organisation, and perforce across the sector);
  - The state/territory approaches are important to consider;
  - Each option has both strengths and weaknesses; and
  - There needs to be acknowledgement of current systems and effective change management processes should reform be indicated

Current service utilisation (Chapter 7)

- For planning purposes we need to know the number of people in AOD treatment. Ours is the first attempt to estimate that number inclusive of generalist as well as specialist treatment.
- Previous chapters have charted the diversity of AOD treatment providers and diversity of treatments.
- No one treatment works for all people and some people try many forms of treatment to find the treatment and the provider that suits them.
- We estimate that approximately 200,000 Australians try some form of treatment over a year. This is an under-estimate because not all treatment is recorded in official datasets.
- On average people who use treatment had approximately 8 episodes of care over the year, with those episodes ranging from a session with a psychologist or a GP visit, to a long-term stay in residential rehabilitation.
- Between one quarter and one half of the people who try treatment are clients of the specialist treatment sector. We have no way of knowing how many clients are unique to that sector.
- Planning needs to acknowledge and accommodate the fact that people legitimately try different modalities of treatment, often provided in different service sectors; and potentially combine those different modalities to create something that works for them.

Projected demand (Chapter 8)

- It is clear that at present, Australia provides comprehensive alcohol and other drug treatment services, across a range of client groups, treatment types and locations.
- There is a greater demand for services than current supply.
- We estimate that between 200,000 and 500,000 more people would be in treatment if demand were to be fully met. [103] This means that current met demand may vary between 26% and 48% of all people who will seek, and are appropriate for, AOD treatment.
- No service system can meet 100% of demand – and indeed, when examined in comparison to international figures, Australia is doing well. International benchmarking of our findings suggests that Australia has a relatively high rate of treatment utilisation and possibly one of the lowest rates of unmet demand in the world.
- There are some readily identifiable gaps. The first is in relation to alcohol treatment – our quantitative estimates of demand suggest that we need more alcohol treatment services.
- Other areas of unmet demand include services for young people; families and women with children; and Aboriginal and Torres Strait Islander people (we note that DA-CCP does not at present include the kinds of treatments appropriate for Aboriginal and Torres Strait Islander people. A specifically designed Aboriginal and Torres Strait Islander DA-CCP is in development).
- Service types that were identified as not meeting current demand were residential rehabilitation, residential withdrawal, pharmacotherapies and counselling. Perhaps this is not a surprise as these categories reflect the core service types across Australia. This accords with the overall extent of unmet demand predicted by the DA-CCP model.
- Increasing the overall amount of AOD treatment provided is important, but given resource constraints, choosing the areas of greatest unmet demand is vital. Responsibility for increasing met demand rests with all the AOD treatment purchasers – both Commonwealth and state/territory governments.

Current planning (Chapter 9)

- AOD treatment planning facilitates an understanding of the needs of a population in relation to AOD treatment and provides a coordinated and comprehensive mechanism for the efficient allocation of resources to meet a specific goal or goals.
- There is strong commitment to effective AOD treatment planning in Australia.
- The consensus appears to be that planning processes need input from the two primary funders — Commonwealth and state/territory governments; in a 'joined up' fashion.
- There is also consensus that service providers and consumers (current and future clients) be engaged in AOD treatment planning in Australia.
- A useful distinction can be drawn between strategic planning and technical planning.
- Strategic planning involves high-level agreement on values, goals and priority areas, and is a good fit with a leadership role for the Commonwealth.
- Technical planning involves specifications of the service types and populations in need of treatment and the required array of services to meet needs, usually best undertaken for defined geographical areas (eg, jurisdictions).
- Planning is a difficult and complex undertaking that can be resource intensive.
- Australia has a national quantitative technical planning tool, DA-CCP that provides national (and state/territory) estimates of the amount of treatment, types of treatment and resources required to meet demand. This information shows, at a national level, the extent of unmet demand for treatment, but this alone does not enable purchasing decisions.
- DA-CCP is silent on who the purchaser should be (and who the provider should be).

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[103] By fully meeting demand, recall that this is based on a DA-CCP treatment rate of 35% - ie full demand is the equivalent of only treating 35% of all people who meet diagnostic criteria.

- Gaps remain in our planning tools and data: inclusion of geography and special needs groups are but two examples, along with the need for good consultative processes over and above any quantitative tool
- At present, there are no formal planning methods used for the NGOTGP and SMSDGF, nor the use of pre-defined formulae for funds distribution (eg, per capita distribution across states/territories).
- Challenges for planning include balancing specificity with flexibility, ensuring innovation is not stifled and marrying local needs assessment with regional, state and national needs assessments.
- The respective roles of national, state and local planning processes are currently unclear.

Current accountability (Chapter 10)
- The Commonwealth's contract management, performance and financial monitoring practices are under reform, along with other aspects of the Commonwealth's grant enabling processes. The reforms are intended, amongst other things, to increase consistency in contract management and monitoring practices across all Commonwealth funding and reduce the contract management and monitoring burden on funded organisations, in line with the principle of proportionality.
- The contribution of ongoing relationships between STO contract managers and funded NGOs to the success of the funded projects should not be underestimated. However, there is variability in the approaches taken by STOs and the ability of the STO staff to undertake these responsibilities.
- NGOTGP and SMSDGFP1 projects are block funded. The Commonwealth distributes tranches of the agreed funding amount to funded organisations. The delivery of those tranches is contingent on the funded organisation meeting obligations, primarily the provision of progress reports against an agreed upon Project Plan and associated financial reports at 6-monthly intervals over the life of the grant. There has been variation in the extent to which the STOs assess the submitted progress and financial reports before funding is delivered. In some cases it is automatic. In other instances funding was delayed on account of inadequate progress reporting. The extent to which the performance measures included in the Project Plans are considered as deliverables is contested.
- Organisations funded under the NGOTGP and SMSDGF (treatment services) are also contracted to report against the AODTS-NMDS or OSR. There is no consistent approach to the process of reporting in each jurisdiction, and it is not clear whether all treatment funded by government is recorded. The Commonwealth does not use these data to assess the value for money of individual projects. Nor are the data considered useful to assess the value for money of the NGOTGP or SMSDGF as a whole. Some key informants from the NGO sector were concerned about the burden of work undertaken by NGOs to meet their contract obligations, particularly smaller organisations. This has salience in view of our finding that the NGO sector does not have a clear understanding of how the Commonwealth uses its Progress Reports. The Commonwealth's grant management reform process, , particularly the establishment of a 'Risk Rating Process', is intended to substantially reduce reporting requirements for low risk organisations and projects, and to establish consistent contract management and reporting approaches for organisations and projects with a similar risk rating..
- The Commonwealth's assurance that funded projects provide 'value for money' is implied through its monitoring of an organisation's progress against the project plan. Yet, there is some concern amongst STO key informants that their ability to monitor value for money is hampered by this approach. The performance measures tend to be output/activity based, and there was a groundswell of support amongst key informants from all sectors for outcome-based reporting; although the consensus view is that the development of suitable

measures was fraught. There is movement towards developing outcome measures in several states.

- The Commonwealth funds a significant number of organisations that are also funded by the state/territory government. There are inherent difficulties in apportioning outcomes to particular sources of funding within a project, or even particular sources of funding within an agency. There is an argument that funded agencies having to report to both jurisdictions is not consistent with the proportionality principle.

- The Commonwealth is concerned to assess value for money of the grant programs as a whole, but has yet to develop an approach. The National Commission of Audit highlighted the fact that the Commonwealth's Budget Reports have not to date reported on the activities and associated performance measures undertaken as Drug Strategy programs (which includes NGOTGP and SMSDGF P1).

- Three-year contracts for AOD treatment service delivery that do not include interim reviews and the option for renewal / extension are problematic for service establishment, routinisation, and sustainability.

Summary: State/territory planning and purchasing processes

We have sought to succinctly summarise the information about planning, purchasing, contract management and reform across all jurisdictions. It should be noted that this information has not been reviewed by the states/territories to date, and represents our summary form the information we were provided in the rapid assessments.

Table 11.1: Summary details of jurisdictional planning, purchasing, contracting and reform

Planning	Purchasing approach	Timelines and reform	Contract management
Northern Territory			
In the NT, according to our key informants, planning is limited. There have been many consultations and mapping exercises over the years, but it appears that these are not necessarily then linked to plan the rollout of services.	Government services are funded on a recurrent basis. The providers are the existing historical government services. Non-government services: The NT uses individually negotiated processes to select the NGO providers, and a block grant approach for funding, with contracts generally for 3 years. There is some competitive tendering (for example, minor grants and capital works). Prices for services are not fixed, and are based on historical amounts funded and/or negotiated with individual providers. At the time of the site visit, it was suggested that a competitive process would be implemented in 2014, to 'move toward submission based funding' and open up the market to new providers. The suggestion was also made that clinical services would move to a regionally based health and hospital network system (similar to the Queensland model).	One-year extension of NGO contracts to June 2014. In 2014 intention is to introduce submission-based funding, details not released as of March 2014.	Individually negotiated contracts, with service performance monitored through calls, visits, KPIs, and audited reports. In future, staff will be working at agencies for a few days to get a better understanding of their work.

Planning	Purchasing approach	Timelines and reform	Contract management
Queensland			
Planning structures and processes are evolving in Queensland, following the disaggregation of planning and government services funding and provision from a central to catchment based arrangement (HHS), although AOD services are yet to be fully devolved to the HHS. Queensland is undertaking AOD NGO treatment commissioning at present, although details of planning processes associated with this were not reported to us.	In Queensland, the government AOD treatment services form part of the 17 Health and Hospital Services (HHS) that is the providers are the existing historical government services. Funding for government AOD treatment services is not distinguishable from the Queensland government's funding of all health and hospitals services. For NGO services, block grants have been provided through competitive tender, for a 3-year period, just recently undertaken (the Request For Offer released on Monday 3 March and submissions are due on Wednesday 2nd April). Residential withdrawal support and/or rehabilitation and NGO AOD sector data support services are considered 'non-contestable' and they are exempt from the competitive process[104]. There is no fixed price per unit/service/activity for the Government or NGO AOD services.	Current grant end dates: June 2014 Outpatient services currently under competitive process, with 3-year service agreements, for implementation from 1 July 2014. Residential withdrawal and rehabilitation and NGO sector data support services; 3 year extension of current agreements.	For government services: each HHS has a service agreement with the Department of Health, for the period July 2013 – July 2016. 'The service agreement defines the health services, teaching, research and other services that are to be provided by the HHS and the funding to be provided to the HHS for the delivery of these services. It also defines the outcomes that are to be met by the HHS and how its performance will be measured'[105]. In 2012-13 there were specific deliverables for the ATODS funding however this is not the case for 2013-14. For NGOs individually negotiated service agreements.

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[104] Queensland Department of Health. Non-government alcohol and drugs sector. Communique March 2014. www.etender.qld.gov.au. Accessed 07.03.2014.
[105] http://www.health.qld.gov.au/hhsserviceagreement. Accessed 03.03.14.

Planning	Purchasing approach	Timelines and reform	Contract management
Victoria			
In Victoria, until recently planning was ad hoc and not always integrated, according to our key informants. The AOD reform process underway at present seeks to address the fragmentation. The reform includes a catchment based planning function which will assist in configuring local responses and contribute to system planning. Demand modelling is informing statewide planning. The consultation and planning process for the reform involved key stakeholders. A performance management framework will be implemented as part of reforms.	To date, Victorian AOD services have been provided by health services, community health services and NGOs. Providers are chosen through competitive selection processes, and the funding mechanism was based on unit costs per episode of care. Unit costs (fixed contract amounts per fixed quantum of episodes of care) were in place from the mid-1990s. The recent reform process involves set costs based on a core Drug Treatment Activity Unit with weightings for particular populations, described as 'activity-based funding' (see Case example, Chapter 17).	Stage One of Victorian AOD reform pertains to non-residential services and will roll out in mid-2014. Agencies will initially be contracted under new service agreements for a single year and, subject to satisfactory performance, agreements will roll over to a standard three year funding cycle from 2015-16. The second stage of the reform process pertains to residential and youth services. This is due to occur in June 2015. The procurement process will be clarified through the reform.	Consistent with pre-reform arrangements, successful providers will be contract managed by DH regional offices.
Western Australia			
WA has undertaken a comprehensive planning process, including the use of DA-CCP as one planning tool. A 10-year plan is being developed, involving a sector framework. Development is happening collaboratively, the sector is working with the Drug and Alcohol Office. There was a workshop for the sector on 23 October where the framework for the plan was introduced and discussed. The goal is to have a plan by end December and details by April 2014. Engagement of stakeholders and regular meetings and consultations are held. The planning framework has	Government services: Next Step is the clinical services directorate of the Drug and Alcohol Office. Funding is recurrent. NGO providers have historically been funded through a mix of competitive and select provider processes. A major reform is under way that involves the development of a 10 year 'Alcohol and other Drug Services Framework 2015-2025', to guide the provision of alcohol and other-drug prevention activities and treatment and support programs and services. This has	There is an ongoing cycle of procurement that generally involves 3 year agreements with 2 options for expiry (review and possible extension): a. Outpatient services, expiry December 2014 / June 2016 b. Residential and 'specialist' services, initial expiry June/December 2016, then June/December 2017, then June/December 2018 c. AOD hubs, expiry June 2015 Restricted processes/preferred provider model for the majority of services (ie where they are considered	Individually negotiated service agreements with a focus on outcomes.

Planning	Purchasing approach	Timelines and reform	Contract management
identified gaps and interventions.	been developed as a Partnerships approach (See case example, Chapter 17). The WA reform will focus on services being purchased on an outcome basis, that is, the government determines what outcomes it wants to purchase (which are defined through consultation with the sector), and services submit applications whereby they demonstrate how they will achieve those outcomes, and at what cost (in this sense it is not P4P, or activity-based funding but relies on the application process as demonstrating the link between services and outcomes). Competitive processes will be used to select providers, across open, preferred provider, or closed processes for procurement[106]. An agreed price for services (that are matched to outcomes) is individually negotiated with providers. The WA reforms are also associated with increased funding, and represent a shift in the approach to funding; 'we don't fund organisations, we buy services'. A substantial amount of preparation and partnership building has taken	'specialist' or have significant infrastructure). Community Drug Services (part of service group a) will go to open tender shortly (at March 2014), with a contract term commencing in January 2015, for 3 years, with 2 expiry options beyond this date.	

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[106] The *Funding and Purchasing Services Policy and Procedures* (March 2013) identifies a two-stage process for procurement planning. First, decide whether to proceed using a grant or service agreement. Then, decide whether to openly tender or use a restricted negotiation with a preferred service provider (PSP). Variations on the open tender include a registration of interest, expression of interest and request for proposal. See p. 11.

Planning	Purchasing approach	Timelines and reform	Contract management
	place to enable the process of change: eg outcomes workshops have been run with services, consultations with the community about what they want, pricing workshops with agencies, exploration of ways to improve consumer involvement.		
South Australia			
In South Australia a major planning process was undertaken for the 2011/2012 funding round, commencing with an internal review of treatment services in 2009 which provided an environmental scan and considered the evidence base More recently annual forums between SA Health and the non-government sector have included DASSA preparing maps of all AOD services and accredited GP prescribers. DASSA has also trialled DA-CCP as one decision-support tool.	Government services in SA, provided by DASSA are block funded, based on historically negotiated amounts. There is no fixed price per activity/output/outcome. The providers are the existing historical government services. All services have key performance indicators to meet.

NGO AOD treatment services in SA are funded with two pools – the Illicit Drug Diversion Initiative and Drug and Alcohol Services Program pools. They are predominantly subject to open competitive tendering (with the exception of direct negotiations with some sole providers, such as SANDAS and Family Drug Support). Detailed tender specifications are used (eg type of service, staff qualifications and so on). All services have key performance indicators to meet.
From each agency SA purchases a certain amount of activity at the agreed upon price.

DASSA is working on defining a set of | Current grant end dates June 2015 (3 year contracts)
Call for tenders in late 2014 for IDDI and DASP funding pools. | KPIs (including activity KPIs), specific to each agency, are used to monitor the delivery of all services from non-government services and DASSA |

Planning	Purchasing approach	Timelines and reform	Contract management
	clinical outcomes (which should be in place by the end of 2014 for its own clients/services, eg level of substance use, level of mental distress, injecting risk, self-report quality of life.		
Tasmania			
In Tasmania, our key informants noted the absence of robust needs analysis. A five year plan was developed, with significant consultation which identified service gaps and where capacity building was required. This informed Tasmanian government purchasing of both government and NGOs services.	Government AOD services in Tasmania, provided by ADS, are funded through annual block funding (negotiated based on previous year). There is no fixed price per activity/output/outcome. The Tasmanian government purchases most AOD treatment from NGOs services through historically negotiated 3 year block grants at an agreed amount specific to that agency, contingent on performance. The Future Services Direction funding (which commenced in 2008/09 as a result of a review) continued existing purchasing arrangements but also introduced competitive tendering (no fixed price). The decision as to what would be competitively tendered was based on Treasury determination regarding whether the services were new/different (these had to be tendered), whereas funding to extend the capacity of existing services need not be tendered out.	All NGOs are not on the same cycle, by virtue of when the services went to tender. Some expire in 2104; some in 2015 and some in 2016 (3 year contracts). No on-going competitive tendering for continuing direct service delivery. May be tendering for new services under the Future Services Directions funding.	For NGO agreements, activity based KPIs specific to the treatment type and each agency, are used to monitor the services Funded NGOs must report against KPIs and the DHHS provides guidelines about how to write the KPIs. According to key informants, the KPIs used in AOD treatment funding have not been bench-marked and can vary markedly between programs. The KPIs are primarily established by the ADS (within Tasmania DHSS) with some consultation with the NGOs. The ADS intends to reform these measures once they have established an effective monitoring mechanism for their own service provision.

Planning	Purchasing approach	Timelines and reform	Contract management
	Unlike South Australia and Victoria, Tasmania does not stipulate the construct of the treatment it is purchasing. Hence its purchase approach is more akin to that of the Commonwealth.		
New South Wales			
In NSW, we were advised that the Local Hospital Networks are responsible for planning and decision making about AOD priorities for the government services. The role of the central ministry is in assisting these planning processes, for example the development of models of care for detoxification. Evaluations are used to inform decisions about treatment services. For the NGO services, planning is undertaken on a very small, local scale if at all. There is currently no endorsed NSW Health AOD Plan (it is under development at present).	Government AOD services in NSW form part of the Local Health Districts (LHD's). Funding to LHD's is largely driven by historical amounts, and are block funded; it is up to the LHD to determine how to spend the block AOD treatment funds. Note this block funding has been quarantined. Drug and Alcohol inpatient beds are using the Activity Based Funding as per the national hospital funding processes. The NSW Ministerial grants program has been the primary funding mechanism for the NSW NGO AOD treatment services. The NSW government purchases most AOD treatment from NGOs services through historically negotiated block grants at an agreed amount specific to that agency. There is some competitive tendering. Fixed prices are not used.	The NSW NGO system is under reform at present: moving from a grants arrangement to a contract arrangement, under the 'Partnerships for Health' reform. The 'Partnerships for Health' will allow government to be transparent, with clear purchasing frameworks and contract performance management systems. AOD and MH have started contract negotiations with the Ministry for the 2014/15 year, but it could be up to two years until fully implemented. Current grants have been extended to 30 June 2015 pending the reform. A contestable tender process is to occur from 1 July 2015. The proposed process is still being finalised but may be largely through contestable tendering processes, open to all providers.	At present, NSW Health and NGOs individually negotiate agreements, with activity measures (AODTS-NMDS) and key performance indicators. Reform will move to more outcome-focussed performance indicators.
Australian Capital Territory			
In the ACT, we were advised that the government uses evaluation data and expert reviews to assess the service	Government AOD services in the ACT are funded through hospital block grants, based on historically negotiated	NGO contracts are renegotiated every three years. Current contracts for the NGOs are (largely) 2013 to 2016.	All ACT contracts are in the public domain. Contracts specify the service

Planning	Purchasing approach	Timelines and reform	Contract management
system and plan for treatment services. There is documentation regarding the current priorities. One-off planning processes are also undertaken. The ACT conducted a review of treatment service needs. This review included stakeholder consultation. The overarching strategy to help inform treatment planning is the ACT ATOD Strategy (whole of government and community approach).	amounts. There is no fixed price per activity/output/outcome. The ACT government purchases AOD treatment from NGOs services through historically negotiated block grants at an agreed amount specific to that agency.		types and performance indicators (activities), along with comprehensive performance requirements (including guideline adherence, specified activities, and policies).

Note: The details provided in the Table 11.1 were given to each state/territory for review/amendment. Feedback was received from ACT, NSW, VIC and SA.

The importance of good process

Central to the Review is a deep understanding of the interdependence between key actors that shape the AOD sector. Specifically, the ways that government and services operate in processes of sector planning and procurement.

In our consultations with key informants for the Review, there was much discussion about the importance of meaningful consultation and communication and about having constructive working relationships between key stakeholder groups; in this case involving the purchasers and providers of services. This issue arises in relation to planning for treatment services; the approach to market; change management (reform); the delivery of services; monitoring outcomes; and the management of contracts. There are two aspects with particular relevance for the Review:

1. The way the Commonwealth does its business; and,
2. Processes that support sector reform processes[107].

In order to attain the principles we identified in Chapter 1, it is essential that there are good processes. Indeed, it may be true that it matters less what choices are made about planning, purchasing and accountability as long as there are good processes. Key informants were very clear with us about the importance of processes – the style and consistency of communications, the clarity of written documentation, the meaningful engagement of all stakeholders – the states and territories, the service providers and the consumers (current and future clients).

In WA there has been substantial reform which has been built on a 'partnerships' approach. We were impressed with what we heard about WA, because it seems that they have achieved a real and meaningful partnership between all the stakeholders, which has facilitated new procedures for planning and purchasing. The case example is given below.

WA Partnerships case example
(The full details of the case example are provided in Chapter 17)

The aim of this case study was to describe the partnership approach used during the reform of WA's AOD sector. In WA, there is a substantial policy history that recognises the importance of working with sector agencies. The Delivering Community Services in Partnership Policy (the Partnership Policy), introduced in May 2011:
"put[s] the interests of citizens at the centre of the relationship between the public and community sectors, and challenges both sectors to redefine the way they engage in the planning, design and delivery of human services" (Government of Western Australia, 2011a, p.2)
The Partnership Policy aims "to improve outcomes for all Western Australians through a genuine partnership between Public Authorities108 [government departments] and the not-for-profit community sector in the funding and contracting of sustainable Community Services in Western Australia" (p. 1). It, "applies to all Public Authorities that provide funding for, or purchase Community Services from, not-for-profit organisations" (Government of Western Australia, 2011a, p.1). Put simply, the Partnership Policy aims for:
A partnership approach involving government and community sectors, focusing on funding and contracting of sustainable community services; and
A reflective and action-oriented approach to enhance the planning, design and delivery of these services; [with the ultimate goal of];

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[107] That is, given that the Review provides opportunity for reform, the question becomes what kind of processes may best support that reform.
[108] A Public Authority is "a department of the Public Service of the State established or deemed to have been established under the *Public Sector Management Act 1994,* or an agency authority or instrumentality of the Crown in right of the State" (Government of Western Australia, July 2011, p. 16.

Improved outcomes for West Australians
The Partnership Policy aims to guide procurement processes with the not-for-profit[109] community sector (Government of Western Australia, 2011a).

Partnership as the core
The Partnership Policy is based on six partnership principles and six behaviours (see Chapter 17). In brief, the principles involve a commitment to shared outcomes, a collaborative approach to decision-making and working together, a partnership based on mutual trust and respect, with openness and transparency, recognising the value and contribution of both sectors, an enduring commitment to sector sustainability, and a commitment to empowering service users in planning, design and delivery. The behaviours comprise a focus on demonstrable improvements in outcomes, consultation on all significant issues, transparency in decision-making, an interdependent approach to service planning and delivery, working together for sustainability, and engaging citizens in planning, design, and delivery processes (Government of Western Australia, July 2011).

Policy actors
We have identified a number of policy actors that are integral to the realisation of the Partnership Policy. Some of these groups reside within government and work both across government departments as well as focusing on sector change and development. Others represent the AOD sector, including services and consumers. The policy actors and a précis of their roles in relation to the Partnership Policy:
The Department of Finance; advice, support, administration
The Partnership Forum; high level joint government-community sector group, supported by the Departments of Premier and Cabinet and Finance
The Drug and Alcohol Authority (DAO); leadership, planning, relationships, change process
The Drug and Alcohol Interagency Strategic Senior Officers' Group (DASSOG); working collaboratively, showing leadership in their own portfolios
The West Australian Network of Alcohol and Drug Agencies (WANADA); representing the AOD sector, supporting two way channels of communication, supporting the change process through practical means
The West Australian Substance Users' Association (WASUA); representing illicit substance users

Implementing reform
In April 2013, 'Procedural Instructions' were released to accompany the Partnership Policy. The procedural instructions include guidelines regarding grants and service agreements along with standardised contract planning, development, and management templates (Government of Western Australia. Drug and Alcohol Office, April 2013). The role and responsibilities of the contract manager include the area of relationship development and management, where "the need for cooperative and non-adversarial relationships with Service Providers is paramount and DAO [Drug and Alcohol Office] will endeavour at all times to maintain open communication and a joint and mutually beneficial approach to problem solving" (Government of Western Australia. Drug and Alcohol Office, April 2013, p. 16). "Continuous dialogue" between all stakeholders is advocated, (Government of Western Australia. Drug and Alcohol Office, April 2013, p. 16), which includes information sharing and a proactive approach to identifying and resolving areas of potential concern. A number of other procedural elements are supportive of a partnership approach, for example "sensitive relationship management" (p. xx) with the service provider when a service agreement is due to expire, ensuring continuity when there are staff changes in contract management, and instituting reduced financial reporting obligations as new service agreements are implemented.

Conclusion
Consistent with the Partnership Policy, and reflecting a willingness and capacity to configure and lead major change, DAO is managing an extensive reform process in the AOD sector. This process commenced in 2011 and (at April 2014) it is ongoing. During our consultations, the energy and drive for reform was apparent. There was strong engagement from the range of actors involved. Principles and behaviours listed in the Partnership Policy are embedded in the parlance that has developed. Strong communication and the sense of working together have been integral, with DAO explaining that, "it is not just a purchasing relationship. There is weekly dialogue, sharing ideas, working together on problems, and operating in a mutually supportive and constructive relationship". Another illustration of the Partnership Policy in action is a two-day AOD conference

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[109] The terms not-for-profit and non-government organisations (NGO) are used interchangeably in this case study.

(May, 2012) entitled 'Implementing State Government Procurement Reforms' included sessions on procurement, sustainability and future funding, outcomes, and proposals. Workshops have been held on pricing, procurement, and workshops by service type. Community consultations have occurred or they are under way, to gather information about regional needs and priorities.

The above shows both how the principles and behaviours in the Partnership Policy have directed AOD reform in WA and also that implementation has been consistent with the goals, principles and behaviours of the Partnership Policy, notwithstanding the challenges (see Chapter 17).

PART 2: THE FUTURE – OPTIONS ANALYSIS

Chapter 12: The role of the Commonwealth in AOD treatment

This chapter considers the mandate that the Commonwealth has in relation to AOD treatment funding. We start with examination of whether indeed the Commonwealth should have a role in purchasing AOD treatment. Whilst we could take as a given that the Commonwealth purchases AOD treatment, we think it is worthwhile first stepping back and considering the question in its broadest sense. This analysis takes us through a brief look at federalism; examining the current roles of the Commonwealth and states/territories in Australia in relation to health care, and then focusing on role delineation for AOD treatment. We then consider the Commonwealth's role and responsibilities in view of its current position as a purchaser of AOD treatment alongside state and territory governments. The chapter concludes with an options analysis of what the Commonwealth could be responsible for and purchase in light of the above.

Importantly, this chapter does not consider the Commonwealth's role in relation to Aboriginal and Torres Strait Islander AOD services. It has become apparent that there are particular and different issues to be considered. These have been treated separately (see separate report). As such, the discussion and conclusions drawn in this chapter do not necessarily apply to Aboriginal and Torres Strait Islander AOD services.

The role of the Commonwealth in health care

In relation to the challenges of federalism and the roles of the two levels of government:
> "The most common complaints concern unhelpful duplication, excessive bureaucracy and administration, inconsistent regulation, buck-passing and costshifting, which are said to limit productivity and lower service quality" (Pincus, 2006, cited in Hinz, 2010).

Key informants for the Review agreed that role clarity and delineation were important. There was considerable interest in establishing a shared understanding about "who is responsible for [funding] what".

As a federated nation the roles of the two levels of government in healthcare planning and purchasing are complex[110]. According to Australia's constitution, originally the Commonwealth role in health services was limited to matters relating to quarantine. While the 1944 constitutional amendment to Section 51(xxiiiA) expanded the Commonwealth responsibilities for health services, Duckett & Willcox (2011) argue that the growing dominance of the Commonwealth in the health system largely arises due to its control of taxation powers, "giving it much greater capacity than state governments to fund the growing costs of health care" (p. 106). Currently, states and territories share responsibility for healthcare with the Commonwealth. States and territories have responsibility for hospital services, the Commonwealth is responsible for funding medical services, and there is shared responsibility for community care and disability services. In more common terms, the Commonwealth funds primary care and pharmaceuticals (through Medicare and PBS) and the states/territories manage hospitals (with pooled funding from the Commonwealth and state). The division of responsibilities between the levels of government is sometimes hard to precisely clarify, and debate about the respective roles and functions of levels of government in our federated nation is common. Furthermore, the broad distinction noted above does not assist in clarifying respective roles in AOD treatment funding or provision, as it is neither primary care nor hospital services.

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[110] We note with interest the National Commission of Audit report (http://www.ncoa.gov.au/), which identified the model of federalism as something worth further consideration. We await the White Paper on the federation. This section summarises the current federalism model between states/territories and the Commonwealth in relation to healthcare, with reference to the previous government's commitment to collaborative/cooperative federalism.

Successive governments have sought to amend, clarify and refine the respective roles of the states/territories and the Commonwealth in health care precisely because of the difficulty in establishing national priorities, planning processes, and decision-making in one part of the system which does not account for or accord with decision-making in other parts of the system (often referred to as "the problem of federalism").

We now turn to examine the Intergovernmental Agreement on Federal Financial Relations (IGAFFR), the healthcare agreements and the National Drug Strategy for documentation about roles and responsibilities of the Commonwealth and states/territories in relation to AOD treatment and funding.

Federal financial relations
The Council of Australian Governments (COAG) agreed to the Intergovernmental Agreement on Federal Financial Relations (IGAFFR) in November 2008, establishing a new framework for financial relationships between the Commonwealth and State/Territory governments. This Agreement established a new framework for financial relationships between Commonwealth and state/territory governments. The framework has three underlying features; flexibility, accountability, and a focus on outcomes.

> "The framework provides the States and Territories with flexibility to deliver quality services where they are most needed, while increasing governments' accountability to the public. This new framework focuses the attention of all parties on the achievement of policy objectives, including those that are part of the COAG reform agenda, which aim to improve outcomes for all Australians" (Council Of Australian Governments, 2008b).

From this understanding, the Commonwealth focus is on service/sector quality and effectiveness, not necessarily on the specifics of what is delivered, which is determined by the states/territories:

> "Rather than seeking to control how States deliver outcomes, the IGAFFR aims to improve the quality and effectiveness of government services by reducing Commonwealth prescription, aligning payments with the achievement of outcomes and/or outputs and giving States the flexibility to determine how to achieve those outcomes efficiently and effectively" (Council Of Australian Governments, 2008b).

The IGAFFR is designed to provide the framework for federal financial relations that supports collaboration on policy development and service delivery and facilitates the implementation of economic and social reforms in areas of national importance. It recognises that "coordinated action is necessary to address many of the economic and social challenges which confront the Australian community"
(http://www.federalfinancialrelations.gov.au/content/inter_agreement_and_schedules/IGA_federal_financial_relations_aug11.pdf).

Role clarity, across different levels of government, is a central principle in the policy:

> "A key objective of the framework is increased accountability of Commonwealth and State and Territory governments to the public, underpinned by clearer roles and responsibilities in respect of each jurisdiction. Clearly specified roles and responsibilities are important so that the community understands which government is responsible for particular outcomes and outputs.
> http://www.federalfinancialrelations.gov.au/content/inter_agreement_and_schedules/IGA_federal_financial_relations_aug11.pdf).

Thus we need to turn to the Agreements under the IGAFFR to examine whether they shed light on the respective roles of Commonwealth and states/territories and how this might relate to AOD treatment services. Under the IGAFFR, health care services are covered by two umbrella agreements, the 2012 National Healthcare Agreement (NHA: with no designated funds attached) and the associated National Health Reform Agreement (NHRA) (with designated funds attached, i.e., National Health Reform Funding). The NHRA was entered into by all states, territories and the Commonwealth, in August 2011.

National health reform
In the 2012 National Healthcare Agreement, the Commonwealth "will continue to subsidise public hospitals and private health services through this Agreement, the Medicare Benefits Schedule, the Pharmaceutical Benefits Scheme and other programs" (Council Of Australian Governments, 2011). In addition to its joint funding responsibilities, the Commonwealth will fund:
- access to private medical care;
- access to pharmaceuticals;
- access to private health insurance;
- education of health professionals;
- health services for eligible veterans;
- residential, community and flexible aged care services;
- purchase of vaccines under national immunisation arrangements; and
- community-controlled Aboriginal and Torres Strait Islander primary healthcare (Council of Australian Governments, 2011b).

States and territories are responsible for the provision of health and emergency services through the public hospital system. In addition to their joint funding responsibilities, States and Territories will fund:
- community health;
- capital infrastructure and service planning;
- ambulance services;
- food safety and regulation;
- environmental health; and
- disability services (Council of Australian Governments, 2011b).

The Commonwealth, States and Territories will jointly fund:
- public hospitals;
- public health activities;
- mental health services;
- sub-acute care;
- Aboriginal and Torres Strait Islander health services;
- health research;
- health workforce training;
- emergency responses; and
- blood and blood products (Council of Australian Governments, 2011b).

The National Health Reform Agreement specifies the following role delineations (Council Of Australian Governments, 2011a):
"Under this Agreement, the Commonwealth and the States will be jointly responsible for:
a) funding public hospital services, using ABF where practicable and block funding in other cases;
b) funding growth in public hospital services and the increasing cost of public hospital services;

    c) establishing and maintaining nationally consistent standards for healthcare and reporting to the community on the performance of health services;

    d) giving effect to the new Commonwealth-State governance arrangements including the establishment of relevant national bodies; and

    e) collecting and providing data to support the objectives of comparability and transparency, and to ensure that data is shared between relevant participants in national health care arrangements to promote better health outcomes.

Under this Agreement, the States will be responsible for:

    a) system management of public hospitals, including:

    b) taking a lead role in managing public health; and

    c) sole management of the relationship with Local Hospital Networks to ensure a single point of accountability in each State for public hospital performance, performance management and planning.

Under this Agreement, the Commonwealth will be responsible for:

    a) system management, policy and funding for GP and primary health care services;

    b) establishing Medicare Locals to promote coordinated GP and primary health care service delivery;

    c) working with each State on system-wide policy and state-wide planning for GP and primary health care;

    d) promoting equitable and timely access to GP and primary health care services; and

    e) planning, funding, policy, management and delivery of the national aged care system noting that there will be different arrangements in Western Australia and Victoria under this Agreement (clause F4 refers)."

What does this mean for AOD treatment? As is apparent, while role clarity is sought and specifics are entered in both Agreements, there remains a lack of clarity for AOD treatment, falling as it does between acute, hospital and primary care services[111]. Indeed, in a verbal briefing provided to ADCA and state/territory peaks in 2012, the then Health Minister Mark Butler identified federalism as one of the key challenges for the Commonwealth in relation to its role in funding AOD treatment. It would appear that the current IGAFFR and health care agreements do not provide a level of detail to clarify the respective roles in AOD treatment. We turn now to examine other national policy documents that may assist.

National drug policy

Since 1985, Australia has had a coordinated, national policy for addressing alcohol, tobacco and other drugs. The inaugural policy, entitled the *National Campaign Against Drug Abuse*, noted that:

> "A national approach is essential with co-operative effort and mutual support across jurisdictional boundaries. Drug problems are a national issue. Patterns vary with location but events in one location influence those in others. Resources and ideas need to be shared. There will be close co-operation between Commonwealth and State/Territory Governments in the development and implementation of the Campaign" (Commonwealth Department of Health, 1985, p. 3).

In the National Drug Strategy (Ministerial Council on Drug Strategy, 1998) the Commonwealth Government was described as "providing leadership in Australia's response to reducing drug-related harm" and the National Drug Strategy Unit in the Department of Health was described as having five

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[111] In early healthcare reform documents (now superseded), alcohol and other drug services were identified as an area to be subject to either "transfer to the Commonwealth" or "strong national reform" (National Health and Hospitals Network Agreement, 2010 page 26 B34: https://www.coag.gov.au/node/126).

primary responsibilities related to the National Drug Strategic Framework. These responsibilities were said to involve:

- Ensuring national policy development, coordination and management, in conjunction with the Ministerial Council on Drug Strategy, the Australian National Council on Drugs, the Intergovernmental Committee on Drugs, the national expert advisory committees and the community-based sector;
- Managing the workplans of and providing policy assistance and executive support for the Ministerial Council on Drug Strategy, the Australian National Council on Drugs, the Intergovernmental Committee on Drugs and the national expert advisory committees;
- Monitoring and evaluating the impact of the National Drug Strategy and any changing trends in order to provide timely advice to the Ministerial Council on Drug Strategy, the Australian National Council on Drugs and the Intergovernmental Committee on Drugs;
- Responding to identified areas of need by commissioning work that is best done at the national level;
- Providing advice on the policy-related aspects of Australia's international treaty obligations (Ministerial Council on Drug Strategy, 1998, pp. 40-41).

The current iteration of the NDS, for 2010-2015, describes a cooperative joint venture between the Commonwealth and states/territories (Ministerial Council on Drug Strategy, 2011). A key mechanism for State and Territory input has been via a formal committee, the Intergovernmental Committee on Drugs (IGCD), which includes jurisdictional representatives from health, law enforcement, and education. The IGCD:

> "Is a Commonwealth, state and territory government forum of senior officers who represent health and law enforcement agencies in each Australian jurisdiction and New Zealand, as well as representatives of the Australian Government Department of Education, Employment and Workplace Relations. The committee provides policy advice to relevant ministers on drug-related matters, and is responsible for implementing policies and programs under the National Drug Strategy framework" (Ministerial Council on Drug Strategy, 2011, p.24).

Two-way communication is advocated; with information from jurisdictions feeding into national policy development and jurisdictional representatives focusing on policy implementation. We note the potential role of the IGCD in other sections of the Review, for example in the approach to joined-up planning (as detailed in Chapter 13). The NDS charges the states and territories to provide leadership within their jurisdictions. "They are responsible for policy development, implementation and evaluation, and for the delivery of police, health and education services to reduce drug-related harm" (Ministerial Council on Drug Strategy, 2011, p.24).

Thus the National Drug Strategy provides some delineation in that the states/territories are responsible for providing the health services (AOD treatment). However, it does not speak to the funding of AOD treatment.

Role delineation

Achieving role clarity in AOD treatment is likely to require substantial reform. For example Hinz (2010), p.4 provides a succinct summary of scholarly debate about the reforms that would be required in the education system:

> "The nature, degree and extent of reforms thought necessary varies widely among scholars and practitioners. On one side, Kenneth Wiltshire (2005), A. J. Brown (2006) and the Business Council of Australia (2006) argue for a major overhaul of what they consider a dysfunctional system. Lingard, O'Brien and Knight (1993) are typical of education scholars who regard Commonwealth intervention and policy uniformity as desirable and necessary to

drive improvement and achieve broad goals such as equality of opportunity and social justice. On the other side, scholars such as Brian Galligan (2008), Cliff Walsh (2006), and Jonathan Pincus (2006) argue that, on the whole, the Australian federation is operating well, with intergovernmental competition and overlap a sign of dynamism and healthy a [sic] sorting of roles. Between these two extremes, are scholars such as Anne Twomey and Glen Withers (2007), Alan Fenna (2007) and Andrew Parkin (2003), who advocate for the maintenance of federal structures, but with a sharper delineation of state and commonwealth roles and responsibilities, and removal of concurrency."

The delineation of roles within federalism is clearly a topic that is currently front and centre in Australia (eg National Commission of Audit). There appears to be a spectrum of options: the Commonwealth could take sole responsibility for service delivery; or primary responsibility with contribution from states/territories; or sole responsibility for the framework for service delivery, with states/territories administering the area with flexibility; or where the states/territories take primary responsibility for service delivery with contribution from the Commonwealth. In general, decisions about roles and responsibilities follow the subsidiarity principle (responsibility should reside as close to the population in need as possible) and fiscal considerations (given vertical fiscal imbalance) (Pincus, 2006). Decisions may also depend on the extent to which uniformity and minimum standards are desirable, the importance of ensuring equity of access to and availability of treatment, and duplication in bureaucracy. We are not going to "solve" federalism, but there is potential for substantial benefit from the Commonwealth and states and territories operating in a more coordinated fashion in the "overlap and entanglement" (Fenna, 2012) of AOD treatment provision in a federal system. Coordination requires cooperation and good will on the part of both the Commonwealth and the states/territories.

This chapter seeks to specify a clear role for the Commonwealth. Before we move to that discussion, however, it is important to acknowledge that even though most scholars (and key informants) have argued for clarity of roles, and role delineation, there are also compelling counter arguments. From the literature, we note that Hollander (2010, cited in Hinz, 2010) argued that duplication, overlap and redundancy can perform useful functions. The imposition of artificial boundaries can reduce the checks and balances in a federated system. These points have been echoed by comments from some key informants:

- "No player wants to be constrained by delineation"
- "Scope creep applies both ways – Commonwealth want flexibility to be able to respond/do anything for a local constituency, in same way states and territories want a similar opportunity".

It is possible that when roles are less clearly delineated (ie more nebulous) then cost-shifting becomes harder. (For example it has been argued that the introduction of hospital ABF funding has seen states/territories shifting activities into the ABF frame, whereas under a vaguer or more loosely defined system this may not be as easy).

Thus it seems clear that a delicate balance is required between the precise specification of jurisdictional roles and flexibility for jurisdictions to respond to need. Clarification of the Commonwealth's mandate is taken up in light of this required balance, and with consideration of the importance of AOD treatment funding (given the extent of unmet demand and the benefits from treatment). In addition, consideration of the issue of duplication is required. (We take up duplication later in this chapter).

The Commonwealth role

This section began with asking about the mandate that the Commonwealth government has in relation to AOD treatment services. It is clear that the issue of the respective roles of the Commonwealth and state/territory governments is complex in relation to both the planning and funding of health care (and that the issue of federalism continues to be vexed). For AOD treatment, there is little specific light shed from the IGAFFR or the health care agreements. The current NDS remains vague about the respective roles and while key informants noted the importance of a role in providing a 'national perspective', this does not perforce delineate the Commonwealth's specific contributions.

In this light then, it can be argued that the Commonwealth has the opportunity to consider its own role and mandate. Arguably this is what has happened. Historically, the states funded all AOD treatment. In the 1990's the Commonwealth government commenced a small grants program to fund largely abstinence-based treatments (the original NGOTGP). This was seen by some commentators as an attempt to ensure a treatment ideology (rather than any shift in role of respective funders). In addition, the Commonwealth identified a significant role in providing funds for the treatment of individuals who would otherwise have been subject to criminal justice interventions ('diversion' programs, including drug courts, police education and treatment referrals and so on). These two things considerably expanded the Commonwealth government's investment in AOD treatment across Australia. Over time, with the known research about the economic and social burden of untreated alcohol and other drug use, coupled with the mandate for achieving equity in healthcare, and the specific responsibility to improve health outcome for Aboriginal and Torres Strait Islander people, the Commonwealth expanded its commitment.

The Commonwealth currently plays a substantial role in funding AOD treatment, with 39% of all government funding coming from the Commonwealth (this includes Medicare and PBS funding) (see Chapter 4). Focusing on AOD specialist services in particular, Commonwealth funding accounts for 21% of this funding (see Chapter 4). This context is important in considering the appropriate mandate for the Commonwealth in the future. There is no doubt that the Commonwealth is a significant player in AOD treatment funding, and that the treatment sector in Australia would be fundamentally reduced if the Commonwealth was not engaged in funding. In the context of high levels of unmet demand (see Chapter 8), this would create substantial problems for services, consumers, and, perforce, the community. The importance of Commonwealth funding for treatment was highlighted by key informants: many services would cease to be viable if it were not for the Commonwealth contribution; and some services are solely funded by the Commonwealth.

Clearly the Commonwealth has a role in this area that is founded in AOD treatment funding. But the Commonwealth role is more than simply a parallel funder of AOD treatment with states/territories. There is a unique and essential contribution by the Commonwealth, inclusive of treatment funding but representing a national mandate. Using the current policy frameworks (IGAFFR, NDS, Health Care Agreements) and key informant perspectives, we have identified four Commonwealth responsibilities. These are:
5. Advancing national priorities
6. Providing leadership in planning
7. Addressing service quality
8. Supporting equity.

Each of these is discussed below.

1. Advancing national priorities

The Commonwealth has a unique role and responsibility to advance areas seen as important *across* multiple states and territories. National health agreements support this role and key informants, particularly from Commonwealth positions, identified national leadership as an important function. In terms of overall Australian healthcare resources, it has been argued that the Commonwealth is best placed to respond to funding challenges and has "more ability than the states to develop new policy initiatives that involve additional spending" (Duckett & Willcox, 2011, p.111).

Key informants noted that the Commonwealth has a particular and unique responsibility in establishing and leading responses on national priorities. As noted by one key informant, the Commonwealth mandate is for "things that have a national roll-out, national consistency and required frameworks of care". It is the only level of government that can provide a "bird's eye" perspective on AOD across the nation.

Funding for treatment services, where those services have demonstrated cost-effectiveness and form part of a national priority is an important Commonwealth role. This may include national priorities in relation to specific population groups and their access to withdrawal services, residential rehabilitation, pharmacotherapy maintenance and/or psycho-social therapy. Or it may include national priority for alcohol treatment (see Chapter 8 for data concerning the significant unmet demand for alcohol treatment).

Another national priority is the capacity building initiatives. The Commonwealth's role in comorbidity capacity building is an excellent example of national priority setting and leadership from the Commonwealth (this example often raised by key informants). For example, it was described as, "very successful re mandate of Commonwealth". This need for a national perspective and a "national coordinating layer", through specific bodies such as the IGCD, demonstrates this key aspect of the Commonwealth's role. A national perspective can guide national investment in approaches targeting emerging issues and unmet demand for services. As expressed by one Commonwealth key informant, the "Commonwealth's role is providing a national approach – this is where we can add value".

2. Providing leadership in planning

As identified earlier in this chapter, federalism brings a level of complexity to healthcare planning and funding. The split in responsibility across Commonwealth and state/territory governments means "that it is difficult to develop comprehensive national policies" (Duckett & Willcox, 2011, p.107). This is compounded by the unusual status of AOD at policy level. It is not identified in funding responsibilities put forward in national policies for the Commonwealth or the states and territories (cf. NHA, NHRA), but occupies an interstice in primary and acute health - an important but undefined intervening space. This makes a comprehensive approach to planning all the more important.

Consistent with the unusual policy position of AOD and the financial framework put forward in the IGAFFR, Australia's National Drug Strategy has a strong emphasis on planning that involves collaboration, co-ordination, and two-way communication channels between levels of government.

The importance of strategic planning for AOD treatment has been repeatedly highlighted by comments from key informants, to increase the certainty regarding treatment fidelity and possible outcomes, and to make best use of available resources across both levels of government. As expressed by one key informant, service delivery needs to be, "directed by a good strategic planning process". This seems an obvious role for the Commonwealth. Strategic planning involves high-level

agreement on values, goals and priority areas and it is a good fit with a leadership focus and a national perspective. This is a particular and specific role for the Commonwealth government. (Further discussion of planning and the Commonwealth role is provided in Chapter 13).

This leadership role has the added benefit of supporting the sustainability of the sector; the existence of quality services that are engaged in meaningful, evidence-based activities, in an environment that involves ongoing commitment to service improvement and sector development. While this is a shared responsibility across different levels of government, the Commonwealth's contribution to strategic planning (and allied elements of the mandate we describe here) is vital.

3. Addressing service quality

Service quality is a key mechanism by which positive treatment outcomes are made possible and the focus on outcomes is a foundational element of national policy. The IGAFFR (Council of Australian Governments, 2008a) emphasises a funding relationship that focuses on outcomes. Capacity building is an important way to build service quality and hence improved outcomes.

Mechanisms that preserve organisational capacity and sustainability include supportive policy and sound governance, along with clear management and leadership structures. Capacity building programs in non-profit organisations have helped to: clarify roles and responsibilities; advance understandings of the nature of and necessity for planning; and enhance management and administrative skills. The three streams of capacity building that we identified in Chapter 5 (Priority topic or client target population; Organisational or institutional capacity building; and Intra- and inter-sectoral systems of care) all speak directly to service quality. Capacity building activities across these three streams include funding direct care (AOD treatment), as well as funding workforce development (for example mentoring and clinical supervision) and inter- and intra-sectoral network building.

Key informants at the national level spoke about the Commonwealth role in relation to service quality. They recognised the benefits from having "national consistency and required frameworks of care". The existing national clinical guidelines, facilitated and led by the Commonwealth, have been important contributions here. Financial support to assist organisational readiness for formal accreditation processes has also been well regarded. Key informants noted that this type of national initiative would highlight "values and quality framework, standards for care". There is a strong argument for a nationally consistent approach to support quality services. A quality framework project is currently underway.

The rationale for building organisational capacity is closely aligned with intentions of the NDS regarding workforce development (Ministerial Council on Drug Strategy, 2011). Initiatives in support of workforce development have been an important focus at Commonwealth level across different areas of need, including co-morbidity and cultural competence (for example).

The Commonwealth has a key role in presenting a national perspective on service quality. As noted by key informants, there is scope to see "the big picture" and avoid "blind spots" that may arise in specific locations.

4. Supporting equity

Equity ensures equal or fair delivery of treatment services and equal or fair treatment outcomes. We refer to both substantive equity (treatment outcomes) and procedural equity (access to treatment) here in the Commonwealth responsibility.

One Commonwealth key informant noted the Commonwealth's role as including "national equity issues – ensuring equity in access across states", while a key informant from one of the states/territories (focused on rural and remote areas) described the Commonwealth's role in supporting equity of access "across the state". Some key informants commented on the importance of models that account for the particular needs of AOD clients (disadvantaged, marginalised) and the importance of models that incorporate a high level of service responsiveness, to facilitate engaging and retaining these clients in care. It is noteworthy that the vulnerable and marginalised populations are raised as a particular issue in the context of equity.

Given *vertical fiscal imbalance* (where one level of government raises more revenue than it needs, and another level needs to spend more than it can raise) the Commonwealth must fund treatment services to ensure equity. The Commonwealth's role in funding core AOD treatment (withdrawal services, psycho-social therapy, residential rehabilitation and pharmacotherapy maintenance) is a direct response to ensuring service equity – where those services do not exist, or are insufficiently accessible, or are not targeted to meet the areas of highest need.

By supporting equity (of access and outcomes), the Commonwealth provides insurance for AOD treatment in Australia. Supporting equity between states/territories is required given that some states/territories have greater need with less capacity to raise revenue. Supporting equity within states/territories is required because changes in a jurisdiction's investment (in AOD and in other areas) can impact on AOD treatment in that jurisdiction. The Commonwealth has a responsibility, in this situation, to ensure minimum service levels and target resources to the most marginalised and vulnerable.

An extension of these considerations on equity of access involves the importance of treatment pathways and associated supports. For example, in one jurisdiction key informants commented that "ensuring equity in access across states and addressing an identified gap, or problem" is an important role for the Commonwealth. In another location, key informants spoke about, "making it easier to get into treatment and at the right level, creating better pathways by need. This may be facilitated by addressing practical barriers to accessing treatment such as placing services close to public transport, or providing a crèche (for example)". Informants from another jurisdiction noted the importance of having "core AOD treatment in place before we can focus on sub-populations, or on service developments", reflecting the need for treatment places. Another specific role for the Commonwealth is providing a timely response to emergency situations. There is a mandate to ensure AOD treatment equity in Australia.

Summary: the Commonwealth role

The four responsibilities (national priorities, leadership in planning, ensuring service quality, and service equity) are grounded in the existing documentation regarding the role of the Commonwealth in healthcare, in the National Drug Strategy, and in the perspectives put forward by key informants. They are also consistent with the principles identified in Chapter 1: effectiveness, efficiency and equity. The Commonwealth's mandate in ensuring nationally consistent quality standards, clinical guidelines and effective planning processes all speak directly to successful treatment outcomes for individual clients. Maximising the likelihood that Australia has treatment service systems that are highly effective in producing positive health outcomes is a clear Commonwealth mandate. Leadership in planning and purchasing by the Commonwealth will demonstrate efficiency. Efficiency is achieved when the best possible combination of services to meet needs is provided. The sustainability of the AOD sector is another aspect of efficiency – the stable provision of needed resources to complete planned activities. Finally, taking the principle of equity seriously means that

the Commonwealth must fund direct AOD treatment where there is a prioritised gap, an emergency situation or a failing by other funders.

The next step in our considerations is the translation of these Commonwealth responsibilities into specific tasks, activities and purchasing decisions. We note that some areas and activities overlap, which is quite appropriate, however it is important to illustrate the dominant activities and focus of purchasing. The table below provides a high-level summary. The next section goes into detail.

Table 12.1: The Commonwealth role and responsibilities for AOD treatment matched to activities and purchasing

Role/responsibility	Types of activities / focus of purchasing
Advancing national priorities	National strategic frameworks
	Treatment services
	Capacity building
	Support for innovation through targeted pilots and other innovations
Providing leadership in planning	Strategic planning at a national level
	Planning in concert with states and territories
	Planning toolkits and practical resources
Addressing service quality	Treatment services
	Capacity building
	National clinical guidelines
	Quality frameworks
Supporting equity	Treatment services
	Capacity building

Options for Commonwealth purchasing

Consideration of approaches to national strategic frameworks, technical planning and other planning processes are detailed in the next chapter (Chapter 13).

Quality framework development is the subject of a separate project.

Here we concentrate on the remaining areas - treatment services and capacity building – but also take these up again in Chapter 14 in relation to purchasing mechanisms, Chapter 15 in relation to accountability, and Chapter 16 which draws all the work together.

As noted in Chapter 5, at present the Commonwealth purchases both AOD treatment and capacity building. The relative investment is 84% treatment; 16% capacity building (when the quantum of funds is used as the metric).

AOD treatment

The following are the core AOD treatment types:
- Withdrawal services
- Residential rehabilitation
- Psycho-social therapy (counselling)
- Pharmacotherapy maintenance

As discussed in Chapter 1, this includes the assessment, case management and support, information and education and aftercare services, along with a variety of modes of delivery, such as telephone services, outreach, group-based, day programs, individual face-to-face services and on-line services.

During our consultations with key informants there was much discussion of the importance of the Commonwealth's role in contributing to the availability of 'core services'. These interventions are evidence based and constitute central elements of an AOD treatment pathway. These treatment types are also the main focus of government investment across Australia, as evidenced by the NMDS (see Chapter 5 also). Unsurprisingly, in the context of unmet demand (see Chapter 8), the commentary about 'core services' often referred to the need to support service access in a sector that is over-stretched and substantially reliant on Commonwealth funding. At times the discussion was about gap filling, but the predominant focus was on maintaining what currently exists, as a first priority. Key informants comments emphasised the need to "keep what we have", that the "the focus should be on consolidating what already exists"; and that, "continuity of Commonwealth funding is essential".

Deciding what types of treatment or what types of clients?

The Commonwealth could rely on strategic and technical planning to determine the relative investment mix across the core AOD treatment types (see Chapter 13). Alternately, it could decide *a priori* about the types of core services that it purchases. The advantage of using a planning process is that decisions are grounded in data on need and demand and focus the Commonwealth's effort in those areas that emerge as highest need. The relative disadvantage is that we already know that there is large unmet demand – and investment in all of the core AOD treatment services would be worthwhile. If the Commonwealth were to consider defining specific service types for funding, we explored four options which emerged from the Review data:
1. a focus on (generalist) primary care alone
2. a focus on one particular service type
3. a focus on specialist low intensity treatments
4. a focus on certain population groups.

One option involved the Commonwealth focussing on primary care. This would be consistent with the Commonwealth's current mandate in healthcare in Australia. It would concentrate Commonwealth resources at the mild/moderate end of the severity spectrum. The significant limitation of this option is the current situation – where the Commonwealth funds tertiary and specialist treatment and the sector is currently reliant on those funds. Thus any move towards shifting the treatment funding toward a greater primary care focus would need to commence with careful and long-term planning. There is a further complexity in that the distinction between primary care and specialist services is tenuous at best in AOD. As noted in the Chapters in Part 1 (see Chapter 1, Chapter 4, Chapter 5) there is a challenge in distinguishing the specialists and generalists in AOD treatment. Certainly there are specialist settings (ie providers who only provide AOD interventions) and generalist settings (such as hospitals and primary care settings) but AOD interventions themselves: withdrawal, psycho-social therapy, pharmacotherapy maintenance are provided in both settings. Thus, this division does not work in AOD, and therefore is not a helpful way of delineating the Commonwealth's service delivery contributions.

Another possibility is a division of responsibility based on service types. At present, the Commonwealth purchases withdrawal services, residential rehabilitation and psycho-social therapy services through the NGOTGP and SMSDGF (see Chapter 5, and it also purchases pharmacotherapy maintenance through Medicare and the PBS). It could choose a focus on one particular service type.

The challenge with this option is deriving sufficient rationale, supported by data, for such a decision. It would run counter to the Commonwealth's responsibilities in relation to national priorities, service quality and service equity. The role of the Commonwealth would appear to be significantly compromised under this option. Furthermore given that the states/territories are responsible for providing the full suite of AOD service types (consistent with their mandate as the primary healthcare provider), this option may encourage or facilitate cost-shifting, inasmuch as states/territories may be tempted to cease their funding of the chosen service type.

It has been suggested that the Commonwealth could move away from funding higher intensity specialist treatments, such as residential rehabilitation. As it stands, the Commonwealth's investment in residential rehabilitation (in mainstream services) is lower than its investment in psycho-social therapy (counselling).As with other options explored here, concentrating the investment in one service type compromises the ability for the Commonwealth to ensure equity, and risks cost-shifting by states/territories. .

Finally, one option is for the Commonwealth to focus its treatment investment into particular population groups. The most obvious, and current priority is Aboriginal and Torres Strait Islander people. The Commonwealth currently invests 48% of the NGOTGP and SMSDGF in Aboriginal and Torres Strait Islander AOD treatment services (see Chapter 5). This should remain as a high priority population group (see separate report). However, if the Commonwealth chose to solely focus on this population group, there would be a substantial and negative impact for mainstream AOD treatment services, which at present are supported through $53 million in annual funds. So the challenge with this option, as with others, is managing a long-term change process. If all Commonwealth AOD treatment funds were expended in the Aboriginal and Torres Strait Islander AOD services area, this would also reduce the leverage that the Commonwealth has with state/territory governments in relation to mainstream services; and create an unusual planning environment (led by the Commonwealth but with the funding priority pre-determined).

The challenge with each of the above options is the lack of flexibility that they create. Some key informants noted the importance of flexibility in the funding schemes, and not wanting "to be too strict here" because this may stifle service innovation, diversity, and responsiveness to changing demands.

Overall, despite best intentions, it has become clear to the Review team that an effort to constrain the Commonwealth's purchasing of core AOD treatment has significant limitations. It runs counter to strategic and technical planning, it creates a level of inflexibility in decision-making, it constrains the possibility of leverage with the states/territories and it conflicts with the Commonwealth's responsibilities in relation to national priorities, service equity and service quality. We sought to identify logical distinguishing features of the core AOD service types that would sit well with the Commonwealth (eg specialist versus generalist; service types or population groups) and our analysis has failed to deliver a clear option in this regard for the short or medium term.

Pilots and innovation

Pilots and innovations can be understood as demonstration projects, or *non-recurrent projects*, which are purchased in a targeted and time-limited way to test new ideas and, through evaluation, build the evidence base for emerging treatments and modalities. Such non-recurrent projects are not regarded as 'core treatment' but nonetheless may contribute significantly to better reaching priority populations, responding to emerging issues, or finding ways of improving service delivery.

At present, the NGOTGP and SMSDGF do not appear to fund pilots or innovations over and above service improvement initiatives within the core AOD treatment service types discussed above. Perhaps this is sufficient, although if the Australian AOD sector wants to be cutting edge, then greater attention to innovations and pilots is necessary. We also note that the Proceeds of Crime Act 2002 (POCA) which allowed the confiscated funds to be given back to the Australian community, has funded pilots and innovation, but is now no longer directing funds to AOD treatment.

Key informants (mainly from state/territory peaks, boards, and services) spoke about the need to support innovation, in an area where treatment needs (and evidence) change over time. They felt it was important to maintain sector responsiveness to emerging and changing patterns of drug use and to trial and evaluate innovative models. For example, key informants from a number of states/territories commented on the need for "continuous improvement – keep thinking about the new things, future, next steps. Need to be responsive and thinking ahead". Some noted that the Commonwealth has a "strong role in 'innovation and capacity building' but this can be managed better; and evaluated", and "innovation – trialling and evaluating pilot projects… maintaining responsiveness is critical".

There was less commentary on the Commonwealth role in supporting innovation from key informants at Commonwealth level. Some commented that, "it would be nice to complement and support innovation" and "we are looking for innovation but the no growth funding situation means there is limited opportunity for this".

Ideally the Commonwealth would support innovation and diversity through its purchasing of direct service delivery. Funding innovations and pilots may be at the expense of 'core treatment' and given unmet demand, may not be regarded as a priority, however pilots and innovations are consistent with the role of the Commonwealth in addressing service quality.

Capacity building purchasing options

In Chapter 5, we identified three streams within capacity building:
- Client/priority topic;
- Organisational/institutional;
- Intra- and inter-sectoral systems of care.

Given the Commonwealth's leadership role in strategically planning for the current and future needs of AOD clients, the Commonwealth has a key role to play in identifying priority issues for capacity building and providing associated funding. This ensures that there is a synergistic relationship between broader planning priorities, and that the sector is well equipped to respond to and fulfil strategic directives. For example in relation to the first capacity building stream, priority issues or populations could be determined in conjunction with planning processes, early warning systems, state and territory consultation, and analyses of unmet treatment need for particular groups.

The Commonwealth government is uniquely positioned to use capacity building to generate national momentum in relation to priority issues and to facilitate cross-portfolio learning. Where the Commonwealth government identifies a particular policy priority area (for example mental health, homelessness, family oriented models) there are opportunities for new funding to be directed towards capacity building in the AOD sector, to ensure that the AOD sector is equipped to address the needs of that priority population and ensure whole of government cooperation. This approach has great potential to rapidly build momentum and responsiveness across government portfolios and ensure the AOD treatment sector is working in synergy with other national priorities. However,

it should be noted that this approach to aligning capacity building with national priority areas may direct funds into an issue which is not regarded as a pressing concern at the local level. As such, an alternate option would be to provide capacity building funds across a suite of priority issues, and allow local areas to mount arguments regarding their particular needs. This approach has the benefit of addressing on the ground issues, but requires astute and joined-up planning so that national priorities remain in focus while maintaining scope for variation to account for jurisdictional needs.

There are compelling arguments for why services should be funded to engage in capacity building, over and above core treatment funds. Given the tight fiscal operating environments of not-for-profit organisations and health services, there is little incentive or flexibility for organisations to engage in quality improvement and capacity building unless they are funded to undertake these activities. Crisp et al. (2000) maintain that change is unlikely to occur without outside resources. One of the services consulted for this Review noted that dedicated capacity building funding allowed organisations to 'back-fill' staff positions while other workers undertake training or planning, which was essential for the service. It was said that the capacity building program, which had been funded through the SMSDGF, had been "amazing" for their organisation. They noted that up-skilling staff and evaluating programs had been incredibly valuable. Another service consulted noted that the SMSDGF capacity building funding had "really helped us set a bench mark" and "lift the bar". It was said that this capacity building funding had been "fantastic and critical" for the organisation – because state funding is so limited - this capacity building funding (as well as trust and foundation money) supplemented staff development and supervision across the organisation.

Almost all key informants valued the investment that the Commonwealth had made in capacity building to date and identified it as a priority investment for the future. Capacity building is consistent with the Commonwealth's role in service quality, equity and advancing national priorities. We conclude this chapter with an examination of duplication and cost-shifting as both these concepts pertain directly to the Commonwealth's role and responsibilities.

Duplication

Self-evidently, there is no concern in relation to 'duplication' regarding the Commonwealth's responsibilities in advancing national priorities and providing leadership in planning. Both of these responsibilities are unique to the Commonwealth and cannot be performed by any other level of government. However service quality and service equity, achieved through funding core AOD treatment services and capacity building have the potential for 'duplication' with the states/territories.

Key informants to the review were asked about duplication and two responses stood out:
> a. concerns about duplication, typically from government personnel, reflecting a level of anxiety and uncertainty about what is occurring; and
> b. sector perspectives that it is important not to misapply notions of duplication to situations where multiple funding sources provide a program of services.

In an ideal world, duplication would be avoided if governments did separate things. That is, one could argue that if the Commonwealth did not purchase AOD treatment, there would be no problem with 'duplication' (however defined – see below). However, role delineation cannot be driven solely by the desire to avoid duplication. As we have noted in this chapter, clear delineation of roles and responsibilities is important but is also associated with risk – the risks include the potential loss of funding; curtailing innovation; reducing the sustainability of the NGO sector; and stifling the opportunity for any one level of government to take initiative.

'Duplication' takes us back to where this chapter started – with federalism and the challenges of effective and efficient coordination between two levels of government. Recommendation 7 of the National Commission of Audit notes:

"There is significant overlap between the activities of the Commonwealth and the States. The Commission recommends that a comprehensive review of the roles and responsibilities between the Commonwealth and State governments be undertaken, informed by:

a. the principle of 'subsidiarity' so that policy and service delivery is as far as is practicable delivered by the level of government closest to the people receiving those services;

b. ensuring that each level of government is sovereign in its own sphere; and

c. ensuring minimal *duplication* (our emphasis) between the Commonwealth and the States and, where overlap cannot be avoided, ensuring appropriate cooperation occurs at all times". (http://www.ncoa.gov.au/)

Clearly 'duplication' is of concern: the National Commission of Audit is replete with references to it. For example: "The Commission supports the proposed review by the National Mental Health Commission and recommends that the review pay particular attention to removing the significant duplication between the Commonwealth and the States that currently exists in mental health services" (National Commission of Audit, Recommendation 40: http://www.ncoa.gov.au/). Yet it is not clear precisely what is meant by duplication[112].

Duplication can refer to a number of different things:

- Duplication of funding: that is the same funds being provided for the same service (otherwise termed 'double dipping'). From the Commonwealth guidelines: "Double dipping occurs where a grant recipient is able to obtain a grant for the same project or activity from more than one source"

- Duplication of administration: that is a doubling up of administrative processes such as competitive grant selection processes, contract management and so on

- Duplication of planning: that is both levels of government engaged in the same level of planning

- Duplication of services: that is, multiple AOD services of the same type; or the same client being seen by two different agencies at the same time.

Clearly the last version of duplication is presumably not what governments (or the National Commission of Audit) are worried about. Multiple AOD treatment services are required in multiple settings. Indeed, in high risk, high population areas one would expect to have multiple AOD services providing the same service types. Given the extent of unmet demand for treatment (see Chapter 8), and the importance of consumer choice in effective treatment outcomes, the existence of multiple services is important. Likewise, clients do attend multiple services – this is how their various treatment needs are met (e.g., withdrawal, counselling, in addition to services on housing, relationship support, etc). We do not further consider duplication under this definition, although we do note that effective planning processes (see Chapter 13) are important in ensuring the most appropriate number and type of services are provided to meet population need, without creating a surplus of AOD treatment. (It is far from possible that a surplus would be created).

Reduction of duplication in administration and planning (the second two types listed above) can occur if the goals and objectives of one party are identical to the goals and objectives of the other party, such that one process rather than two processes can achieve the objectives required. As will be seen in Chapter 14, the Commonwealth could potentially reduce its administrative role in

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[112] And we suspect that it is misused. The notion that there is "significant duplication" in mental health services does not seem credible to us.

provider selection through outsourcing that function to states and territories. Likewise in planning, as detailed in Chapter 13 there is little point in the Commonwealth engaging in planning processes that are then replicated at state/territory level. As we discuss in Chapter 13 a sensible division of planning responsibilities between strategic and technical planning will avoid duplication. In Chapter 15 we consider whether the Commonwealth can use state/territory reporting functions to avoid administrative duplication both for government and for service providers.

The version of duplication that we think represents the gravest concern is the first, 'double dipping'. Clearly governments want clarity about what they are purchasing and that the funds they provide to a service are expended in accordance with the funder's expectations (and not spent on other activities, if the activity being purchased is actually funded by another party). This issue is also discussed in Chapter 5.

If the Commonwealth was funding an agency for exactly the same things as a state health department, this could be duplication. Where that agency then delivered and reported on the same activities to both funders, it is clearly duplication, and we would argue unethical behaviour on behalf of the agency. This kind of duplication is unacceptable. However, there is perhaps a more subtle and complex version of duplication. For example, in the context of excess demand, the state/territory could fund the same organisation to provide the same services as funded by the Commonwealth and the organisation could legitimately expand the service with those additional funds, through for example extending the opening hours; employing another staff member and so on. This is not duplication inasmuch as additional services, more episodes of care or greater service accessibility is achieved with the additional funds. The critical issue is how to ensure that this is measured against the respective funder's investment. We were told of examples where agencies divide their reporting up by funder: specific episodes of care are reported against state funding; whereas other episodes of care are reported against Commonwealth funding. Where the service types differ, this is relatively easy. Where the service types are the same (in the example of expanding the opening hours), this becomes more difficult. It is the responsibility of the funder to ensure accountability measures are in place; and it is the responsibility of organisations to behave ethically, to use the funds for the purposes to which they were given. (The issues associated with effective and efficient contracting and performance monitoring are taken up in Chapter 15).

We do not wish to imply that these issues are easily resolved. Funding provided by two levels of government to an organisation to support their ongoing service delivery activities can be difficult to distinguish. Indeed, as argued in Chapter 5, we see the advantages of co-funding (Commonwealth and state/territory funding of the same organisation) as a strength. But effective planning, formalised communication mechanisms between funders, good contract management, effective performance monitoring and quality assurance (including ethical behaviour by organisations) are ways of managing concern about duplication.

A brief word about cost-shifting; the Commonwealth should not fund AOD activities that would otherwise be the responsibility of states/territories. The Commonwealth grant guidelines note that, "agency staff should minimise opportunities for cost shifting and substitution of effort ie grant money shouldn't be used for activities that would normally be paid for by a state/territory or local government." The exception to this is in circumstances where an emergency situation has arisen, and consistent with the Commonwealth's mandate in relation to equity, the Commonwealth may fund services on an interim or medium term basis, until such time as the state/territory resumes responsibility. The Commonwealth should undertake its responsibilities in relation to the AOD treatment with regard to minimising the potential for cost-shifting. The problem of moral hazard, the unintended negative consequences where the Commonwealth 'picks up the tab' which provides disincentives for states/territories to provide funding, can be potentially avoided if the kinds of

communication, cooperation and collaboration that we are suggesting throughout Part 2 of this report is enacted between the two levels of government.

Conclusion

It is clear that duplication should be avoided, and cost-shifting minimised. Whatever processes the Commonwealth follows, it needs to minimise the chances of duplication and maximise the chances that states and territories feel and take responsibility for AOD treatment. This is important because states and territories are the primary funders of AOD treatment, and the Commonwealth's role is to both provide national leadership for that endeavour and value-add to specific state/territory processes. The responsibilities identified earlier, that is advancing national priorities, leadership in planning, addressing service quality and supporting service equity, can be achieved without duplication.

Summary

- The Commonwealth has a unique and specific role in AOD treatment in Australia. The responsibilities comprise:
  - Advancing national priorities
  - Providing leadership in planning
  - Addressing service quality
  - Supporting service equity
- These responsibilities are fulfilled through investment in direct service delivery and capacity building projects, along with leadership for the nation in planning, quality frameworks and ensuring equity.
- There is a continuing role for the Commonwealth in funding direct service delivery. Funding direct service delivery is consistent with the Commonwealth's mandate in supporting service equity, advancing national priorities and enabling service quality.
- We have sought to identify any logical distinguishing features of the direct service delivery that would sit well with the Commonwealth (eg specialist versus generalist; service types or population groups) and our analysis has failed to deliver a clear option in this regard for the short or medium term. The significant disadvantages of a primary focus on one service type include creating potential for cost-shifting, reducing leverage with states/territories, running counter to planning processes and compromising the Commonwealth's responsibilities in relation to national priorities, service quality and service equity.
- Ideally the Commonwealth would support innovation and diversity through its purchasing of direct service delivery. Funding innovations and pilots may be at the expense of 'core treatment' and given unmet demand, may not be regarded as a priority.
- Capacity building is consistent with the Commonwealth's role in service quality, equity and advancing national priorities. Capacity building is a legitimate role for the Commonwealth and provides scope for ongoing sector improvement. A planned approach to capacity building is important, to progress sector development in areas identified as national priorities while allowing for local variations.
- The Commonwealth should purchase both direct service delivery and capacity building activities, consistent with this mandate.
- Duplication can be avoided with good planning, communication and best practice contract management.

Chapter 13: The role of the Commonwealth in planning

Planning for AOD treatment is essential. Chapter 9 reviewed the relevant literature on planning, and considered key informant perspectives about AOD planning. The conclusions drawn from those data were:

- AOD treatment planning facilitates an understanding of the needs of a population in relation to AOD treatment and provides a coordinated and comprehensive mechanism for the efficient allocation of resources to meet a specific goal or goals.
- There is strong commitment to effective AOD treatment planning in Australia.
- The consensus appears to be that planning processes need input from the two primary funders — Commonwealth and state/territory governments; in a 'joined up' fashion.
- There is also consensus that service providers and consumers (current and future clients) be engaged in AOD treatment planning in Australia.
- A useful distinction can be drawn between strategic planning and technical planning.
- Strategic planning involves high-level agreement on values, goals and priority areas, and is a good fit with a leadership role for the Commonwealth.
- Technical planning involves specifications of the service types and populations in need of treatment and the required array of services to meet needs, usually best undertaken for defined geographical areas (eg, jurisdictions).
- Planning is a difficult and complex undertaking that can be resource intensive.
- Australia has a national quantitative technical planning tool, DA-CCP that provides national (and state/territory) estimates of the amount of treatment, types of treatment and resources required to meet demand. This information shows, at a national level, the extent of unmet demand for treatment, but this alone does not enable purchasing decisions.
- DA-CCP is silent on who the purchaser should be (and who the provider should be).
- Gaps remain in our planning tools and data: inclusion of geography and special needs groups are but two examples, along with the need for good consultative processes over and above any quantitative tool
- At present, there are no formal planning methods used for the NGOTGP and SMSDGF, nor the use of pre-defined formulae for funds distribution (eg, per capita distribution across states/territories).
- Challenges for planning include balancing specificity with flexibility, ensuring innovation is not stifled and marrying local needs assessment with regional, state and national needs assessments.
- The respective roles of national, state and local planning processes are currently unclear.

This chapter builds on the data presented in Chapter 9 to consider the specific role of the Commonwealth in relation to AOD treatment planning. The questions we consider are:

- Is planning necessary?
- What role does the Commonwealth have in strategic planning?
- Who is best placed to undertake technical planning?
- How is planning resourced; what data and tools are required?

Importantly, this chapter does not consider the appropriate planning mechanisms for Aboriginal and Torres Strait Islander AOD treatment services. It has become apparent that there are particular and different issues in the planning for Aboriginal and Torres Strait Islander AOD services. These have been treated separately (see report). As such, none of the discussion or conclusions drawn in this chapter necessarily apply to Aboriginal and Torres Strait Islander AOD service planning.

Is planning necessary?

Should the Commonwealth engage in planning? This may seem like a facetious question, but there are reasons why the Commonwealth may wish not to plan. The current status quo, the absence of formal planning processes at the Commonwealth level, has facilitated a highly flexible and responsive process to purchasing AOD treatment, and a focus on addressing key gaps. Arguably, the Commonwealth's role is to fill gaps in the AOD treatment service system (see Chapter 12). Knowing where those gaps are requires a planning process, but at the same time, filling gaps may occur in a non-systematic fashion. Indeed, key informants observed that "gap filling can be seen as ad hoc, random, driven by multiple informal processes". This can be the very nature of gap filling, especially when those gaps arise unexpectedly. The Commonwealth most recently did not use pre-defined formulae for fund distribution. This is consistent with the desire by the Commonwealth to distribute funds based on gaps and areas of highest need. [113] Planning processes that result in the full allocation of resources can inhibit "gap filling". Balancing gap filling with strategic, thoughtful, long-term planning is a challenge.

Another consideration that applies to AOD treatment planning is the current context. At present we have an absence of formal planning processes. It is generally true that when purchasing decisions appear to be fragmented, people call for consistency (indeed, most key informants argued for increased attention to planning which informs purchasing decisions). When there is comprehensive planning, however, people argue for localised exceptions.

There may be risks associated with planning. Some key informants reflected on the role that political decisions can play in funding decisions, and suggested that effective planning processes may place the sector at lower risk of political decision-making. Other key informants argued that political decision-making was an inherent part of the process. The risk of planning, as argued by one key informant, is that it takes the politics out of funding AOD treatment and it is actually the politics that gives AOD treatment the best chance of being funded.

Does planning run the risk of stifling local innovation? This speaks to the question of what planning results in, and the extent to which these products are highly prescriptive. Some key informants reflected on this issue – noting the problem of having both clarity and rational plans to inform resource allocation, at the same time as maintaining a level of flexibility for tailoring decision-making and for innovation. Key informants acknowledged the importance of flexibility and discretion, but at the same time also argued for systematic, rigorous, and scientific approaches to funding decisions built from comprehensive medium and long-term planning.

It could also be argued that because the potential treatment gap is large, perhaps planning is not required, that is, we can maintain the status quo of an absence of formalised planning. This line of thought suggests that any investment by the Commonwealth will fill a gap, given the extent of gaps identified (see Chapter 8). However, given finite resources, it behoves the government to invest in the most important or significant gaps, rather than merely 'any' gap that is identified. Thus planning in the context of large unmet demand needs to focus on prioritising the highest areas of unmet need.

While the absence of planning may facilitate highly responsive and flexible funding decisions, there may be potential for cost-shifting and duplication. In the absence of an agreed national plan, states/territories could withdraw funding from high need areas (whether defined as population

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[113] We do note, however, that despite the absence of formal use of per capita distributions across each state/territory, the actual distribution obtained for the NGOTGP and SMSDGF was remarkably similar to what may have been achieved with a formula. See Chapter 5.

groups or treatment types), knowing/hoping that the Commonwealth will step in and provide funding for these areas. Where planning specifies the respective roles of governments, this is less likely. Our consultations reveal a pressing need for clarity about the respective roles of different AOD treatment funders. Planning at a national level would entail resolution of the respective roles and mandates of the different purchasers. Effective planning and role clarity would obviate government concerns about the risk of duplication. Documentation of agreed medium and long-terms plans for AOD treatment funding would, in theory, reduce the likelihood of any one funder cost-shifting and the possibility of duplication.

We conclude that planning is necessary. Reliance on individual agencies to specify how they meet needs (in the purchasing process) is insufficiently rigorous.

Strategic planning by the Commonwealth

On the basis of the above considerations, there is a particular and specific role for the Commonwealth government to lead strategic planning for AOD treatment. The Commonwealth has a natural role to provide leadership in national strategic planning for AOD treatment. As our key informants (across government and service provider levels) noted:

> "The Commonwealth's role is providing a national approach – this is where we can add value".

> A "national coordinating layer" is required.

This role in developing a national AOD treatment strategy is consistent with the Commonwealth mandate for national leadership (see Chapter 12).

The National Drug Strategy – is this a sufficient strategic plan for AOD treatment?

The current National Drug Strategy 2010-2015 (Ministerial Council on Drug Strategy, 2011) is built on three pillars, the first of which, demand reduction, pertains to both prevention and treatment: "demand reduction to prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol and the use of tobacco and other drugs in the community; and support people to recover from dependence and reintegrate with the community" (page ii).

"Planning and quality frameworks for treatment services" was identified as a structural priority for the NDS 2010-2015 (there were 4 structural priorities: the internet, data collection and links and coordination with mental health services were the other three). There are specific actions under each of the pillars. The actions of relevance for treatment planning per se, as specified in the NDS 2010-2015, are:
- Develop planning models for treatment services that anticipate needs.
- Develop new evidence-based national planning tools to help jurisdictions better estimate the need and demand for alcohol and other drug health services across Australia. This should include the full spectrum of services from prevention and early intervention to the most intensive forms of care, and a range of services across the life span.

This speaks to the importance of planning, but does not provide direction about purchasing arrangements.

The NDS is an essential part of Australia's response to AOD. It provides a comprehensive umbrella document that guides and directs Australia's responses across the three pillars. It does not, however, provide specific direction about AOD treatment (and nor should it as this is not its intent),

As can be seen below, the actions pertaining to treatment in the current NDS are:

- Build on efforts to increase the range of, access to and links between evidence-based treatment and other support services.
- Develop and implement quality frameworks for treatment services.
- Sustain efforts to increase access to a greater range of culturally-sensitive services.
- Improve access to screening and targeted interventions for at-risk groups such as young people, people living in rural and remote communities, pregnant women and Aboriginal and Torres Strait Islander peoples.
- Increase awareness, availability and appropriateness of evidence-based telephone and internet counselling and information services.
- Strengthen the capacity of the primary healthcare system to manage prevention, early intervention and treatment of tobacco use and harmful alcohol use.
- Create incentives for people who misuse drugs or are dependent to access effective treatment and to make healthier choices.
- Encourage family members to access and make use of support services to help improve treatment outcomes for clients.
- Explore and develop opportunities in the criminal justice system, including correctional services, to assist drug users through education, treatment and rehabilitation services.
- Develop a set of national clinical standards for alcohol and other drug treatment services.
- Improve the links and coordination between primary health care and specialist alcohol and other drug treatment services to enhance the capacity to deal with all health needs and to facilitate the earlier identification of health problems and access to treatment.
- Improve the communication and flow of information between primary care and specialist providers, and between clinical and community support services to promote continuity of care and the development of cooperative service models.
- Investigate appropriate structures that could be developed to help engage families and other carers in treatment pathways and ensure that information about the pathways is readily accessible and culturally relevant.
- Identify and link the necessary services to provide those affected by drug use and dependence, such as family members, children and friends, with ongoing support including links to child welfare and protection services.
- Move towards a nationally consistent approach for non-government treatment services including quality frameworks and reporting requirements.
- Develop a sustained and comprehensive stigma reduction strategy to improve community and service understanding and attitudes towards drug dependence, help seeking and the related problems of individuals.
- Improve links and coordination between health, education, employment, housing and other sectors to expand the capacity to effectively link individuals from treatment to the support required for them to reconnect with the community.
- Support whole-of-government and whole-of-community efforts to build parenting and family capacity, creating communities that support the positive development of children. This may include evidence-based approaches to drug prevention in schools.
- Continue to implement skills training to provide individuals with coping skills to face situations that can lead to risky behaviour including harmful drug use.
- Provide support services to parents in recovery to ensure the needs of dependent children are met.

This represents a comprehensive list, and it is hard to think of an area that is not covered. This in itself is a problem. The NDS is insufficiently specific to operate as a strategic plan for AOD treatment. It provides guiding principles alone. There are a number of sub-strategies to the NDS but none of

these are specific to AOD treatment.[114] A specific treatment strategy would be consistent with the current NDS structural priority of "treatment planning" and the actions specified, such as "develop planning models for treatment services that anticipate needs". Thus it would sit underneath the NDS and articulate up to it.

Further examination of the NDS reveals that it does not have a section on roles and responsibilities. (It does have a section on governance but this is governance of the Strategy itself, rather than roles and responsibilities in taking the priority actions forward). The MH Roadmap and the draft National HCV Strategy, to give two examples, both have role statements. Such a role statement for AOD treatment seems essential in light of our findings regarding mandate and the challenges of federalism (see Chapter 12). In addition, a National AOD Treatment Strategy would include performance measures and targets. Whilst the current NDS has performance measures, these are 'high-level', not specific to treatment outcomes and do not have associated targets. (The draft National HCV strategy has a target of 50% reduction in the incidence of new HCV infections – again, one example of a strategy document that contains specific targets). The specification of performance measures and targets within a National AOD Treatment Strategy would also be consistent with the Report on Government Services performance indicator framework. Performance measures and targets are important in monitoring the outcomes associated with a National AOD Treatment Strategy.

Two further features of a successful National AOD Treatment Strategy are the process of development and sign-off. The process of developing an agreed national AOD Treatment Strategy would most sensibly be led by the IGCD, and engage all stakeholder domains. As noted in Chapter 9, stakeholder engagement in planning is essential. [115] The 'sign-off' process for a National AOD Treatment Strategy seems critically important and formal endorsement by health ministers would appear to be essential for its success.

The purpose of a National AOD Treatment Strategy[116] would be to document a ten-year treatment plan as a decision-support tool for treatment funders – facilitating clarity in relation to resource distribution in the context of finite resources (however strategic planning does not operationalise. It is at the technical planning level where specification of the allocation decisions occurs, eg: number of beds, amount of treatment places for sub-groups within the population). This Review has demonstrated the complexity and diversity of AOD treatment funding and purchasing arrangements in Australia. A nationally endorsed Strategy would form the foundation for better, more coordinated, more efficient planning, funding and purchasing.

An appropriate timeframe for a National AOD Treatment Strategy is required. A 10 year planning cycle at this strategic level, with interim review and adjustment, appears to be most appropriate. This would provide a sufficiently long-term view to enable policy and sector development to occur strategically and incrementally.

Importantly, we appreciate that the process of developing national strategies can be complex and unwieldy. One way of managing this is to carefully define the scope of the strategy, and ensure that the scope is maintained. For example, the National AOD Treatment Strategy may be restricted to

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[114] There are seven sub-strategies currently to the NDS 2010-2015 (and numerous previous ones as well). The sub-strategies tend to focus on drug classes or on population groups. At no time has there been a treatment sub-strategy.
[115] By way of example, a comprehensive consultation process is underway for the the current draft National HCV strategy (2014-2017) (and the previous version had a steering committee and writing team clearly specified in the front notes).
[116] It may be preferably termed a "Framework" rather than "Strategy". At present the sub-strategies to the NDS are currently referred to as 'strategy documents' so we have retained this term in this chapter, but acknowledge that framework may be a better term.

secondary and tertiary treatment (that is exclude primary prevention explicitly). Some may argue that this sidesteps the relationship between prevention and treatment (which is true), but if the purpose of the national treatment strategy was clearly allocative planning for tertiary treatment, the policy priorities regarding prevention as compared to treatment could be taken up elsewhere[117].

The other significant consideration in defining the scope of a ten-year nationally endorsed AOD Treatment Strategy is the extent to which it also engages with other sectors (see key informant comments in Chapter 9). This is a difficult issue. On the one hand, for simplicity and focus we would argue that other sectors not be involved in the first iteration of the national treatment plan. This is more likely to ensure its successful passage through to sign-off, and is advantageous in relation to the level of specificity that can be achieved at a strategic planning level (ie greater specificity because of more confined scope). On the other hand, as we noted in Chapter 9, planning should extend beyond AOD treatment in the health context ("go beyond the boundaries of health systems"(World Health Organization, 2010, p. 1). It can be argued that effective planning needs to move beyond the boundaries of the traditional AOD specialist treatment system because of the strong intersections between AOD clients' needs and other health and welfare services. The areas of intersection include mental health, housing, child protection, childcare and family services, primary health, and community health. Thus the boundary for a National AOD Treatment Strategy needs careful consideration. If it extends beyond the AOD treatment service system the development of the strategy will be more complicated, with more stakeholders, and with increased risk of being less specific. One option is to follow a two-step process: in the first instance concentrate on AOD treatment alone, and in the next step broaden that out to include all the support and inter-sectoral engagements that are a necessary part of achieving reductions in alcohol and other drug related harm within the treatment sphere.

The content of a ten-year nationally endorsed National AOD Treatment Strategy could include:
- Articulation of the value and importance of AOD treatment
- Clear delineation of respective roles of Commonwealth and state/territory governments
- Identification of the priority areas and long-term planning needs for treatment
- Articulation with the Quality Framework
- Principles for a nationally consistent planning process
- Principles and processes for collaboration between funders of AOD treatment (ie states/territories and Commonwealth)
- Principles for AOD treatment funding
- Priority areas (eg areas of greatest need)
- Performance indicators and targets
- Some specifically identified 'empty boxes' for future iterations i.e. inter-sectoral planning, as identified above

The development of the first ten-year plan will involve resources, require wide stakeholder consultation, and ultimately form the platform for the Commonwealth funding rounds. While this is resource intensive at the outset, benefits will flow in over a longer time frame. For each funding cycle (eg three or five years), the national ten-year plan could be consulted to draw down specific plans for the individual funding round. While resources to develop the plan would be required, downstream savings would occur in terms of reduced planning for each funding round, and savings in terms of preventing poor purchasing decisions.

The nationally endorsed ten-year AOD Treatment Strategy needs to be led and driven by the IGCD. However, its writing and development by a team independent from government may be worth

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[117] And they are fully articulated at the higher level in the NDS 2010-2015

considering. Aside from specific expertise requirements, we note that other strategies are developed independently from government. The establishment of a steering committee and an independent writing team appear to afford it the greatest chance of success: the writing team must have content expertise (past experiences with generic consultants have proved that this approach does not work). The independent consultants also require good links with the sector such that there is trust and capacity to consult as widely as possible. It is important that the development process has a clear (and brief) timeframe, and that vested interests and federalism are managed sensitively (another reason for the use of independent consultants).

The advantages of a nationally endorsed ten-year AOD Treatment Strategy include:
- It demonstrates Commonwealth leadership and provides a secure foundation from which to operationalise future funding rounds
- It provides formal documentation of the Commonwealth and state/territory roles
- It provides the basis on which to determine funding decisions
- It enables both clarity of principles but with sufficient flexibility within individual funding rounds to facilitate appropriate decision-making (that is, it is not technical planning)
- It provides a level of sustainability for the sector
- It may strengthen processes in other jurisdictions
- It sends forward signals to the sector; about future plans and priority setting processes allowing appropriate agency-level planning
- It provides states/territories with guidance and enables their jurisdictional planning to flow from the ten-year national plan
- It potentially reduces fragmentation of the sector
- It brings a level of communication and cohesion; greater sharing and understanding of what is happening across Australia
- It can build on the momentum and goodwill demonstrated by the Review process – it is a logical next step

There are challenges with a ten-year National AOD Treatment Strategy:
- National plans can be too generic, and result in lowest common denominator planning
- It requires buy-in from each jurisdiction and the sector
- Resources are required to develop the plan (although confining its scope and specificity will assist with this)
- It is best supported by a bipartisan support – or at least neutrality - across the life of the plan.

The nationally endorsed AOD Treatment Strategy affords the platform for joined up planning. As noted in Chapter 9, joined up planning is vital because it potentially improves the likelihood of value for money from any one funder; it potentially avoids duplication of funding; it increases the chances of cohesive treatment service systems; it potentially reduces the likelihood of gaps being created; and it is cost efficient (that is good planning requires resources, which can be shared).

Technical planning

If we assume that a nationally endorsed ten-year National AOD Treatment Strategy is developed, this would provide the platform for shared decisions between the funders (Commonwealth and state/territory governments) in relation to roles, responsibilities, principles for treatment funding, and priority areas (areas of greatest need). However, technical planning within the ten-year cycle of the national plan is also warranted. Technical planning would enable decisions regarding the number of treatment places, beds and types of treatment required based on existing service spread, population needs and those specific to a location/region or area. Strategic planning at a national

level can only identify broad priorities – the actual funding decisions within each region require a different level of planning data and acumen.

Before examining the options for technical planning there are two important considerations. The first is duplication of effort. Given the resources required for effective planning, consideration should be given to using existing planning processes. A number of key informants reinforced the importance of building on existing processes, and avoiding duplication. "If [there are] good processes [which] already exist – build on them". Duplication of planning efforts should be avoided. The second is the unit of analysis for technical planning. In Chapter 9 it was noted that technical planning is best focussed at a local level. There are a number of reasons for this: research has shown variation in needs across local areas; key informants noted differing needs; the importance of geography in planning; and consultative processes with stakeholders to planning are best undertaken at local level (notwithstanding the need to plan for statewide services such as residential rehabilitation).

Technical planning, as detailed in Chapter 9 uses a variety of tools and processes, such as DA-CCP along with qualitative analysis and engagement of stakeholders. Technical planning aims to specify the priority areas of need in terms of specific service types (bed numbers, outpatient treatment places and so on), population groups and the location of services. The Commonwealth requires technical planning, specific to regions (or states/territories) to inform its purchasing decisions in the NGOTGP and SMSDGF grant rounds.

There are three options for the Commonwealth:
1. engage in technical planning themselves (through the state offices or through some other local process)
2. use the existing planning processes by Commonwealth bodies (such as Medicare Locals)
3. use the state/territory planning processes.

Before considering each of these options, it is important to be clear that here we are referring to technical planning for the specific purchasing decisions made by the Commonwealth within each grant round.

The first option, the Commonwealth undertaking technical planning at a regional/local level does not seem to be a good use of resources. There is a risk of over-planning in a poorly coordinated fashion. Key informants were mindful that we may end up in a situation where local planning occurs (ML's and LHN's/LHD's), state/territory planning occurs and then national planning also (for Commonwealth purchasing decisions). If the Commonwealth designs its own planning how would this be coordinated and articulate with the other plans? ("There is a risk of multiple and disparate approaches to planning across regions"). It represents duplication of effort with states/territories and is not a good use of limited resources. We do not consider this option further.

The second option is to use an existing planning framework. The Commonwealth could rely on plans developed by others. One idea we explored early in the project was the possibility that the Medicare Local planning process could be a springboard for the Commonwealth planning and specifically to assist with allocative funding decisions. Since that time, Medicare Locals have been subject to changes. Furthermore it became apparent that the Medicare Local planning option was not a well-supported by key informants, who were largely negative about their experiences of Medicare Local planning: it appears to remain highly variable across different agencies, there is little attention to alcohol or illicit drugs treatment in most Medicare Local plans and in those that do consider it, it is limited to alcohol and tobacco; and, finally, the focus for Medicare Local's has been on primary healthcare – AOD treatment extends beyond primary health care. We do not consider this option further.

The third, and only remaining option is for the states/territories to lead technical planning with the Commonwealth at the table – enabling the Commonwealth to be engaged in and informed by the state/territory technical planning and use that process to make grant decisions. One way of configuring this is that for each Commonwealth funding round a request is put out for state/territory plans for AOD treatment: priority areas, needs and gaps and this is used to inform the Commonwealth development of priorities for each funding round, and then more detailed technical planning led by the states/territories with the Commonwealth as a participant can then inform the subsequent funding decisions (such as which service, in what location and so on). One advantage of this option is that it is not resource intensive for the Commonwealth. But it may represent slightly higher risk – some states/territories may not have adequate planning. The advantage however, is that it would be consistent with both the planning literature (see Chapter 9) and key informant views about the importance of articulation between state/territory planning and the Commonwealth purchasing decisions. The view was expressed that sometimes national priorities do not meet state/territory needs: "If there were national priorities, what meaning do they have for a state like [X] …. Planning needs to take account of where the state/territory is at". It is likely that there will be different priorities for different jurisdictions. In this sense, treatment planning needs to be conducted on a scale such that the needs, gaps and context are taken into account. This planning process applies equally to capacity building – identification of the gaps and priorities areas for capacity building with consideration of the relative balance between the three streams of capacity building could be lead by the states/territories in collaboration with the Commonwealth. The states/territories are aware of their own capacity building investments, and planning could therefore focus on specific national capacity building priorities that would complement other investment.

The significant strengths of this option are the joint working relationship between the two funders (Commonwealth and state/territory), such that duplication can be avoided. In addition, decisions around co-funding of organisations (see Chapter 5) are likely to be better managed with a joint planning framework. We believe that technical planning is best done at a regional/local level and coordinated within each jurisdiction.

Priority areas: gaps and highest unmet need

It is assumed that the technical planning undertaken by the states/territories in concert with the Commonwealth will reveal the specific areas for each funding round. Our Review findings (see Chapter 8) noted that gaps existed in relation to:
- Alcohol treatment
- Population groups with high need
  - Young people
  - Families, parents/carers with children, and women
  - Offenders and prisoners
  - Individuals with co-morbid AOD and mental health problems
  - Aboriginal and Torres Strait Islander people
  - Culturally and linguistically diverse groups
- Service types
  - Residential rehabilitation
  - Residential withdrawal
  - Pharmacotherapies
  - Counselling and other outpatient services
  - Integrated models

A greater level of technical planning is required in order to translate these overall priority gaps into specific services by location in each jurisdiction.

Pre-defined allocations

Technical planning can lead to pre-defined allocations: that is specific amounts allocated for certain population groups, or for certain geographic regions. The pre-defined allocations would direct resources to the identified gaps and areas of highest need.

The Commonwealth needs to consider whether the adoption of pre-defined allocations is a sensible strategy for the NGOTGP and SMSDGF grant rounds. There are two ways in which pre-defined allocations could work:
1. Allocations of fund amounts to states/territories
2. Allocation of fund amounts to population groups or service types.

Pre-defined allocations of fund amounts to each state/territory is possible[118]. The allocations would be determined based on a formula, which would take into account the overall rate of AOD problems, the extent of unmet demand for treatment and other variables, such as remoteness/rurality and socio-economic disadvantage. It is important that the Commonwealth invests in every state/territory, and pre-defined fund allocations would ensure this (noting however this has not been a problem in the past). The advantages of a pre-defined allocation largely reside with the states/territories knowing the Commonwealth contribution. This is likely to enhance their planning, and reduce the likelihood that they would cost-shift (ie the Commonwealth contribution is clearly specified up-front at the start of a grant round). Depending on the extent of transparency (ie whether applicants where aware of the state/territory allocations), it may also be a good strategy for managing expectations. [119] This disadvantage of pre-defined allocations is that it reduces flexibility in the actual grant decision-making. In addition, one would need to ensure that some reserve funds were kept aside for emergency situations. Fixed allocations to each state/territory decrease flexibility on behalf of Commonwealth and may compromise the mandate to ensure equity (ie in ensuing equity, the Commonwealth may need to invest relatively more in one jurisdiction than another).

Other variant of allocations is to specify certain amounts for target groups (eg Aboriginal and Torres Strait Islander services, or rural and remote services). This issue is discussed in Chapter 12. Choosing to fund a specific service type or population group is linked inextricably with planning – good planning will force discussion and decisions about priority groups, given finite resources. What then remains is whether a specific fund allocation is made or not. In association with detailed technical planning then, pre-defined allocations into priority areas is sensible and consistent with good decision-making processes. It is also useful in managing expectations (of both state/territory governments as well as individual organisations). Thus it becomes clear what the Commonwealth is prioritising and what the fund allocation will be in that area. Decision-making around individual organisations can then proceed as usual (see Chapter 14). In another example, capacity building across the three streams (see Chapter 5) can be planned and priority areas for capacity building investment determined in association with a pre-defined allocation of funds.

There is some tension between the jurisdictional allocation model versus the priority groups allocation model to the extent that jurisdictional allocations may be different from the relative

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[118] We note that the PIR process largely followed a pre-defined fund allocation process.

[119] Instead of organisations reading the grant guidelines stating that there is for example $500million available (over three years), they would be apprised of the allocation to their state/territory and thereby manage their application process with an eye to proportionality (of their effort) and with an understanding of the limitations.

priority setting that occurs when AOD treatment and equity of access is considered at a national level. Further review of whether the advantages outlined here for pre-defined allocations are able to be realised is required.

Resourcing planning: what data and tools are required?

Planning takes considerable time, and requires sufficient resources. The consequences of not taking sufficient time and adequately resourcing the planning process can be negative. From one key informant reflecting on reform in his/her jurisdiction: "the intention of recommissioning is to improve planning. Some areas were rushed and the change process was poor". The need for solid expertise in planning was noted. Key informants recognised the technical skill-base required to engage in comprehensive planning, including for both strategic and technical planning.

The Commonwealth has a leadership role in providing tools, such as DA-CCP, for technical planning. The IGCD leadership on DA-CCP has shown the importance and usefulness of the development of nationally consistent tools. DA-CCP has proved valuable in this Review and we are aware that at least one jurisdiction is using it in planning. Ideally, all jurisdictions would engage with DA-CPP, but some further development work is required for that to occur[120]. This includes:
- Training and support to facilitate implementation
- Revision of the tool to improve its sensitivity and specificity for jurisdictions
- Simplification of the care packages (at present they are complex and unwieldy)
- Clarification and documentation about appropriate uses and misuses of DA-CCP.

The Commonwealth could undertake to lead and fund the update and implementation of DA-CCP as one decision-support tool across Australia (this does not preclude other technical planning tools being developed for use in providing national consistency).

As noted elsewhere, DA-CCP alone is not sufficient. Other planning tools and planning processes are required. This includes:
- Surveys, focus groups, consultative groups and in-depth interviews of stakeholders
- Planning benchmarks from Australia and other countries
- Expert opinion, clinician opinion
- Systematic reviews of the evidence for treatment effectiveness and cost-effectiveness.

Again, the Commonwealth has a potential leadership role in coordinating toolkits for technical planning (for example the development of "Guidelines for AOD Treatment Planning"). Guidelines for AOD treatment planning could be used by states and territories but also organisations such as hospital networks or other planning bodies. This would encourage consideration of AOD treatment in generalist settings and hopefully lead to greater treatment provision in those settings. Thus, the value of guidelines extends beyond the immediate purpose of providing planning tools and speaks to improving health outcomes for people with alcohol and other drug problems.

Over and above documenting planning tools and processes, there are also data requirements. As seen in Chapter 9, planning can be data-intensive. The Commonwealth already has a role in national minimum datasets and specifying standards for data. The kinds of data required for effective planning include:
- Socio-demographic data, population count, age, sex, education, occupational status, socioeconomic status, Aboriginal status, CALD, income distribution, poverty
- Geographical information about where people with needs reside

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[120] Already the IGCD has approved the revision of the Indigenous-specific care packages. This work is being undertaken by the Drug Policy Modelling Program.

- Epidemiological data about the nature of the disorder
- Information on services, what exists, location, specification of activities
- Data on current treatment utilisation and trends
- Workforce data.

Existing investments by the Commonwealth (for example in the AODTS-NMDS, and the NSMHWB) could be more strategically used to support an explicit technical planning agenda.

Relationship to Principles

The purpose of planning is ultimately to achieve positive health outcomes for people with alcohol and other drug problems. Good planning will lead to effective, efficient and *value for money* purchasing decisions, which in turn will lead to the best possible coverage of services, in the places where need is the highest, and articulated with other funders. The options explored in this chapter for the Commonwealth are consistent with the principles of *robust planning and design*, notably that planning occur in a joined-up fashion with stakeholders. This approach to planning also demonstrates the principle of *partnership and collaboration*, given the engagement of all stakeholders in the planning processes. The approach considered here also has regard to *proportionality*. We do not think it would be appropriate for the Commonwealth to directly engage in its own technical planning – this would not be proportionate to its current investment in AOD treatment. The ten-year National AOD Treatment Strategy speaks directly to the principle of *governance and accountability*. As proposed, the strategy would clearly specify the roles and responsibilities of the various funders, facilitating subsequent accountability.

Summary

- A nationally endorsed ten year National AOD Treatment Strategy would provide the framework for future funding decisions that are co-ordinated across two levels of government and follow clearly specified role delineation.
- Technical planning, led by states/territories with Commonwealth engagement, would provide the basis for specific funding decisions in each funding round.
- Specification of priorities and the application of pre-defined allocations to priority areas within each grant round would provide transparency to states/territories and applicants, enhancing the likelihood of value for money investments by the Commonwealth.
- National leadership by the Commonwealth on the roll-out of planning tools would be consistent with the Commonwealth mandate and be an important step forward in technical planning.
- Likewise, national leadership on guidelines for AOD treatment planning and data would provide the future basis for effective, efficient and equitable AOD treatment services based on areas of highest need.

Chapter 14: Commonwealth purchasing mechanisms

This chapter considers how the Commonwealth should purchase services. In Chapter 6 a distinction was drawn between the choice of provider and the choice of payment method.
There are four options for the Commonwealth to select the AOD treatment providers:
> 1. through competitive selection processes
> 2. through individually-negotiated arrangements (often based on historical agreements)
> 3. through an accreditation and/or registration process
> 4. through transfer to states/territories.

There are also four options for the Commonwealth in relation to how to provide the funds:
> 1. through a block grant (lump sum)
> 2. through a price per unit of activity
> 3. through a capitation model
> 4. through payment for outcomes.

This chapter considers each of these options. In the first instance, we provide the summary conclusions from Chapter 6:

- Multiple purchasing mechanisms are in play at present. For example, the Commonwealth currently purchases AOD treatment through four mechanisms: competitive processes (grants schemes), fee-for-service (Medicare), activity-based funding (hospital services), and transfers to states/territories (special purpose payments).

- The way in which AOD treatment is currently purchased by the Commonwealth and states/territories through the NGO sector is predicated on models that exist for social welfare services, not those for health. Thus, governments purchase social welfare services, such as employment services, and homelessness services, largely through competitive grant schemes. Arguably, alcohol and other drug treatment services have simply been subject to these social welfare processes because the providers are NGOs. However, if one considers AOD treatment as a health service, then the usual mechanisms for health funding (such as ABF or fee-for-service) would be more appropriate.

- It is useful to distinguish the mechanism by which the provider is chosen (eg: competitive selection, historical or negotiated, preferred-provider, or via accreditation/registration processes) from the mechanism by which the payment occurs (block grant, activity/episode-based, capitation and outcome-based).

- Each of these has advantages and disadvantages. Existing literature and key informants to the Review have informed our analysis of the relative strengths and limitations.

- Competitive processes to select the providers of AOD treatment are widely used. These approaches have a number of general advantages, particularly transparency and fairness. There is also a perception that competition is a driver of quality and may involve reduced price. However, there are a number of disadvantages that apply to AOD. A limited number of potential providers exist. Funders risk undermining sector viability through processes that do not account for a) organisational characteristics (eg, size and capacity to write proposals) and b) the vulnerability of organisations to uncertain funding arrangements.

- The competitive process, if effective, needs to be designed with consideration of the pool of potential providers and it should be well-resourced. Assessment panels need to include experts with a sound understanding of service delivery and clinical excellence. A selective process, possibly focused on a pool of preferred providers is worth consideration.

- Individually-negotiated processes to select the provider are common for government service provision. In some cases, individually-negotiated selection of providers occurs with NGOs. The key criticism of this process is the lack of transparency and fairness.

- Transfer of funds to states/territories is the way in which healthcare in Australia has evolved through special purpose payments and the National Health Funding Pool (NHFP). The advantages of such an approach are the reduced administrative costs to the Commonwealth, and the increased potential for coordinated planning and purchasing. The key disadvantages are the risk of loss of funds, and the lack of checks and balances provided by the two levels of government.
- Accreditation of approved providers who can then submit invoices for services rendered (ie the Medicare model) is unlikely to be feasible for AOD treatment that is funded by the Commonwealth. This model increases the amount of services provided but operates in a largely uncapped budget environment.
- The use of block grants (whether with or without specifications of activity within the contract) is a common mechanism for funding flows – and is the one currently used by the Commonwealth for the NGOTGP and SMSDGF. The advantages are its simplicity and flexibility. The disadvantages include potential inconsistency in funding between agencies (no fixed or unit price), limited incentives for efficiency, and potential limitations on the specificity regarding what is sought and delivered (depending on the nature of the agreement).
- Price per episode is becoming the prevailing model for funding healthcare in Australia. The hospital funding through ABF and the Victorian AOD ABF are important developments for consideration. ABF models provide clarity about what is being funded, can promote efficiency and increase budget control (assuming funding is capped), and provide benchmarks for service pricing. One way in which the Commonwealth can use an ABF model is to specify its funding contribution to AOD treatment (which is then managed by the states/territories). However, establishing high quality ABF systems can be expensive, prices need to be set correctly, and infrastructure established to adjust prices over time.
- Capitation, a price per population, is a model widely-used in US healthcare. It has not yet been fully implemented in Australia. It is unlikely to be the solution to funding Australian AOD treatment services.
- The use of outcome-based payments has not shown the necessary positive results to make it a viable model for implementation at this time.
- In considering all the options, it is important to bear in mind that:
  - Mixed models are most common (for example an ABF and a block funding approach for the same organisation, and perforce across the sector);
  - The state/territory approaches are important to consider;
  - Each option has both strengths and weaknesses; and
  - There needs to be acknowledgement of current systems and effective change management processes should reform be indicated.

Currently, the Commonwealth chooses providers and uses the following payment mechanisms illustrated in Table 14.1

Table 14.1: Commonwealth payment mechanisms

Provider selection	Commonwealth example
Competitive selection	NGOTGP and SMSDGF
Individually-negotiated arrangements (often based on historical agreements)	SMSDGF for some services
Transfer to states/territories	IDDI funds given to states/territories via NHFP
Accreditation and/or registration process.	Medicare, Better Access
Funding mechanism	
Block grant	NGOTGP and SMSDGF
ABF	Hospital funding
Capitation	NA
Outcome-based funding	NA

This means that at present the Commonwealth is deploying four different provider selection processes and two different funding mechanisms for AOD treatment.

The selection of the most appropriate funding mechanism will depend on a range of factors, including the following:

- What is being purchased (units of treatment of which type; capacity building projects)
- Whether there are multiple potential providers or a limited pool or only one potential provider
- Whether there are multiple purchasers/funders or sole purchasers/funders
- How risk is shared: whether the purchaser/funder largely bears the financial risk or whether the provider largely bears the financial risk
- The goals and priorities of the purchaser – such as a relative focus on quality of services or a focus on quantity of services or a focus on containing costs
- The amount of funds
- The planning considerations
- Prevailing political ideology.

We "can't wind the clock back" – any funding approach for the future needs to start with acknowledgement of the current systems in place, including existing providers, approaches to price, multiple funders and partnership arrangements.

Importantly, this chapter does not consider the appropriate mechanisms for Aboriginal and Torres Strait Islander AOD treatment services. It has become apparent that there are particular and different issues in the selection and contracting of Aboriginal and Torres Strait Islander AOD services. These have been treated separately (see report). As such, none of the discussion or conclusions drawn in this chapter apply to Aboriginal and Torres Strait Islander AOD service purchasing by the Commonwealth.

Provider selection

Ruling out accreditation/registration

In the first instance, we rule out the accreditation/registration option as the method for selecting providers for AOD treatment funded by the Commonwealth. This option requires a sufficiently distinct professional body to recognise individual practitioners (see Chapter 6). This is not feasible in AOD given the multiple professional groups and, to be frank, the nascent professional category for AOD with the exception of Addiction Medicine Specialists. Planning under this model is effectively achieved through the consumer; that is, it is a demand-led model whereby prospective clients

effectively determine the supply. For people with AOD problems, who are highly marginalised, this is unlikely to be effective (and would only work if there was real choice). There are other reasons why this model is not feasible for the Commonwealth:

- It is associated with fee-for-service, resulting in an uncapped budget situation and thus potential Commonwealth overspending
- Fee-for-service provides payment for occasions of service, rather than episodes of care and is thus a less refined mechanism (Australia has championed the move from occasions of service to episodes of care through the ABF model, regarded as a superior way of purchasing healthcare)
- AOD treatment requires a number of contacts or occasions of service – it is not the same as a single visit to a GP
- None of the states/territories purchase AOD treatment through this particular process of selection of providers and hence there is less likely to be synergy between the Commonwealth processes and the state/territory processes
- Fee-for-service is not a sustainable model for an AOD NGO unless it is done in concert with other forms of base funding, particularly for smaller and more rural services
- It requires an invoicing/payments administrative infrastructure (eg MBS).

Reserving individually-negotiated selection as a fall-back option

It has become clear that the selection of providers based on individually-negotiated arrangements is not an ideal model (see Chapter 6). It is associated with a lack of transparency, can be subject to political whim or idiosyncratic decision-making (rather than part of a planned approach) and, perhaps most importantly, as the standard or prevailing approach it is inconsistent with the Commonwealth Grant Guidelines for general funding rounds. Furthermore, whatever process the Commonwealth chooses for selection of providers needs to be one that has a level of coordination and communication with states/territories. This would be hard to realise for this option. For these reasons, this is not the preferred option for the Commonwealth to use for the NGOTGP and SMSDGF.

That being said, some level of flexibility is required such that the Commonwealth can respond to crisis situations in a flexible manner and be afforded the opportunity to select a provider through this mechanism. This is consistent with the current funding guidelines for the flexible funds, whereby one choice available to the government is "one-off/unsolicited funding". There are likely to be two possible scenarios where this may occur:

1. where there is an immediate crisis or gap in AOD services for which the Commonwealth needs to respond quickly/ immediately
2. where there are no other possible providers — that is, there is only one suitable provider.

It is important that this mechanism only be used in those types of situations, given the prevailing concerns about transparency. Needless to say, the use of this process to select a provider should be consistent with the priorities and objectives of the grant scheme. In addition, it may be worth considering that contracts made under such arrangements be clearly time limited (eg, one year, or involving an interim review at 12 months), to maintain the potential to modify provider selection in the context of evolving circumstances (eg, crisis passed, service not performing).

Finally, a comment about unspent funds and appropriate processes for disbursing those funds in the short-term is warranted. This situation, not uncommonly encountered by governments, creates tension between due processes and the necessity for rapid action. With the assumption that the Commonwealth wants a transparent and clear process that can be subject to scrutiny and engagement by the stakeholders (including states/territories) it is worth considering how best to

approach this kind of funding situation. One possibility is to have a short-list of priority items (e.g., highly ranked proposals that just missed out on funding) that can be utilised to dispense funds quickly and to use this mechanism of provider selection (individually negotiated) in the short-term.

Consortia

Consortia have a number of advantages (as detailed in Chapter 6) and lend themselves to the kinds of inter-sectoral, coordinated care approaches that are well regarded in AOD treatment. At the same time they require deft management by the lead organisation. It seems that this approach to selecting providers is best considered in the context of what is being purchased. If the Commonwealth is seeking to purchase coordinated or joined-up systems of care, then a consortia approach may be most suitable. (This could then be subject to competitive processes for the selection of the lead agency). As a way to select providers for the provision of core AOD treatment (as currently funded under NGOTGP for example) it is less likely to produce the kinds of benefits for which it is designed. Importantly, we distinguish between the purchaser determining that consortia are the best provider configuration compared to when providers decide to create a consortium for the purposes of submitting a proposal to a grant scheme. It is the former that we are referring to here (ie it is the Commonwealth's decision to deliberately solicit applications from consortia only). This was the case with the Partners in Recovery initiative (see Chapter 6 for the case example). Some examples of where a consortia approach to provider selection may be suitable include:

- Capacity-building projects focused on quality improvement across a number of services
- Coordinated care across health and welfare systems
- Combining resources, skills and experience to explore systemic solutions to intractable problems.

Transferring the funds to states/territories

Under this option the Commonwealth transfers the funds to state and territory health departments for them to then allocate/purchase AOD treatment. The primary rationale for considering this option seriously is the problem of coordination. With multiple funders, purchasing arrangements, planning systems and contract management arrangements, the current system is a tangled web. As described by one respondent to the review "...the problems of 'programmatic confetti' where the Commonwealth sprinkles relatively small amounts of money around creating, I suspect, coordination problems on the ground". Better service planning could occur under a single purchaser model, with articulation between planning, needs assessment and purchasing decisions. There may also be reduced administrative burden for service providers (who currently report multiple times to multiple funders). It also may reduce perceived 'duplication'.

Planning under such a purchasing model would logically fall to the jurisdictions themselves (in the same way as current hospital services are planned by states/territories and Commonwealth funds are provided through the NHFP). Consistent with the current IGAFFR (see Chapter 12), states and territories would have flexibility to deliver quality services where they are most needed. The Commonwealth would not seek to control how states/territories deliver the agreed outcomes. It appears to be a model well suited to the purchase of core AOD treatment (service delivery). It is not, however, suited to purchasing capacity building or other national projects. This then creates potential problems for proportionality, inasmuch as the Commonwealth investment in capacity building has been and is likely to continue to be significantly smaller than for direct treatment: creating a proportionality problem in terms of managing an approach to market for a relatively small fund. There are also a number of complexities that would require resolution: notably the timelines for purchasing by states/territories are not aligned with the current Commonwealth grant rounds.

There are examples where this model has worked well (indeed, SPPs function in this way). We were told that it has worked well when:

- The state has a clear plan
- No "trimming" occurs (ie, funds are dedicated and specifically passed from federal to state government)
- Priority and planning occur at state level
- There are good relationships between stakeholders
- There is clarity about what is being purchased and at what price, as under ABF
- Framework documents exist that have been signed off nationally (and there is ministerial engagement).

One key feature mentioned by a number of key informants was the vital importance of quarantined funds – signed agreements would be needed to ensure the states/territories reserved all the funds for AOD treatment. (This reflects the concern expressed by some key informants about the IDDI funds – these were Commonwealth funds provided to states/territories to fund diversion initiatives. Since the change from individual service agreements between the Commonwealth and each state/territory to the amalgamation into the NHFP, key informants were concerned that the funds have now become lost: see Appendix B). Thus the particular experience in AOD is less than positive.

There are other significant concerns with this approach. This model could result in a loss of specified AOD treatment funds. Given the extent of unmet need and demand, any reduction in Australian AOD treatment funding is a significant problem. From the service providers point of view, it is perceived as high risk because it effectively takes away one potential funding source. Having multiple purchasers reduces the risk that any one purchaser will make choices driven by politics, or engage in poor funding practices. Multiple funders were seen to improve the survival of the sector. In addition, multiple funders can improve sector diversity. The AOD treatment sector in Australia needs to support a variety of treatment types, treatment philosophies and approaches. The removal of one level of funding from the mix raises the potential for loss of diversity. It was also noted that there are some organisations that are solely funded by the Commonwealth (see Chapter 5 for details) — the implications for these services are unclear under such a model.

It is important for the Commonwealth to have clarity about its investment. Transferring the funds to state/territory governments may reduce the Commonwealth's ability to both direct and monitor the investment.

Finally, there was some concern that while outsourcing may work well in the case of some states/territories, it may not work well in others — it appears risky where there is poor faith in current state/territory processes. One variant proposed to us was bilateral arrangements – that is the Commonwealth could negotiate individually with those states/territories with which there was confidence and provide the funds to them, whilst directly selecting and purchasing AOD treatment from services in other jurisdictions. This approach would require that the Commonwealth pre-determine the fund allocations for each state/territory. (While jurisdictional allocations have occurred in the past, it was not used in the 2012 round).

Thus, there are some potentially significant strengths to this option, but also considerable risks. This option may be suitable when:
- Streamlined planning and purchasing (at jurisdictional level) is preferred
- There is confidence in the jurisdictions.

This option has significant risks, including:
- Potentially leaving the service sector more vulnerable to reduced funding
- Removing the checks and balances that occur with two separate funders.

Pincus (2006) provides a succinct summary of the advantages of federated arrangements (ie two levels of funding): it disperses power; allows for diversity; enhances the competitive pressure on governments; and creates opportunities for interjurisdictional learning (p. 26). These advantages would be lost under the option of transferring the funds to states/territories.

Competitive selection process

As reviewed in Chapter 6 there are both strengths and limitations to competitive selection processes. The *Commonwealth Grant Guidelines* require that, unless specifically agreed otherwise (by the Minister, Chief Executive or delegate), competitive merit based processes be used to allocate grants (Department of Finance and Deregulation, 2013). We also note the Productivity Commission (2010): "The Commission is not of the view that the transition to a market-based approach to the procurement and funding of human services has been to the detriment of the Australian community" (p. 315).

There are a range of options for competitive selection: open, targeted, and preferred provider panels. The extent, strength, and viability of the 'market' along with the funding (whether existing or new funds) are key to identifying the most appropriate option, along with what is being purchased.

Key informants to this Review argued that it was important for the purchasing mechanism to enable retention of a specialist sector. We concur that a sustainable specialist AOD treatment sector is important. An open grants process was perceived by key informants to allow and even encourage non-specialist services to submit applications, although this is not necessarily inevitable, especially when managed in concert with planning processes and careful documentation in the grants selection process.

At present, competitive processes are sometimes used to fund an entire service (i.e., base level of funding). Some key informants wondered whether a better model would be to use a different funding approach for base (or core) services and reserve competitive processes for innovations, pilot programs and where additional or new funds are being provided. This point is also relevant to our later discussion on funding mechanisms. Likewise consideration of open competitive processes is linked to decisions about how to manage price. Most open competitive processes do not involve a fixed price (that is the applicants are competing on both price and quality). It is possible for AOD treatment, however, to be purchased at a fixed or unit price (discussed below) in which case the competitive process is concentrated on quality.

Open competitive processes may be appropriate for the Commonwealth in the following circumstances:
- For core AOD treatment types (eg counselling, withdrawal, residential rehabilitation)
- When there is more than one potential provider
- Where there is likely to be genuine competition between providers
- When the Commonwealth is seeking innovations, pilots, new ideas
- When there is new money (rather than existing money)
- When expanding the pool of potential providers is a major goal.

And, conversely, possible risks and shortcomings of open competitive processes include their potential to:
- Limit purchaser choice (as organisations may not meet all requirements / may not bid)
- Place a higher administrative burden on the service providers
- Threaten the development and maintenance of a skilled and experienced workforce (ongoing uncertainty of funding may impact staff retention rates)

- Engender distrust and divisiveness among the limited specialist service providers that are available.

Open competitive selection processes are questionable for situations where the Commonwealth is purchasing services that are highly specialised and provided by a limited number of organisations that have long-standing networks with related services and systems. This is where targeted competitive processes are better suited.

Targeted competitive processes may be appropriate for the Commonwealth when:
- The pool of potential providers is constricted/limited (eg rural/remote, highly specialised services)
- There are specific gaps (highly specified ITA)
- It is existing funding
- When funders have worked in a partnership arrangement with sector representatives to lay the ground work for sector change and this is enacted through the targeted competitive process (refer to the WA partnership case example for illustration).

Limitations of the targeted competitive process include:
- Potential unease at the seeming lack of transparency in the process
- Reduced bargaining power for the purchaser
- Judging the merits of service in isolation from consideration of other services.

Is the notion of a 'preferred-provider panel' a feasible option?

A preferred-provider panel is different from a targeted selection process. Here the purchaser accredits or in other ways approves a select group of potential providers, who are then eligible to compete in grant rounds. It generally involves a pre-approval process, where organisations demonstrate that they have met quality standards, accreditation and so on. This could be applied to the Commonwealth grants, such that only organisations on the preferred-provider panel would be eligible to apply for funding. We note that the Department of Veterans Affairs (DVA) is pursuing the option of establishing a panel[121], and is likely to progress towards accredited providers over the coming year. A watching brief should be maintained on the DVA process. The preferred-provider panel approach is highly consistent with quality framework implementation – only organisations that meet the quality standards are eligible to enter the provider panel.

This option appears most suitable if the Commonwealth is purchasing direct treatment services and if the Commonwealth considers that it wants to maintain a sustainable specialist sector (ie, it values that goal over other goals). Given the long-term investment in building up the sector and the level of public interest in providing for those with high levels of need (in addition to practical investments in buildings etc) it seems prudent for the Commonwealth to consider how best to contribute to sector sustainability when selecting approaches to purchasing.

There is a substantial amount of work in establishing the criteria and selecting the preferred providers. One option put forward by key informants was that all existing funded organisations could become the 'preferred-provider panel' (see Chapter 6). This argument is not particularly compelling unless it is explicitly linked with accreditation and quality framework initiatives[122]. None of the

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[121] The DVA preferred-provider panel will then be eligible for fee-for-service payments, whereas for the Commonwealth grants scheme the preferred-provider panel would form the organisations which would then be eligible to compete in funding rounds.

[122] Just because an organisation has in the past received Commonwealth funds under NGOTGP and SMSDGF does not necessarily or automatically mean that they have attained a certain standard of quality.

discussion about preferred provider panels obviates the need for strong accountability and for decisions that are based on merit.

Clear cooperation and coordination with states and territories would be required for this option: preferred providers under a Commonwealth scheme would perforce need to be considered as preferred providers by states/territories (even if the states/territories did not explicitly use this as a purchasing mechanism).

Preferred provider panels would be suitable if:
- The Commonwealth was purchasing core treatment
- The Commonwealth intended to retain a specialist sector (or core group of providers)
- The states/territories participated in and supported the selection of preferred providers
- Existing funds were being distributed
- Sustainability was in focus (e.g., involving rolling contracts, long-term funding arrangements with regular interim reviews)
- The Commonwealth was generally satisfied with the performance of current service providers.

The limitations include:
- This process does not facilitate the entry of new providers into the market (once the pre-qualification round is done) until the next pre-qualification round
- There may also be a reduction in the perceived fairness and transparency of the process.

Expressions Of Interest – a two-step process
Within competitive processes, we noted differences of opinion about a two-step competitive process amongst the two groups of key informants (both groups of providers) who discussed this option. Some key informants thought that the "EOI process is worse than full tender. More work". On the other hand, some key informants felt that the EOI process was worthwhile as it gave providers an opportunity to 'sell' an idea or innovation prior to putting in all the work required in a full application. The EOI process, it was argued, has the potential to capture a broader market and it is useful for new innovations. It "allows agencies to demonstrate what they can do" and relatively quickly eliminates inappropriate providers. The purchaser also does not need to review full applications until an EOI process has determined a smaller number of potential applicants. However, as noted by key informants, a two-step process is more work for the providers, it potentially gives false hope to those shortlisted, and the process is longer (both for services and funders). At this time, it appears that a two-step process (EOI followed by full application) does not have sufficient benefits given its limitations. We do not explore this option further.

Summary of provider selection

Provider selection	Preferred/suitable when:	Limitations:
Competitive selection: open	- For core AOD treatment types (eg, counselling, withdrawal, residential rehabilitation); - When there is more than one potential provider; - Where there is likely to be genuine competition between providers; - When the Commonwealth is seeking innovations, pilots, new ideas; - When there is new money (rather than	- Limits purchaser choice (as organisations may not meet all requirements/may not bid); - Places a higher administrative burden on the service providers; - Threatens the development and maintenance of a skilled and experienced workforce (ongoing uncertainty of funding may impact staff retention rates); and

Provider selection	Preferred/suitable when:	Limitations:
	existing money); • When expanding the pool of potential providers is a major goal.	• Engenders distrust and divisiveness among the limited specialist service providers that are available.
Competitive selection: targeted	• The pool of potential providers is constricted/limited (eg, rural/remote, highly specialised services); • There are specific gaps (highly specified ITA); • It is existing funding; • When funders have worked in a partnership arrangement with sector representatives to lay the ground work for sector change and this is enacted through the targeted competitive process (refer to the WA partnership case example for illustration).	• Potential unease at the seeming lack of transparency in the process; • Reduced bargaining power for the purchaser; and • Judging the merits of service in isolation from consideration of other services.
Competitive selection: preferred provider panel	• The Commonwealth was purchasing core treatment; • The Commonwealth intended to retain a specialist sector (or core group of providers); • The states/territories participated in and supported the selection of preferred providers; • Existing funds were being distributed; • Sustainability was in focus (e.g., involving rolling contracts, long-term funding arrangements with regular interim reviews); • The Commonwealth was generally satisfied with the performance of current service providers.	• This process does not facilitate the entry of new providers into the market (once the pre-qualification round is done) until the next pre-qualification round; There may also be a reduction in the perceived fairness and transparency of the process.
Individually negotiated arrangements (often based on historical agreements)	• Where there is an immediate crisis or gap in AOD services for which the Commonwealth needs to respond quickly/immediately; • Where there are no other possible providers — that is, there is only one suitable provider.	• Concerns about transparency; Can cut across planning processes.
Consortia	• Capacity-building projects focused on quality improvement across a number of services; • Coordinated care across health and welfare systems; • Combining resources, skills and experience to explore systemic solutions to intractable problems.	• Only suitable for some types of services.
Transfer funds to	• Streamlined planning and purchasing (at	• Potentially leaves the service sector

Provider selection	Preferred/suitable when:	Limitations:
state/territories	jurisdictional level) is preferred; • Consistency between jurisdictional purchasing processes and mechanisms is sought; • There is confidence in the jurisdictions; • To avoid "programmatic confetti", perceived 'duplication' and potentially increase the value for money in purchasing.	more vulnerable to reduced funding; • Removes the checks and balances that occur with two separate funders.

Choice of payment mechanism

As noted at the outset, there are four possible payment mechanisms: block grant, price per unit of activity/episode, capitation and outcome-based payment (see Chapter 6). We can immediately rule out capitation — this is not a feasible model in Australia for AOD treatment purchased by the Commonwealth. We also think that there are serious limitations to the application of outcome-based funding, as discussed next.

Outcome-based funding — only for incentivising aspects of practice
Our review of outcome-based funding (see Chapter 6 and Working Paper # 5) noted the confusion about this approach, and the varying terminology. To be clear, there is a vast literature identifying the payment of bonuses to individual health staff for achievement of outcomes as an additional incentive to healthcare practice. The evidence in this regard is somewhat supportive, but a recent systematic review found that controlled studies were less supportive than uncontrolled studies (Houle, McAlister, Jackevicius, Chuck, & Tsuyuki, 2012). A recent randomised trial of individually targeted incentives in alcohol and drug treatment found improvements in processes of care but no significant effect on outcomes (Garner, Godley, Dennis, Hunter, Bair, & Godley, 2012). The other way in which outcome-based payment has been reported is in relation to tying the outcomes to the core contract for service delivery at the service/organisational level. This is the UK experience with "payment by results" – organisations are paid for the services they deliver based on the achievement of specified client outcomes, including alcohol and drug abstinence, improved employment, reduced crime and improved social integration (UK Government, 2013). In the case of AOD, process measures such as increased admissions, longer lengths of stay, and improved referrals have been linked to target payments (McLellan et al., 2008). There is currently limited and mixed evidence to support this model of payment (UK payment by results, or US pay-for-performance) for core treatment services (Brucker & Stewart, 2011; Commons et al., 1997; Haley, Dugosh, & Lynch, 2011; Lu, 1999; McLellan et al., 2008; UK Government, 2013). It is this latter version of outcome-based payment that we do not recommend.

It is important to clarify that outcome-based payment methods should be distinguished from services being asked to report on their outcomes. As the key informants noted, rejection of outcome-based funding models should not be interpreted as a rejection of the commitment to achieving sustained outcomes for clients, nor the importance of accountability and services having reflective feedback and evaluation processes such that they strive for continuous improvement in client outcomes. It is the explicit linking of client outcomes with the mechanisms for funding that is not justified based on current evidence.

A brief comment about Western Australia is warranted, as they describe their approach to purchasing as an outcomes-based approach. In WA, an extensive collaborative process has occurred between government, service providers, consumers and the community to arrive at a sustainable model for the future of AOD treatment (in fact it is much broader than just AOD treatment). (See case example given in Chapter 11 for a description of the partnerships process). As a result of this consultative process, a model was determined for government purchasing of services, which is described as outcomes-based. There is clear specification of the outcomes that the government is seeking to achieve. These outcomes are defined through a collaborative planning approach involving government and potential providers that occurs prior to the procurement process. Different approaches to competitive processes are utilised dependent on the type of service involved. The organisations subsequently selected as service providers are then paid through a service agreement, which uses a block grant approach, with clearly specified deliverables. That is, in WA the organisations are not paid per outcome achieved. This distinction may seem subtle but is essential in understanding the difference between a commitment to outcomes (which is shared across the entire sector, and should be a primary concern of the Commonwealth and any other purchaser) and the choice of a payment method focussed on outcomes.

The use of outcome payments may be appropriate for the Commonwealth in the following circumstances:
* For specific, additional components of a contract over and above any core component
* To purchase improved care practices, specifically identified as national priorities
* To incentivise specific aspects of clinical care (eg use of an assessment tool) or clinical supervision (eg, bonus payments if the organisation can demonstrate that all clinicians receive at least once monthly individual supervision from a supervisor with more than 5 years direct AOD clinical experience).

Outcome-based payments are not appropriate for:
* The payment mechanism to purchase core AOD treatment
* Capacity-building grants, given that the causal relationship between capacity-building endeavours and client outcomes may be difficult to establish (many other factors impact operational environments) and outcomes often take considerable time to be realised.

Outcome-based payment which incentivises specifically chosen aspects of clinical care has potential, however, it will not suffice as the primary payment mechanism for the Commonwealth to purchase core treatment or capacity building. We now turn to the two other options; block grants and ABF.

Block grants

As noted in Chapter 6, block grants vary in terms of the extent of accountability – and this depends entirely on the associated KPIs (see Chapter 10). Thus a block grant can be a lump sum not associated with any performance criteria, or it can be a block grant with a highly specified set of KPIs. We would argue that, even if KPIs are stipulated for purchasing treatment, ABF has a number of advantages over block grants. The process is transparent and the intent (treatment goals) can be highly articulated. With strong attention to planning to deal with fundamental elements of ABF (e.g., unit price) there is a clear framework regarding what is being purchased, for how much, and regarding what desired outcomes. So block grants are not necessarily a preferred mechanism for treatment purchases. We were interested to note that the Productivity Commission reached a similar conclusion.[123] However, this option resides on whether a version of ABF (discussed in detail

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[123] "The Commission considers that the shortcomings of the block funding model warrant its use only in very specific circumstances. That is, self-directed funding or other avenues for consumer choice (such as choice of supplier) should become the norm for the industry. Some of the rationales for retaining block funding have little merit. In particular, arguments about uncertainty or the need to cover fixed costs are not generally accepted reasons for government

below) could be sufficiently specified. If it were determined that an ABF-type payment mechanism was not feasible in the short or medium term, block grants with clearly specified performance indicators are likely to be the most parsimonious option. For capacity building, block grants are highly suitable (and there is not an alternate option).

Block grants are an appropriate payment mechanism for the Commonwealth when:
- The feasibility of an ABF-type model for core treatment is not realised
- The Commonwealth is purchasing capacity building projects
- It is purchasing a new or innovative type of service/project that requires a level of flexibility to enable experiential learning and support new ideas
- When the goal is capacity building and the individual client outcomes are not easily highly defined
- When pilot projects or service enhancements are being trialled (as these may not have established activities/episodes).

Activity Based Funding – the way of the future

Given the extensive use of ABF, the Victoria model for AOD and the move by the IHPA to develop activities and a process for ABF to apply to mental health care, it seems that the Commonwealth should seriously consider providing NGOTGP and SMSDGF funds through a version of ABF.

There appear to be three variants of an ABF model worth considering (see Chapter 6):
1. AOD treatment funded in the same way as Australian hospital Activity-Based Funding (ABF)
2. A variant of ABF used to specify the Commonwealth's contribution to particular service types purchased by the states/territories
3. A fixed price for the Commonwealth's direct purchasing of AOD treatment.

In the first instance, ABF as implemented to fund hospital separations, and with the work underway to develop mental health ABF items, the Commonwealth could use this structure to fund AOD treatment. Establishing the DRGs and price weights is a highly technical and data intensive process, which would require substantial resourcing. This is some time away (see below), and may not be feasible. It is predicated on the assumption that the Commonwealth does not directly purchase services from organisations; rather funds are made available through the NHFP which the states/territories then draw down as the Commonwealth's contribution to AOD treatment. Currently for hospital ABF the Commonwealth contributes 36.5% of the NEP. We understand that with the May 2014 Federal Budget there may be changes to the ABF system, including the proportion of Commonwealth contribution and the governance structures. In addition, some significant concern has been expressed by experts[124] as to the extent to which the ABF system is suitable for non-admitted care and more specifically suitable for AOD treatment given the large variability in practice and lengths of stay. There are other complexities: do only those AOD treatment organisations funded by state/territory governments receive the ABF component? (what does this mean for the organisations that are sole funded by the Commonwealth?); how does the Commonwealth deal with inequity between states/territories, since the Commonwealth contribution is driven by state/territory contribution (does it need to hold funds back)? This option may compromise the

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intervention in comparable industries and should not be accepted here. However, block funding should continue to play a role: to ensure that crisis care needs are met; to support research, experimentation and innovation in the industry; as a tool to redress market failure such as: in rural areas where lack of scale and remoteness may result in under- provision or competition issues; for groups less willing or able to engage with service providers (such as Indigenous Australians) or who service providers may be reluctant to take on (such as those with very challenging behaviours); inadequate public goods such as community capacity building" http://www.pc.gov.au/projects/inquiry/disability-support/report

[124] Review Advisory Committee members Dr Lintzeris and Prof Farrell.

mandate to ensure equity in the short-term given that once the three- or five-year allocations are made, the Commonwealth has no further funds to distribute in emergencies or in situations where future inequities arise. For these reason, it seems that a fully implemented ABF the same as for hospitals is subject to considerable uncertainty.

The second option under a variant of ABF is for the Commonwealth to use the model (without the current mechanics through the NHFP) to make a contribution towards specific service types. What this would mean is that a unit cost is established for AOD treatment services (whether that is an individual unit cost for each service type [segmented approach], or one 'price' with weights applied for each service type [national efficient price approach]). These unit costs would then be used to determine the contribution by the Commonwealth towards AOD treatment which was planned and purchased by the states/territories. Thus, for example, if the Commonwealth determined that its investment should reside in primary care services, then it could provide funds at a proportion of its specified unit cost to states/territories to then fund service providers. The priority areas could shift over time, as the Commonwealth identified national priorities, gaps and special initiatives. This option would remove the direct purchasing responsibilities from the Commonwealth (and hence may reduce administrative duplication) but enable sustained contribution to AOD treatment through national priorities.

The third option is the establishment of a fixed price for each service type which the Commonwealth will purchase. This is effectively the original Victorian model (see Chapter 6)[125]. The competitive grants programs would then have a listed unit price for each service type and applicants compete on quality, but not on price. (Block grants are then used to contract the service.)

As will be apparent, for all three options, some version of establishing agreed units of activities, and the associated costs (and subsequently the price[126]) need to be derived. Work for the third option could then subsequently feed into the second or first option.

The relationship between an ABF payment mechanism and planning processes is complicated. In hospitals the planning is decoupled from the ABF funding system. Is this possible for AOD or does the ABF payment method need to be directly linked to the planning approach? If the third variant of ABF (use of unit price for Commonwealth purchasing) was preferred, then the planning processes would be straightforward, and as articulated in Chapter 13.

The advantages of any of the ABF options include transparency and consistency on price (including scope for loadings to account for issues such as remoteness or disadvantage). It also signals the possibility of a nationally consistent approach to purchasing AOD treatment (if option 1 were realised) but at a minimum essential work on costs and price would be completed and be available for use by all purchasers across Australia. Finally, given that AOD treatment is a healthcare intervention, a key advantage of an ABF-type model is that it puts AOD treatment alongside other healthcare interventions (rather than keeping it marginalised in the space between health, social and welfare services).

The disadvantages of the ABF approach do not reside in its payment mechanism features (these are widely acknowledged as best practice) but rather in the amount of resources and data required to

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[125] The report from the consultants who developed the revised Victorian model is not in the public domain, and we do not know how much time, technical skill or resources were required to specify the activity and the unit price.
[126] Note the difference between cost and price. Here cost refers to how much it costs (total cost) to provide an activity/service. Price refers to how much the funder is willing to pay (and does not necessarily entail the full cost, especially when split between different funders). See Chapter 6 for discussion of the difference between cost and price, and how ABF can incentivise different aspects of clinical care depending on how the price is set.

establish the system. Under hospital-based ABF, the specification of the 'activity' has involved analysis of large datasets of representative service types, lengths of stay, occasions of services, activities (bed days, FTE and so) which is then statistically analysed for clusters (bundles of related groups) which share similar cost structures. In light of the technical complexity, we cannot yet determine the feasibility of ABF or a variant as specified above. Research is required to fully evaluate these three options and to draw final conclusions about the feasibility of this approach.

The questions that would need to be answered in a feasibility analysis include (in no particular order):
- Of the three ABF options above, which is most feasible and able to implemented with the end goal of improving health outcomes?
- Is there sufficient evidence to suggest that an ABF model is worth pursuing?
- Would IHPA consider AOD within scope?
- What are the technical details of the Victorian AOD model?
- Would it mean that Commonwealth funds for AOD treatment were passed through the NHFP? Can NGOs access the NHFP?
- What is the relationship between planning processes and ABF funding? How could technical planning work under the three variant ABF models?
- How would equity be managed under an ABF type model?
- Do only those AOD treatment organisations funded by state/territory governments receive the ABF component? (What does this mean for the organisations that are sole funded by the Commonwealth?)
- How does an ABF model work alongside the different state/territory funding cycles?
- How much is the Commonwealth willing to invest in the establishment of a national AOD ABF payment method?
- Is the type and quantity of AOD treatment service data sufficient to develop a robust cost and price framework?
- What time horizon is reasonable? (If it took five years to develop, would this be problematic?)How are states/territories monitored under an ABF model?
- Do the mooted changes to hospital ABF under the May 2014 Budget have implications for the model for AOD treatment?

The feasibility analysis would entail answering the question: is it worthwhile to pursue a national ABF payment method for AOD services funded by the Commonwealth and would the investment in its development result in better health outcomes?

Mixed models
As will have become apparent, we are suggesting that the Commonwealth tailor the selection of providers and the payment method to what they are purchasing and to the planning processes involved. Thus by default there will be mixed models, inasmuch as the Commonwealth will need to flexibly deploy the most appropriate funding method for the task at hand. By way of example, if the determination is to purchase innovative new AOD treatment models, then a competitive selection process followed by a block grant payment method seems most appropriate. On the other hand, if the Commonwealth is purchasing core AOD treatment types then a preferred provider competitive process followed by ABF is the most appropriate. In addition, the model that may work best for residential rehabilitation may not be the model that works best for counselling services. So there is also a tailoring of service types against purchasing models. This also means that within organisations there may be mixed models – for example a variant of activity-based funding for direct treatment services and then a competitive process for a pilot/innovation service.

Is this too much to expect of the funder? There is certainly a level of administrative resolve required to tailor the funding mechanism appropriately. This means there is a higher load of policy work, and the potential for confusion in the sector. Clear communications about what is purchased by which method, and under what payment regimen, would be required. Is the sector ready for this level of sophistication - and is the Department of Health able to resource such a process?

Over and above consideration of the Commonwealth deploying mixed methods based on planning processes and what it is purchasing, there is also the possibility (referred to above) that the Commonwealth uses mixed methods depending on the individual jurisdiction within which it is purchasing. Thus, if a jurisdiction uses a unit cost payment method for AOD treatment, the Commonwealth could consider adopting that for services purchased in that jurisdiction, and so on. This substantially increases the level of complexity for the Commonwealth (and would again require significant administrative resolve and clarity of communication). Indeed, if the Commonwealth were to seriously consider following the individual jurisdictional processes, then it would be preferable to adopt the option of transferring the funds directly to the states/territories for them to subsequently lead and manage the purchasing processes (which they no doubt would do consistent with their own current purchasing arrangements).

Given the national mandate (see Chapter 12) it is also true that the Commonwealth has a leadership role and part of its purchasing decision-making (whether that is selecting providers or the payment method) could set the standard for all jurisdictions to follow. This would be consistent with a national leadership role, and serve the AOD sector well. The Commonwealth demonstrates its leadership and national role by setting the standards for and conducting purchasing (and planning) in such a way as to be a best practice model for other jurisdictions.

Relationship to principles

The purpose of purchasing is ultimately to achieve positive health outcomes for people with alcohol and other drug problems. Referring back to the principles in Chapter 1, the Commonwealth should seek funding processes that are effective, efficient and equitable. In relation to the options and issues discussed in this chapter, the principles of grant administration (see Chapter 1) are highly relevant. These are:

1. Robust planning and design
2. Collaboration and partnership
3. Proportionality
4. An outcomes orientation
5. Achieving value with public money
6. Governance and accountability
7. Probity and transparency.
   (Department of Finance and Deregulation, 2013)

Whatever the choice of purchasing mechanism, robust planning is required. This means engagement with states/territories and necessary groundwork (such as the feasibility study of ABF). Proportionality is an important principle to consider for the options in this chapter. Recalling that the states/territories carry the responsibility for the bulk of core AOD treatment provision, the purchasing systems that the Commonwealth selects should be commensurate with its investment. Some of the options explored above have greater infrastructure requirements than others. Achieving value with public money is an essential end-goal for any purchasing. A focus on outcomes, —understanding that there is a relationship between what is being purchased, how it is purchased, delivery of the service, and client health outcomes — is essential. Consideration of purchasing absent from a focus on client health outcomes will be to the detriment of achieving value for money. As with all government processes, probity and transparency are important. Some of the mechanisms

noted above (such as one-off grants) can be less than transparent and subject to probity concerns. As will have been apparent, we consider these as less strong options. Competitive processes, notwithstanding their limitations and context-specific strengths, can provide transparency, probity, and achieve value with public money. The trade-off can be collaboration and partnerships, especially between the grant provider and the service provider. Attention to communication processes and a foundation partnership approach (as we explored in the WA case example, see Chapter 11) will reduce the risk of compromising those principles under a competitive selection process.

Conclusions

At the risk of over-simplifying what is a complex set of decisions, our analysis concludes that:
- A feasibility study be undertaken regarding ABF models for AOD treatment to inform the Commonwealth's future purchasing
- For the purchase of core AOD treatment, the provider selection process follows one of the competitive processes outlined above (depending on the nature of the pool of potential providers). For the payment method, block grants with clearly delineated performance criteria (taken up in Chapter 15) are used pending a feasibility analysis of the application of ABF to AOD treatment.
- For capacity building projects, the provider selection process follows one of the competitive processes outlined above and block grants with clear performance criteria are the payment mechanism.
- One-off grants are used in emergency situations.
- Outcome-based payments are piloted, using well-designed, independent evaluation, to incentivise specific quality standards.
- Consortia arrangements are used only in particular circumstances, for example where what is being purchased is an intra- or inter-sectoral service. These arrangements do not apply as a general principle for purchasing.
- The states and territories participate in the processes for determining the most effective, efficient and equitable purchasing mechanisms for use by the Commonwealth.

Chapter 15: Ensuring accountability through contract management and value for money

This chapter considers how the Commonwealth should ensure accountability through contract management and value for money of its funding programs.

Chapter 10 reviewed the relevant literature and considered key informant perspectives about accountability. The conclusions drawn were:

- The Commonwealth's contract management, performance and financial monitoring practices are under reform, along with other aspects of the Commonwealth's grant enabling processes. The reforms are intended, amongst other things, to increase consistency in contract management and monitoring practices across all Commonwealth funding and reduce the contract management and monitoring burden on funded organisations, in line with the principle of proportionality.

- The contribution of ongoing relationships between STO contract managers and funded NGOs to the success of the funded projects should not be underestimated. However, there is variability in the approaches taken by STOs and the ability of the STO staff to undertake these responsibilities.

- NGOTGP and SMSDGFP1 projects are block funded. The Commonwealth distributes tranches of the agreed funding amount to funded organisations. The delivery of those tranches is contingent on the funded organisation meeting obligations, primarily the provision of progress reports against an agreed upon Project Plan and associated financial reports at 6-monthly intervals over the life of the grant. There has been variation in the extent to which the STOs assess the submitted progress and financial reports before funding is delivered. In some cases it is automatic. In other instances funding was delayed on account of inadequate progress reporting. The extent to which the performance measures included in the Project Plans are considered as deliverables is contested.

- Organisations funded under the NGOTGP and SMSDGF (treatment services) are also contracted to report against the AODTS-NMDS or OSR. There is no consistent approach to the process of reporting in each jurisdiction, and it is not clear whether all treatment funded by government is recorded. The Commonwealth does not use these data to assess the value for money of individual projects. Nor are the data considered useful to assess the value for money of the NGOTGP or SMSDGF as a whole. Some key informants from the NGO sector were concerned about the burden of work undertaken by NGOs to meet their contract obligations, particularly smaller organisations. This has salience in view of our finding that the NGO sector does not have a clear understanding of how the Commonwealth uses its Progress Reports. The Commonwealth's grant management reform process, , particularly the establishment of a 'Risk Rating Process', is intended to substantially reduce reporting requirements for low risk organisations and projects, and to establish consistent contract management and reporting approaches for organisations and projects with a similar risk rating..

- The Commonwealth's assurance that funded projects provide 'value for money' is implied through its monitoring of an organisation's progress against the project plan. Yet, there is some concern amongst STO key informants that their ability to monitor value for money is hampered by this approach. The performance measures tend to be output/activity based, and there was a groundswell of support amongst key informants from all sectors for outcome-based reporting; although the consensus view is that the development of suitable measures was fraught. There is movement towards developing outcome measures in several states.

- The Commonwealth funds a significant number of organisations that are also funded by the state/territory government. There are inherent difficulties in apportioning outcomes to particular sources of funding within a project, or even particular sources of funding within an agency. There is an argument that funded agencies having to report to both jurisdictions is not consistent with the proportionality principle.
- The Commonwealth is concerned to assess value for money of the grant programs as a whole, but has yet to develop an approach. The National Commission of Audit highlighted the fact that the Commonwealth's Budget Reports have not to date reported on the activities and associated performance measures undertaken as Drug Strategy programs (which includes NGOTGP and SMSDGF P1).
- Three-year contracts for AOD treatment service delivery that do not include interim reviews and the option for renewal / extension are problematic for service establishment, routinisation, and sustainability.

The questions considered in this chapter are
a) Can the Commonwealth increase the consistency of decision-making around the release of tranches of funding?
b) Should project-level performance indicators be output or outcome based?
c) What approaches can the Commonwealth consider using to show value for money of its grant programs?
d) Can the contract management and performance monitoring work undertaken by funded organisations be made less burdensome; especially when organisations are jointly funded by the Commonwealth and states/territories?
e) Is there value in funded organisations continuing to report to the AODTS-NMDS?
f) What is the appropriate length of contracts?
g) Should the Commonwealth be concerned about variations in jurisdictional funding cycles?

Achieving accountability

The contribution of contract management and monitoring to achieving accountability of funded agencies depends crucially on the purchasing approach. In Chapter 14 we propose that in the short to medium term at least, block grant funding should continue to be the payment method used by the Commonwealth for purchasing core treatment and capacity building projects alike. In the case of ABF, consideration of the appropriate form of contract management and monitoring would need to be part of the feasibility analysis; although we anticipate it could play a lesser role.

The Commonwealth's system of ensuring accountability from individual projects, for the 2012 to 2015 funding agreements, relies on the funded organisation developing a detailed Project Plan for the funded project to the satisfaction of their STO, reporting regularly against that Project Plan; as well as STO monitoring of those reports against the Project Plan. Project Plans include a set of performance indicators, agreed upon by the funded agency and STO. These performance indicators are a combination of activity activity/output based and outcome based indicators.

A good working relationship between local contract managers (based in STOs) and the funded organisation over the life of the project will benefit both the Commonwealth and the organisation, by helping to ensure sustainability of the funded project and agency and achievement of project aims. Relationships develop where the STO contract manager has a good working knowledge of the AOD treatment sector and expertise in grants management.

We reiterate the importance of "clear and mutually understood specifications of each party's contract obligations and how the contractor's performance will be assessed" (Romzek & Johnston,

2005, p. 438). This is also integral to satisfying the probity and transparency principles (Department of Finance and Deregulation, 2013). Ensuring consistency in what triggers the Commonwealth's release of the tranches of funding is key; that is, how the progress reports are monitored and assessed. The Commonwealth's ongoing reforms are intended to further standardise and streamline grants management and monitoring processes; while allowing STO staff some flexibility in their day-to-day management of contracts. The demands of contract management and reporting on some funded organisations, particularly smaller ones, is construed as burdensome by some in the AOD treatment sector, and may be out of proportion to the risks involved. In view of this, the Commonwealth's establishment of a "Risk Rating Process" with the intent to reduce the contract management and reporting burden associated with low risk projects is a welcome reform. What it will mean for smaller organisations is unclear. Rationalising the amount of information requires clarification of the purpose of the information required for acquittal. Ensuring the information collected is of value to the funded organisation can offset the performance reporting burden (McGregor-Lowndes & Ryan, 2009).

As we discussed in Chapter 12, there is potential to reduce duplication in administration for organisations funded by the Commonwealth and states/ territories, if they have similar goals and objectives. The Commonwealth funds many of the same agencies funded by state and territory health Departments and, as we outlined in Chapter 10, funded agencies feel the burden of multiple and oftentimes different contract management and reporting requirements. The Commonwealth has the option to outsource contract management and monitoring to the states and territories; undertake these activities jointly or take over the responsibility itself.

The advantages of maintaining involvement in these activities is that the Commonwealth preserves its day-to-day attachment to the AOD treatment sector and its knowledge bank of the day-to-day activities of AOD treatment provision; one would think essential for effective and efficient purchase of AOD services. Funded organisations have (and do take) the opportunity to report qualitatively on issues of relevance to planning, such as recent developments in AOD use and unmet need for treatment. It is not clear how the Commonwealth currently makes use of this information; certainly there are no formal mechanisms for collection (including from the various STO offices) and analysis The disadvantages are the cost of undertaking these activities; including the cost of developing the skills of Commonwealth contract managers and having staff in STOs. Although we should be mindful that the AOD treatment sector contracts are a small part of the Commonwealth's contracting activity, and that STO staff are oftentimes managing other contracts with the organisations funded to provide AOD treatment or capacity building.

The advantages of undertaking these activities jointly with the state/territories are that the contract management and reporting burdens faced by organisations could be substantially reduced. As well; the two levels of government could work towards specialising their administrative activities, thus reducing their own administration costs. In this model, there is potential to substantially reduce the involvement of STOs in day-to-day contract management activities.

Full reliance on the states/territories for contract management and monitoring activities would probably come at a financial cost to the Commonwealth, as well as the cost of losing knowledge about the services it is purchasing. That knowledge bank grows with each year of engagement with the AOD treatment sector.

Performance measures at the funded project level

In Chapter 6 we concluded that the way in which services are purchased (the payment mechanism) should not be linked to outcomes – that is payment for services is not contingent on achievement of

client outcomes per se. However assessment of the effectiveness of a project is an important and worthwhile exercise for the Commonwealth, as articulated in the Commonwealth Grant Guidelines principles (Department of Finance and Deregulation, 2013).

Currently, the Commonwealth assesses each project's progress against specific performance measures outlined in the Project Plan. As we explained in Chapter 10, the Commonwealth currently uses a hybrid of performance measures, predominantly activity or output based with some outcome measures.

While an outcome-based performance management framework is in development in Victoria, and Western Australia is currently combining some outcome measures with activity measures in its performance monitoring, other states and territories rely on activity measures and process measures, such as throughputs, client numbers and completed episodes of care. Even so, those other states and territories are looking to develop outcome measures, although they are in different stages of development. For example, South Australia is working on defining a set of clinical outcomes (which should be in place by the end of 2014 for its own clients/services, eg level of substance use, level of mental distress, injecting risk, self-reported quality of life). NSW is also in the process of developing a framework. However, it is by no means clear that the treatment sector and treatment consumers are active partners in those developments. One state/territory key informant told us, "there is more and more pressure to demonstrate outcomes".

The Commonwealth has three options, if it continues to purchase treatment services from the NGO sector. It could continue with its current approach; it could establish an outcomes framework itself; or it could capitalise on the state/territory efforts and work cooperatively to establish one. It has started down the route of developing outcome indicators and there is a mood amongst the key informants of the value of outcome monitoring. Still, there is substantial work to be undertaken in establishing a set of meaningful outcome indicators.

It would be most efficient for the Commonwealth and states/territories to work cooperatively and the Commonwealth could consider at the outset evaluating the outcome measures used in the current funding round, looking at the data collected as a whole (rather than project by project). It would not be cost effective for each jurisdiction to develop an outcomes framework in isolation. There is scope for the Commonwealth to show leadership in this exercise, for example by leading a cooperative effort. It could also ensure the input of all stakeholders including grant beneficiaries and treatment clients, thus satisfying the principle of collaboration and partnership.

Nonetheless, there is an argument that the resources required by NGOs to measure the most appropriate outcomes might render this form of public accountability inefficient. Furthermore, where it takes time for the outcomes of a project, to become apparent (in particular capacity building projects), the measurement of outcomes might require separate funding that extends beyond the life of the funded project. The Commonwealth's Quality Framework, currently under development, combined with the joint state/territory and Commonwealth planning process may alleviate the need for outcome performance monitoring at a project level. Were organisations awarded contracts on the basis of their capacity to demonstrate their ability to provide quality services, and given the knowledge about demand and need for treatment required for planning, the outcomes of their projects could be assumed on the basis of treatment activity (Ryan, 1998). We suggest that this option be considered when considering the worth of outcomes monitoring. While we perceived enthusiasm for outcomes monitoring we also heard scepticism. The fact that there are yet to be international models of outcome monitoring in the AOD treatment field, despite efforts to create them, highlights the difficulties of such an approach.

Finally, we have discussed at some length in Chapter 10 the difficulties that agencies with multiple funders might have in apportioning the outcome of a funded project to a particular funder. This limits the ability of the Commonwealth to evaluate the value for money of individual projects, an essential task given the principle of achieving value with public money. It is clear that this is also an issue for state/territories and the NGO sector itself, funded as it is by myriad organisations. Perhaps surprisingly, we found no review of the approaches taken to apportioning outcomes to funders. It seems that the approach taken would be contextual, dependent on the project funded, what it is that the two levels of government were purchasing, and other factors such as the extent of need for the service and the target population for the service.

In some circumstances the Commonwealth could consider following the approach of those organisations that report to the AODTS-NMDS; attribute the project's performance to a funder on the basis of its proportionate investment in the project. This would be most appropriate in a situation where there was excess demand for the service, and the Commonwealths' investment was used to expand a service already funded by the state/territory or vice versa, which could not meet demand for its services.

In the situation where the Commonwealth intends for its funding to allow access to a new sub-population, say to enable a residential rehabilitation service to host children so as to meet the needs of mothers, the Commonwealth's contribution could be assessed on the basis of its specific objective – the number of mothers who undertake treatment. The down-side of this approach, however, is that the residential rehabilitation service would not exist without state/territory funding. Perhaps the state/territory should share some of the return to the Commonwealth's investment in terms of justifying the value for money of its funding. On the other hand, the fact that the Commonwealth is taking over the financial responsibility of providing a more expensive form of treatment to mothers, enables the state/territory to recoup the benefits of providing treatment more cheaply to others.

There is a pressing need for the Commonwealth to develop a process for being able to measure its return on investment for individual projects. However, this is a fraught exercise and would need to be negotiated with the funded organisation and the state/territory; a process that would be substantially easier if the Commonwealth's planning, contract management and performance monitoring was undertaken cooperatively with states/territories.

Performance measurement at grant scheme level

In meeting the principle of achieving 'value with public money' the Commonwealth needs also to consider whether to measure performance at the grant scheme level. Currently it has no formal process to do this. In light of the National Commission of Audit (2014) we consider this a priority, regardless of whether the Commonwealth chooses to transfer funds to states/territories.

Were the Commonwealth to transfer its funds to the states/territories and use ABF payments or an ABF-variant to make payments, we note that the Administrator of the National Health Funding Pool provides monthly reports of the Commonwealth's ABF contribution at national and state/territory levels, as well as the number and types of services the funding provides[127]. States and territories are required to provide patient identified data regarding actual hospital services delivered for those public hospital functions funded by the Commonwealth on an activity basis.[128] We note that the states/territories are currently, in concert with AIHW, developing the capacity to report client level data to the AODTS-NMDS.

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[127] http://www.publichospitalfunding.gov.au/national-health-reform/reporting
[128] http://www.publichospitalfunding.gov.au/Media/Determination%2003.pdf

Nonetheless, assessment of the 'value for money' of a grant program as a whole, requires a population-level analysis relating to the objectives of the program rather than the level of activity, such as is undertaken for the Report on Government Services (ROGS) (Steering Committee for the Review of Government Service Provision, 2014). It makes little sense to sum the performance measure of individual agencies and programs. For the ROGS exercise the Productivity Commission assesses the equity, effectiveness, efficiency and outcomes of service delivery. The ROGS performance indicator framework for the health system, for example, is based on the objectives of the National Healthcare Agreement. There is a set of specific indicators for sectors within the health system derived from the ROGS conceptualisations of effectiveness, efficiency, and equity. AOD treatment is not one of the sectors at present.

The objectives of the National Healthcare Agreement are at too high a level to be of value for detailed scrutiny of the AOD treatment sector's performance. The current objectives of the two funding schemes, as outlined in Chapter 10 are a good starting point, although measurement of the SMSDGF P1 objectives is potentially more complex. Importantly, it takes time for capacity building outcomes to become apparent. The data necessary for this exercise are currently lacking. It would require information such as: the number of people who received treatment (attached to Commonwealth and state/territory funding specifically); what treatment they received, where that provided was provided; all in relation to need and demand for treatment. As we outlined in Chapter 13, these are data requirements integral to successful planning.

The Commonwealth and state/territory governments have invested substantial resources in the AODTS-NMDS collection over many years. There is some duplication of effort where state/territories have their own administrative collections. The AIHW and state/territory health departments are making ongoing improvements to the data collection (including the introduction of a means of identifying individual treatment recipients). However, based as it is on closed episodes of care, the data are little used by the research community, government and the treatment sector in efforts to understand treatment provision and met demand for treatment. Despite the potential for an administrative dataset to be a valuable input to planning and monitoring, the stakeholders are understandably ambivalent about its current capabilities. In view of this fact, we suggest that the Commonwealth and states/territories invest in its improvement; this investment could include a review of the state/territory processes for collection of AODTS-NMDS as a starting point for developing consistency in the data provision, as well as an independent review of how the data could be made 'fit for purpose'. All jurisdictions need to show value for money of their programs, especially in the current climate of austerity.

With the range of AOD treatment options available (and used) in Australia's health sector, demand, need, and use of specialist treatment, depend on activity in other areas; such as GPs, opioid pharmacotherapy treatment, and hospitals. To fully understand the effectiveness of the specialist sector, or specialist AOD treatment funded by government, requires data from the other treatment sectors. Ours was the first attempt to estimate health-sector-wide treatment provision (Chapter 7). The distance between the upper and lower bounds of our estimates highlights the pressing need for improvements in those data collections to better reflect AOD treatment. With much of that treatment funded by the Commonwealth, it has a responsibility to improve data collection.

Length of contracts

The Productivity Commission advises that governments 'align the length of the contract with the period required to achieve agreed outcomes'. This is consistent with the recommendations of the Grants Management Improvement Program Taskforce Report to the NSW Ministry of Health (Puplick et al., 2012). It is clear then that the length of standard contracts should match the nature of the project.

For core AOD treatment, which by its very nature needs to be long-standing, agencies require secure funding to make a commitment to enduring effective service provision and continuous quality improvement. This requires planning. A regular competitive tendering process every three years is time-consuming and costly for agencies. We learnt that it can take away from the provision of treatment services and is not equitable; making it more difficult for small agencies to compete with larger ones. It inhibits agencies from planning and makes it difficult for agencies to attract and keep quality staff, which has the flow-on effect of discouraging agencies from training staff. We heard from some in the NGO sector that once trained in AOD treatment, AOD workers can find conditions more attractive in other sectors such as the homelessness sector.

The Commonwealth Grant Guidelines, under the principle of 'achieving value with public money' suggest that longer term contacts be used where possible; consideration of the costs of the funding agency and grant recipients being of prime importance (Department of Finance and Deregulation, 2013). Considered alongside the principle of proportionality, we conclude that 3-year cycle of competitive tendering is too short to meet the principle of proportionality for core treatment.

A possibility is to competitively tender for a 3-year contract, which is rolled over for 1 year at a time for 5 years in total (a 3+1+1 model), conditional on the funded agency meeting its performance measures. Western Australia is moving towards this model for AOD treatment funding. It seems moderate when compared with the South Australian Council for Social Services' call for a 3+3+3+3 model[129].

In relation to capacity building projects, or innovation projects, with time-horizon goals, the ideal approach is to match the contract length with that time-horizon. To allow for flexibility and for "quick responses" by the Commonwealth, the length of contract could run from 1 to 3 years depending on the project funded.

Many of the states and territories have 3-year funding cycles as well. But not all state and territory treatment programmes go to competitive tender. There is also a question of whether the Commonwealth should attempt to align its funding rounds with those of the states and territories. As detailed in Table 11.1; there is marked variation in the jurisdictional funding cycles. These are linked to structural factors within each jurisdiction, such as election cycles. A possible advantage is that alignment would allow for better planning and reduce the potential for cost-shifting and brinkmanship. There are also practical difficulties for the Commonwealth where the state/territory does not continue funding an organisation; with the Commonwealth needing to roll-up its funding, for example. However, this eventuality would be less likely were the two levels of government planning jointly. However, NGOs would prefer that the two jurisdictions were on different cycles for two reasons. Firstly, it doubles the administrative burdens of completing grant applications if they were on the same time cycle. In South Australia for example, where the state government has a 3-year funding cycle there was some discontent that the Commonwealth tender opened just after the state and territory tenders closed. Spreading out the work of competitive tendering seems preferable. The second reason to have the Commonwealth and state and territory funding rounds on different cycles is because it potentially gives an organisation that loses funding from one source time to source funding from elsewhere. Given the structural factors noted above, and the key informant views, we think it is neither possible nor practical to align the funding cycles.

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[129] SACOSS undated:
http://sacoss.org.au/sites/default/files/public/documents/Election%20SA%202014/Better%20Contracting%20and%20Red%20Tape%20Reduction%20Plan_Booklet.pdf

Relationship to Principles

The purpose of contract management and monitoring is to ensure that the community obtains the best 'value for money' from public money; the goal being to maximise the health outcomes for people with alcohol and other drug problems. Referring back to the principles in Chapter 1, in relation to the options and issues discussed in this Chapter, the principles of grant administration (see Chapter 1) are highly relevant. These are:

viii)   Robust planning and design
ix)   Collaboration and partnership
x)   Proportionality
xi)   An outcomes orientation
xii)   Achieving value with public money
xiii)   Governance and accountability
xiv)   Probity and transparency (Department of Finance and Deregulation, 2013)

The Commonwealth's consideration of the relevance of outcomes measures has the potential to achieve a better articulated account of the outcomes achieved and outputs delivered – in line with the principle of *an outcomes orientation.* In establishing an approach for population-level assessment of the outcomes of its funding programs, the Commonwealth will enhance its ability to determine the *value for money* of its programs. The principle *of collaboration and partnership* runs through most of the suggested options; collaboration and partnership with the funded organisations, the NGO sector as a whole and state and territory funders has the potential to *improve client outcomes* and reduce unnecessary administrative burden on funded agencies, in line with the principle of *proportionality*. Clear documentation of the expectations of both parties in the delivery of a granting activity and support of performance monitoring frameworks are key aspects of the *governance and accountability* principle; which speaks to our concerns about the role of performance monitoring and performance indicators in decisions about making milestone payments.

Summary

- Ensure that payment of funding tranches or milestone payments are contingent on the submission of satisfactory progress reports and that there is clarity and consistency in what makes a satisfactory report
- Performance monitoring is important at both project and program level
  - Continue to build contracts around project level performance indicators to judge the performance of the Commonwealth's investment in projects
  - Assessment of the 'value for money' of the programs as a whole requires a population-level analysis analogous to that undertaken for ROGS; using indicators developed from the objectives of the grant programs.
- The Commonwealth is obliged to identify the return to its investment exclusive of other funders, both at project level and grant program level. In view of that obligation we suggest that it review the possible approaches, appreciating the significant challenges. Undertake an independent (of AIHW) review of ways to improve the AODTS-NMDS so it could be used as a source for planning and evaluation of the grants schemes. Undertake a review of the state/territory processes for collection of AODTS-NMDS data, as a starting point for developing consistency in the data collected.
- Consider ways to improve the capacity to identify AOD treatment in data sets counting service delivery in sectors other than the specialist AOD sector.
- Review the feasibility of establishing an outcomes framework for monitoring project-level performance; including considering the possibility of using the Quality Framework alongside activity indicators as an alternative.

- Where possible, combine Commonwealth's project-level performance monitoring efforts with state and territory governments when a project is jointly funded.
- Competitive tendering of treatment delivery on a tri-annual cycle is not compatible with sector continuity. The length of core treatment contracts are most appropriately matched to a longer cycle, with consideration of a fixed term (eg 3 years) with annual extension for 2 years subject to evaluation.
- The contracts for capacity building projects should match the time horizon of the project from 1 to 3 years.

Chapter 16: New Horizons

This chapter summarises the options to "help focus future government funding activities", providing "a pathway forward to achieve distribution" of Commonwealth funds in a coherent way. The chapter brings together the various options that emerged from the analyses outlined in Part 2 of the Report, which built on the data and analyses presented in Part 1 of the Report. We have used schematic representations of the possible pathways (showing activities/actions and associated endpoints) to assist the reader to navigate the options. As with other chapters in this main report, the findings presented here do not apply to Aboriginal and Torres Strait Islander AOD treatment services.

The chapter only considers processes in relation to the current funds (that is, the existing funds within the NGOTGP and SMSDGF), rather than any consideration of the most appropriate value for money investment of new funds (although the planning processes outlined here would be appropriate to deploy). New funds could be directed towards pilots and innovations – an area that is currently not a priority but one which would ensure that the sector continues to develop more effective treatments for alcohol and other drug problems. New funds could also be directed towards incentivising aspects of quality of care (such as through a pay-for-performance scheme, see Chapter 14). However, we have limited ourselves to existing funds and for that reason have focussed on treatment and capacity building as the two core investments (see Chapter 12).

The Commonwealth has an important and compelling role to play in Australian AOD treatment. Four responsibilities have been identified (see Chapter 12):
1. Advancing national priorities
2. Providing leadership in planning
3. Addressing service quality
4. Supporting equity.
(See Chapter 12 for the groundwork that we have completed to derive these four elements).

The Commonwealth operates at a national level and provides national leadership in planning and in delivering on priority areas (such as responding to those most vulnerable and with highest needs who would otherwise 'fall through the cracks'). The Commonwealth provides the checks and balances essential to ensuring service quality and equity across Australia for those with alcohol and other drug problems through the funding of core AOD treatment and capacity building.

There are two ways in which the Commonwealth can plan for and fund core AOD treatment and capacity building:
1. through leading the planning and purchasing; or
2. transferring those responsibilities to the states/territories (along with the funds).

We consider these trajectories in this order: the first part of this chapter reviews the options where the Commonwealth leads planning and engages in the direct purchasing of AOD treatment and capacity building; the second half of the chapter reviews the options in relation to transferring the funds to states/territories.

So as to provide a logical structure to consider the options, we have used a decision-tree approach below. This approach clarifies where alternatives are dependent on earlier choices and where they are not. For example one can proceed with technical planning in the absence of strategic planning, although in our opinion, this is not ideal. In addition, we consider the scope for the Commonwealth

to commence a longer-term reform agenda, coupled with the need for shorter-term decisions in order to proceed with the 2015 grants round.

The Figures provided in this chapter are a schema of the options and paths. These are necessarily simplified and should not be read in isolation from the accompanying text. The text outlines the contingencies for the options, the strengths and weaknesses of the options and the associated outcomes. There are more details regarding the planning options in Chapter 13, the purchasing options in Chapter 14, and the accountability options in Chapter 15. The shorter-term path has been configured with the 2015 funding round in mind, but taking this path does not and should not preclude taking action along the longer-term path.

Commonwealth planning, purchasing and accountability

Planning processes

Figure 16.1 provides the decision-tree for planning, with the shorter-term and longer-term paths. It should be noted that progress can begin on the longer-term options, while the shorter-term options are deployed for the 2015 grant round.

In the longer-term, a nationally endorsed ten-year AOD Treatment Strategic Plan would specify the roles and responsibilities of each funder (state/territory and Commonwealth) and identify the priority service types, population groups and locations for funding. This plan should articulate with

> Option: Develop ten year priority setting: National AOD Treatment Strategy

the National Drug Strategy. Under this option, the Commonwealth fulfils its responsibilities in providing leadership in planning and setting national priorities. To achieve meaningful change across policy and practice, planning should be a partnership between the Commonwealth and the states/territories, which incorporates the interests of both parties and includes real engagement of service providers and current and prospective clients.

To continue with the longer-term path, the development of a Strategic Plan lays the foundation for comprehensive technical planning built from solid data. As noted in Chapters 5 and 13, there is a current lack of needs-based data for planning (notably regarding the current treatment investment mix and impacts of capacity building). In the longer-term, and possibly in conjunction with the strategic planning processes, collection, collation and analysis of planning data

> Option: Current treatment funding investment mix (national funding data: funder, amount, service type)

will provide a foundation for technical planning into the future.

Figure 16.1: Decision tree: Planning

Outcome: 10 year strategic plan; role delineation & priority setting

Shorter-term

Planning: Strategic

Longer-term

NO

YES

Option: Develop ten year priority setting: National AOD Treatment Strategy

Option: Provide tools to states/territories for technical planning

Planning: Technical

YES

NO

Option: Current treatment funding investment mix (national funding data: funder, amount, service type)

Outcome: Better planning support for longer-term path

NO

YES

Evaluate impacts/outcomes of capacity building investment to date

Option: Consultation determining mix (between treatment & capacity building) and types of services/projects (S/T submissions/expert panel)

Outcome: Funding priorities & allocations subject to short-term processes

Option: Technical planning completed by states/territories

YES

NO

Outcome: The 2015 grant round priorities based on S/T priority areas and expert panel

Outcome: CW determination of priorities & funding mix

Outcome: Funding priorities & allocations derived from technical plan, driven by data/need/context & collaborative.

The longer-term path results in grant round funding priorities (both the share of treatment and capacity building, and the types of treatment and capacity building), derived from technical planning and articulated with a strategic plan. Decisions are grounded in data on need and demand, and focus the Commonwealth's effort in those areas that emerge as highest need. AOD treatment and capacity building funds (by both the Commonwealth and state/territory governments) can then be strategically and sensibly used to maximise treatment availability and treatment access, and thus health outcomes for those with AOD problems. This enables the Commonwealth to discharge its responsibilities in relation to national priorities, service quality and equity.

In the shorter-term, focussing on the tasks required for the 2015 grant round, there will not be time to establish a strategic plan to inform the priorities (nor to establish high level agreement on the roles and responsibilities of the Commonwealth and states/territories). Still, in this context, the Commonwealth has a number of options to incrementally improve the planning associated with the 2015 grant rounds and lay the foundation for longer-term reform. The provision of planning tools and support materials to states/territories is one such short-term option (Chapter 13).

> Option: Provide tools to states/territories for technical planning

For the 2015 round there is the option to proceed in the same way as the 2012 round – the Commonwealth can pre-determine the funding mix between core treatment and capacity building (currently 85% treatment; 15% capacity building, see Chapter 5) and the priority areas for 2015 without consulting with states/territories and without seeking advice from experts. The Intention to Apply materials could be directly prepared on this basis. This would represent the status quo. The disadvantage of this option (discussed in Chapter 12) is that there is little basis for an *a priori* decision about service types, it runs counter to strategic and technical planning, it creates a level of inflexibility in decision-making, it constrains the possibility of leverage with the states/territories and it conflicts with the Commonwealth's responsibilities in relation to national priorities, service equity and service quality. It also represents a missed opportunity for incremental improvement to the grant rounds.

Alternatively the Commonwealth could consult and collaborate on determining the 2015 priorities (both the mix/share of capacity building and treatment and the specific service types and capacity building domains). This option would be consistent with a partnerships approach and it signals incremental improvement over the 2012 processes. The key decisions to be made include:
- What proportion of funds should be used to purchase direct service delivery versus capacity building?
- What types of service delivery are most appropriately purchased by the Commonwealth?
- What types of capacity building activities (across the three streams, see Chapter 5) should be purchased in the short-term?

If a consultative process is undertaken, seeking submissions from the states/territories that identify their priorities for treatment and capacity building would be a building block towards technical planning into the future (longer-term path). In addition to input from the states/territories, an expert stakeholder panel would enable input from service providers, peaks and consumers. The advice obtained from the expert panel, combined with the priorities given by states/territories could then be used by the Commonwealth to determine the 2015 grant round priorities and form the basis of the Intention to Apply. The advantages of this shortened consultation process include engagement of

> Option: Consultation determining mix (between treatment & capacity building) and types of services/projects (S/T submissions/expert panel)

the stakeholders, which both facilitates management of expectations and represents the beginning of the process of technical planning.

Purchasing processes

The decision-tree for purchasing is given in Figure 16.2.

Figure 16.2: Decision tree: Purchasing
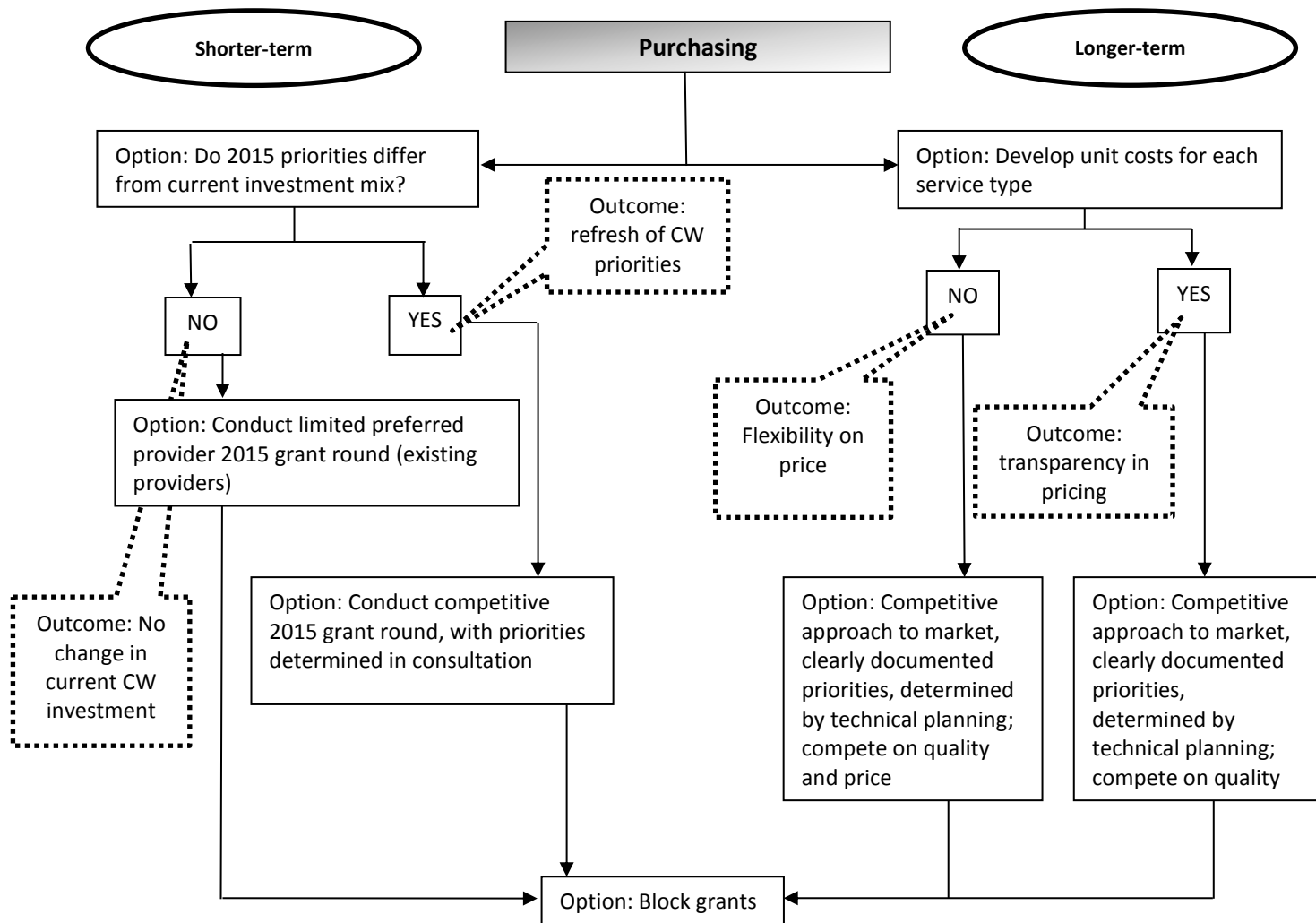
As noted earlier, purchasing in the longer-term would follow from strategic and technical planning, with clarity about the share of treatment and capacity building and the Commonwealth priority areas within each of these. For the treatment services, consideration of a fixed unit cost per service type is a longer-term option (distinct from ABF-type mechanisms which apply when the Commonwealth is transferring funds to states/territories – discussed later under the transfer to states/territories section). The use of unit costs has a number of advantages (as detailed in Chapter 14): enabling the Commonwealth to be transparent about the price for service types, and facilitating competitive processes to focus on quality. (It also articulates with work required for an ABF type

funding mechanism). A competitive process (open, preferred provider, targeted or selected) can then be undertaken. The choice between the different competitive processes is determined based on what is being purchased and an assessment of the likely number of potential providers (for treatment and for capacity building), as well as their experience and links with other parts of the sector. The development of unit costs will take some time, and would not be available in the short-term.

In the short-term, an immediate question is the extent to which the priorities for 2015 grant round (as determined by the short-term path represented in Figure 16.1 above) result in a similar or different array to what is currently being purchased. Where there is little difference, and states/territories consider that the current Commonwealth investment articulates with their plans, the principle of proportionality would suggest that a highly targeted processes (such as selecting preferred providers based on current contracts) be undertaken. A minor review of current contracts/providers would allow adjustments where there are problems with services, changes in other funding resulting in viability concerns, or where the need for the project no longer exists.

> Option: Conduct limited preferred provider treatment grant round in 2015 (existing providers)

Where the 2015 priorities differ from current provision or there is an interest in purchasing from services not currently funded, a competitive process is an option. The choice between the different competitive processes is determined based on what is being purchased and an assessment of the likely number of potential providers (for treatment and for capacity building). For capacity building projects a targeted process may be preferable depending on assessment of the potential provider market. Clear specification of the priority areas for the grant round and engagement of states/territories in the assessment and selection process are important parts of the competitive processes in the short-term.

> Option: Conduct competitive grant round in 2015, with priorities determined in consultation

Contract management and performance monitoring processes

The decision-tree/schema for accountability differs from the others inasmuch as there are fewer contingencies (Yes/No options) here; rather, there are simply options to implement (see Figure 16.3).

In the longer-term path, the Commonwealth's contract management and performance monitoring approach will sit alongside the potential development of a nationally endorsed ten-year strategic plan, and collaborative technical planning undertaken by the states/territories and the Commonwealth. The Commonwealth has the choice to maintain its responsibility for contract management and performance monitoring, hand that responsibility over to the states/territories, or to share its responsibility with the states/territories. A major down-side of the current approach is the contract management and reporting burden felt by organisations funded by both tiers of government. Were the Commonwealth to hand over some or all its responsibility to the states/territories the work-load of jointly funded organisations could be reduced, but the Commonwealth risks depleting its knowledge of the treatment sector and funded organisations; more so with a complete handover of responsibility.

Figure 16.3: Decision tree: Accountability
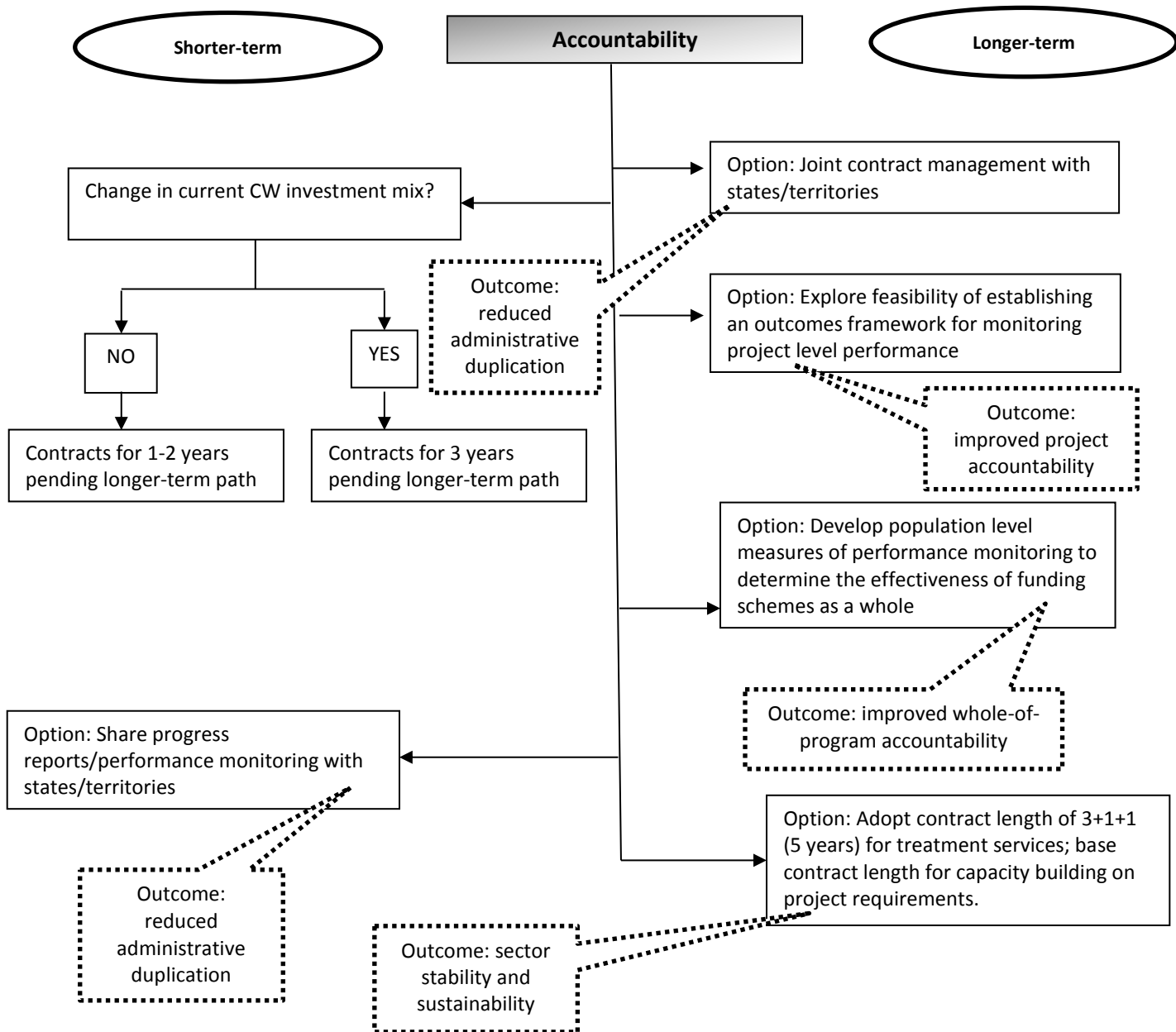
As discussed in Chapter 15, the Commonwealth has the option to consider the feasibility of establishing an outcomes framework for performance monitoring at the project level, in cooperation with the states/territories. A feasibility review could also consider the possibility of using the Quality Framework and fixed unit cost per service type alongside activity indicators, rather than an outcomes framework. A suggested starting point is an independent evaluation of the usefulness of the outcome based indicators for the 2012-2015 funding round.

Option: Explore feasibility of establishing an outcomes framework for monitoring project level performance

In terms of showing the value for money of the programs themselves, the Commonwealth could consider developing population level measures of program outcomes, based on the objectives of the

NGOTGP and SMSDGF P1 schemes. The NGOTGP objectives have parallels with the ROGS indicators for health programs (see Chapter 15). Collaboration with the states/territories would be beneficial for this work, as all levels of government need to demonstrate program outcomes.

Another longer term consideration is the opportunity to increase sector sustainability and stability by extending contracts on core treatment provision, conditional on the funded project meeting performance measures. One option is to roll over 3 year contracts for core treatment provision for 1 year at a time for 5 years in total (a 3+1+1 model). Rolling over contracts is not an appropriate option for capacity building projects with time-horizon goals, where ideally the contract length would be matched with that time-horizon (see Chapter 15).

> Option: Adopt contract length of 3+1+1 (5 years) for treatment services; base contract length for capacity building on project requirements.

While these longer-term options are considered, a more immediate question is how to incrementally improve contract management and performance monitoring in the 2015 round. If the Commonwealth decides not to change priorities and allocations (see Figure 16.2), it has the option to shorten contracts (less than 3 years). Thus, with no change in the service types being purchased, contracts for 1-2 years could be made, pending a new grant round driven from the longer-term path. This would represent administrative efficiency, although it would give a level of continued uncertainty for services.

The Commonwealth also has the option to work with each state/territory to see whether progress reports can be shared when a project is funded by both jurisdictions, or at the least that consistent performance indicators are used.

Transfer funds to states/territories

The above analysis assumes that the Commonwealth discharges its responsibilities in planning and purchasing of core AOD treatment and capacity building directly – that is, it manages and maintains a direct relationship with service providers. The second series of options concern the transfer of funds to the states/territories. This decision means that planning, purchasing and accountability reside with the states/territories, while funding is still provided by the Commonwealth.

Figure 16.4: Decision tree: Commonwealth transfers funds to state/territory
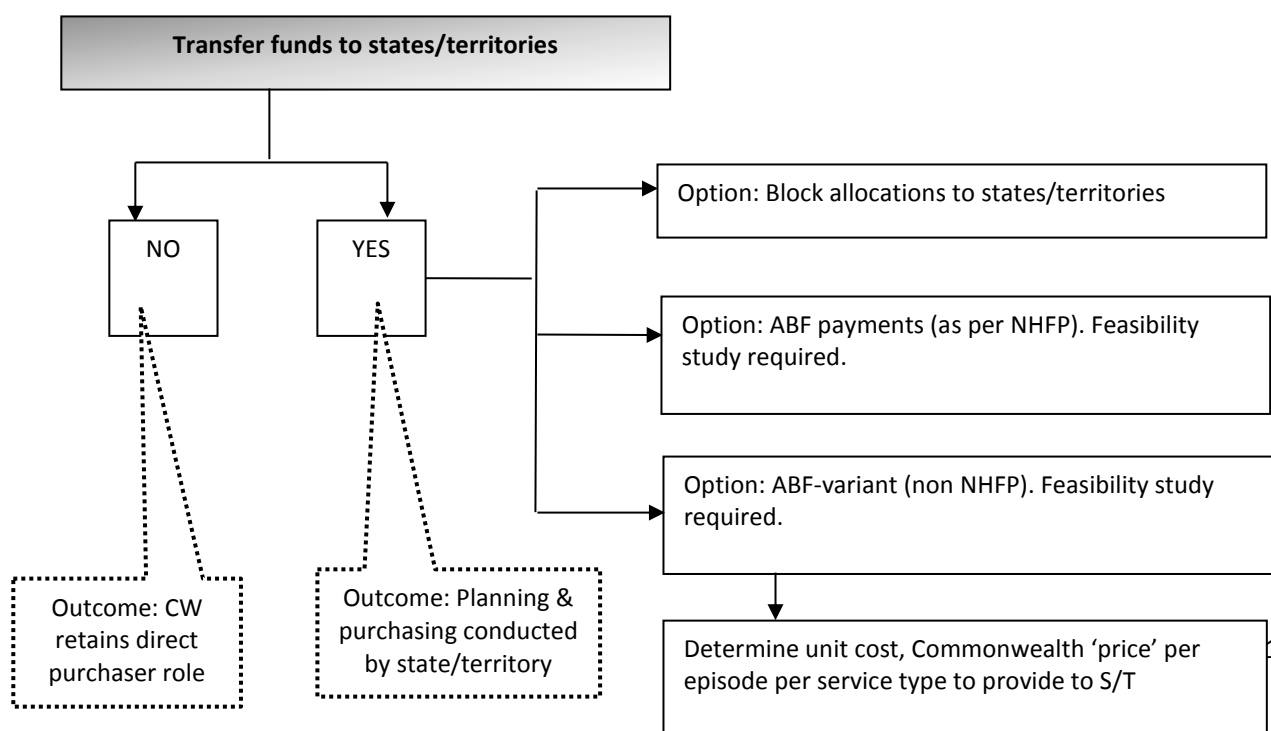
There are a number of advantages and a number of disadvantages to this option, as fully detailed in Chapter 14. If the Commonwealth chose this option, the states/territories would have the responsibility for technical planning, purchasing and accountability. This is where the advantages of this option lie: states/territories would be able to plan and purchase AOD treatment in an internally consistent way. It would reduce the likelihood of service duplication, eliminate administrative duplication for both government and service providers and reduce the possibility of cost-shifting. This is a particularly attractive option where the Commonwealth investment in AOD treatment represents a small proportion of the overall AOD treatment budget in Australia, because it would be consistent with the principle of proportionality for the Commonwealth. But at present the Commonwealth contribution is 21% of the specialist AOD treatment services (and 39% overall, Chapter 4). This is not a small contribution but represents a significant part of Australian AOD treatment. For this reason it is a less attractive option, and the argument about proportionality is less compelling.

It should be pointed out that this is an "all-or-nothing" option. The benefits of this option (reduction in administrative duplication, better jurisdictional planning and streamlining of purchasing and accountability) are lost if the Commonwealth retains some proportion of the funds. This is a significant disadvantage.

There are two variants of this option.

1. Transfer block allocations to states/territories

One option is the transfer of the funds to each state/territory in a single (block) grant. The allocations to each state/territory could be determined based on a formula, which would take into account the overall rate of AOD problems, the extent of unmet demand for treatment and other variables, such as remoteness/rurality and socio-economic disadvantage. The Commonwealth could take into account equity issues in its allocations of funds to each state/territory, consistent with its role in ensuring minimum service levels and equity of access to AOD treatment across Australia. This may mean that some jurisdictions receive substantially more per head of population than others. At the same time, this option may compromise the mandate to ensure equity in the short-term given that once the three- or five-year allocations are made, the Commonwealth has no further funds to distribute in emergencies or in situations where future inequities arise. Choosing this option for the 2015 grant round may present some complexities to the extent that the states/territories commissioning processes (see Chapter 11 Table 11.1) are not aligned with the Commonwealth timelines, which would result in service gaps in the short-term.

> Option: Block allocations to states/territories

The major concern expressed by key informants (across government and non-government) to the Review is the potential loss of these currently dedicated AOD treatment funds. There is a fear, based on past history, that the funds will be potentially lost within the state/territory systems. (Chapter 14 outlines more details about this). It would require careful quarantining of the funds and mechanisms to ensure that the funds were expended according to the original Commonwealth intention (that is the purchase of AOD treatment and capacity building). On balance, we consider this to be a high risk option, despite its seeming attractiveness.

2. Transfer of funds to states/territories via an ABF type mechanism
An alternative to the lump sum tied grant is for the Commonwealth to employ some type of Activity Based Funding model as its way of transferring the funds to states/territories. As detailed in

Chapters 6 and 14, there are two ABF models that may work here: the hospital ABF system (via NHFP payments) and a variation of that, using unit costs as the basis for state/territory payments.

Both of these ABF options have as a key feature that the Commonwealth is involved in providing funding, but not in the determination of the planning or the mix of service types, nor the contractual elements with providers (see Chapter 14). A feasibility study is required before the design and implications of these options can be fully understood (see Chapter 14) and hence they are not options available for the 2015 grant round.

The Commonwealth could use the current ABF hospital funding system to provide funds for AOD treatment. Establishing the diagnostic-related groups and price weights is a highly technical and data intensive process, which would require substantial resourcing. This is some time away, and may not be feasible. Currently for hospital ABF the Commonwealth contributes 36.5% of the national

> Option: ABF payments (as per NHFP). Feasibility study required.

efficient price. We understand that with the May 2014 Federal Budget there may be changes to the ABF system, including the proportion of Commonwealth contribution and the governance structures. In addition, some significant concern has been expressed by experts as to the extent to which the ABF system is suitable for non-admitted care and more specifically suitable for AOD treatment given the large variability in practice and lengths of stay. There are other complexities: do only those AOD treatment organisations funded by state/territory governments receive the ABF component? What does this mean for the organisations that are sole funded by the Commonwealth? How does the Commonwealth deal with inequity between states/territories, since the Commonwealth contribution is driven by state/territory contribution? Does the Commonwealth need to hold funds back, to distribute in emergencies or where inequities arise? It also leaves the issue of capacity building unaccounted for in this option. For these reasons, it seems that a fully implemented ABF the same as for hospitals is subject to considerable uncertainty.

An alternative to the hospital ABF model is transfer of funds to the states/territories via an agreed unit cost approach (variant of ABF). That is, the Commonwealth uses the ABF model (without the current mechanics through the NHFP) to make a contribution towards specific service types. What this would mean is that a unit cost is established for AOD treatment services (whether that is an individual unit cost for each service type [segmented approach], or one 'price' with weights applied for each service type [national efficient price approach]). These ABF type costs would then be used to determine the contribution by the Commonwealth towards AOD treatment which was planned and purchased by the states/territories. Thus, for example, if the Commonwealth determined that its investment

> Option: ABF-variant (non NHFP). Feasibility study required.

should reside in psycho-social therapy services, then it could provide funds at a proportion of its specified unit cost to states/territories to then fund service providers. Similarly it could choose residential rehabilitation as the service type. The priority areas could shift over time, as the Commonwealth identified national priorities, gaps and special initiatives. This option would remove the direct purchasing responsibilities from the Commonwealth (and hence reduce administrative duplication) but enable sustained contribution to AOD treatment through national priorities. This ABF variant approach, however, is likely to only apply to direct care services. There remains the responsibility for planning and purchasing capacity building – creating a proportionality problem (the Commonwealth investment in capacity building has been and is likely to continue to be significantly smaller than for direct treatment).

With any of these options, the Commonwealth would still need to fulfil its responsibilities in relation to AOD treatment through: establishing national strategic frameworks, national clinical guidelines,

and quality frameworks; and leading national planning processes, and providing planning tools. So the work of the Commonwealth would include leading the ten-year National AOD Treatment Strategy, supporting jurisdictions with planning tools and resources, and providing a nationally endorsed quality framework.

Summary
The first option (block allocations to states/territories) is very high risk, and the second and third options (purchase via ABF type mechanisms) require a feasibility study, and have various other disadvantages. Taken together, the analyses provided in Chapter 6 and 14 and summarised here, we consider that the disadvantages of the transfer options outweigh the advantages.

Communication and partnership processes

We want to reinforce that *how* these activities are undertaken is as important as *what* is actually undertaken. A commitment toward a shared purpose and a partnerships approach should enable positive sector change and assist with managing risks and rewards – as services and governments work from a single understanding of what is involved and for what benefit. Key informants were at pains to express the importance of good processes – the style and consistency of communications, the clarity of written documentation, the meaningful engagement of all stakeholders (states/territories, service providers and current and future clients) and the establishment of partnerships amongst stakeholders. The scholarly literature also reinforces the importance of good processes. Moore's (1995) book "Creating Public Value: Strategic Management in Government" was a seminal work in documenting both a philosophy of public management and guidelines for effective action, which speak directly to the role of government in creating public value. Carson & Kerr (2012) draw literature together which suggests that there has been a shift from contractualism between governments and the NGO sector under New Public Management, to a more collaborative partnership approach where government has alliances with the third sector to "co-create public value" (p. 3). The Productivity Commission's (2010) report on the contributions of the not-for-profit sector reinforced the need for strengthened relationships between government and the not-for-profit sector. The National Compact between the Federal government and the not-for-profit sector signalled partnerships, working together to create public value and respectful relationships. We chose the WA case example (see Chapter 11 and Part 3) precisely because it provides a detailed example of an effective partnerships approach. The case example also demonstrates that its approach is more than merely a commitment to values, but involves time and resources in setting up structures and processes that develop and maintain the partnerships.

The options we established for planning, purchasing and accountability are contingent on the development and maintenance of collaborative respectful partnerships. This applies equally to the Commonwealth and to states/territories – that is planning, purchasing and accountability by both levels of government needs to be engaging and respectful of the other level of government. Investment by the Commonwealth in building those working relationships is required. This would include:
- Bolstering the resources available to the IGCD by increasing the frequency of meetings, and improving the communications (assuming that this is the body where a partnership between the Commonwealth and states/territories is best formulated and sustained)
- Establishing a mechanism(s) to consult and coordinate with the NGO treatment sector
- Establishing a mechanism(s) to consult with current and prospective clients of AOD treatment.

An allocation of funds from the NGOTGP and/or SMSDGF would be required to achieve this. It is possible to establish these mechanisms for the short-term (focussed on the next Commonwealth funding round for the NGOTGP and SMSDGF), although achieving value for money and improving

health outcomes for people with AOD problems in the long-term will require sustained partnership mechanisms and ongoing attention to relational management.

Conclusions

There is a complex array of decisions that need to be made. Some of these are decisions in the short-term, pertaining to the 2015 grant rounds for the NGOTGP and SMSDGF. We hope that the options articulated through Part 2 and summarised in the left hand side of the decision trees will form the basis for rapid and effective determination of next steps.

In the longer term there is opportunity to reform the NGOTGP and SMSDGF grant rounds. They provide essential funds for the provision of alcohol and other drug treatment across Australia. The time is ripe to explore new horizons for these funds, with opportunities to strengthen effectiveness, efficiency and equity.

All the options speak to the role and responsibilities that the Commonwealth has: advancing national priorities; providing leadership in planning; addressing service quality; and supporting equity.

In Chapter 1 we noted the importance of being client-centred. While the focus of the Review has been on the planning, purchasing and contracting of AOD treatment services, these are merely a means to an end – the reduction in the harms associated with alcohol and other drug use, and improved physical, psychological and social well-being for people experiencing problems with alcohol and other drugs and their family and friends. The success of the Review will be judged by the improvements in the well-being of these people, some of the most disadvantaged and stigmatised people in Australia today, consequent on the Commonwealth's analysis of options and subsequent implementation.

PART 3: CASE EXAMPLES

Case studies are an established social science method that provides an in-depth investigation of complex social phenomena (Yin, 2009). They are useful for describing and understanding 'how' or 'why' something works in a contemporary context (Yin, 2009).

For the purposes of the Review, nine cases were chosen to illuminate aspects of the Review under investigation and provide detailed illustrative examples. We have chosen to call these studies 'case examples' as they do not involve a large-scale data collection approach and, for some case examples, the principal source of data was publically available information.

The Review case examples focus on planning mechanisms, funding mechanisms, sector capacity building and supporting treatment functions, and the experiences of non-government organisations (NGOs) in relation to government funding, multiple funders, reporting issues, logistics of seeking funding, timelines for tendering and so on.

The cases were not designed to be broadly representative, but rather have been selected as single-case examples to add depth to analysis. Aspects of the cases have been used as brief illustrative examples, in text boxes, throughout Parts 1 and 2 of the Review. Here, each of the case examples is presented in full.

Table 17.1: List of case examples

Case	Illustrative example
Organisation A	Experiences of a non-government organisation in relation to government funding
Organisation B	Experiences of a non-government organisation in relation to government funding
Department of Veterans' Affairs	Funding mechanisms - preferred providers
Partners in Recovery	Funding mechanisms - competitive grants
Victorian AOD sector reform	Funding mechanisms - activity-based funding
Drug user organisations	The role of drug user organisations in supporting treatment
AOD state/territory peak bodies	The role of AOD state/territory peak bodies in sector capacity building
Medicare Locals	Planning and needs assessment
WA AOD sector reform	Partnership approaches

Chapter 17: Case Examples

Case example: Organisation A

The aim of this case study was to document the experiences of an NGO in receipt of Commonwealth AOD treatment funding with a view to ascertaining the experiences and perceptions of: competitive tendering; management of multiple funding sources; funding reporting requirements; and strengths and weaknesses of current government processes. The NGO staff members interviewed for this case study (n=5) had been identified as having experience and expertise regarding the organisation's funding arrangements, and could speak knowledgeably about the subject matter under investigation. To maintain confidentiality and anonymity, the name of the organisation and the jurisdiction in which it operates will not be reported.

Description of the organisation and AOD treatment services

The organisation has a long history of residential rehabilitation service delivery (particularly within the therapeutic community model) and is a large, well established, specialist AOD treatment provider within its jurisdiction. Since its initial establishment as a residential rehabilitation treatment service, the organisation has expanded its service delivery purview and aims to "provide a comprehensive range of community-based treatment and support services to address alcohol and other drug problems, along with any associated mental health, vocational, health, relationship and family issues".

The organisation currently has 110 residential rehabilitation treatment beds (at two locations across the state, one short-term and one longer-term program). The organisation also has 50 supported accommodation beds (in 25 houses across the state). In addition to residential services, the organisation provides a range of outpatient programs both in the central city and in urban growth corridor areas.

The organisation provides a range of community-based treatment and support programs including financial and gambling counselling services, and child and family support programs (including home visits with parents and family therapy programs for families with children who have a dual diagnosis). A youth and family team provides outpatient counselling services as well as outreach across community schools (including counselling services, curriculum delivery, youth camps etc.). The organisation is also engaged in prevention work in multiple ways (for example in conjunction with sports clubs and schools). The organisation is also a Registered Training Organisation (RTO) and provides training for approximately 250 students (mainly professionals seeking qualifications for work in the AOD and mental health sector, as well as clients who may be engaged in courses such as hospitality training or business administration).

The organisation partners with universities to develop and evaluate new programs, and regards building the evidence base for what they do as part of their role within the sector.
The organisation also plays a key role in policy and advocacy within the AOD sector by supporting committees and sector reform processes (including quality framework development).

Funding

In the interviews conducted, it was estimated that 55% of the organisation's activities are state funded (primarily through the state Department of Health, but sometimes also Department of Education and Justice etc.); around 25% of activities are Commonwealth funded (historically and variously through the Department of Health and Ageing, FACSIA, and AGs proceeds of crime

funding); 10% of activities are funded through fee for service (primarily through clients' Centrelink contribution to treatment in residential programs, as well as fee for service for training programs which are nonetheless heavily subsidised); and 8-9% of activities are funded through donations, trusts and foundations, philanthropic/corporate support. Participants noted that this final category of funds "fills gaps" and is used to supplement programs and resource capital works, as well as fund discrete programs and innovations (e.g. employment programs; financial counselling; community school programs). The organisation very occasionally receives consultancy funds, but participants were of the view that these services were mainly provided in-kind as part of their contribution to the development of the sector.

The organisation is in receipt of both NGOTGP and SMSDGF funding. The NGOTGP funds equate to approximately $1.1 million a year which fully funds a 15 bed residential rehabilitation program (in a country area, which has approximately 20% Aboriginal and Torres Strait Islander clients). The funding available to the organisation through the NGOTGP has grown over time through the various funding rounds. Initially, the funding provided allowed the program to be open only 6 months within 2 years, and only funded 8 beds (as a 24/7 residential service, there are some fixed operational costs, including planning requirements that 2 staff be present at all times). One participant said there was "community uproar" that the service was only open 6 months a year, due to the perceived need within the community. It was said that the partial funding of the program "worked for the residents for that period of time, but it was a terrible way to run it". In each subsequent funding round the organisation has made a case to government to build on the program with additional funding. Over time the program was built up to 12 beds, then 15, and moved to continuous funding (11 months of service delivery per year, with a close down over Christmas/New Year period). The program remains "sustainable at that level".

The organisation is also in receipt of capacity building funding through the SMSDGF. The organisation has used this funding to build on earlier dual-diagnosis (comorbidity) work that had been unfunded at a state level, but which had been initially developed through philanthropic funds. This was a perceived need as 80-90% of the organisation's clients have a dual diagnosis. One participant noted that the first round of SMSDGF capacity building funding "really helped us set a bench mark" and "lift the bar". The second round of funding has since extended the initiative into GLBTQI, CALD and Aboriginal and Torres Strait Islander capacity building initiatives. This has included, for example, supporting the activities of an Aboriginal Advisory Group, employing an Aboriginal Consultant who works part time to improve links at a systems level, as well as employing a young Aboriginal woman to give her work experience in this area. These activities were undertaken so as to extend capacity building beyond mental health and into areas where there was need for staff development. It was said that this capacity building funding had been "fantastic and critical" for the organisation – because state funding is so limited, this capacity building funding as well as trust and foundation money supplement staff development and supervision across the organisation (which should be basic requirements).

Within the organisation's financial management system different accounts are used to separately manage the range of different programs, and the organisation tries to reflect the true costs of that program in the account. It was noted that in the past the organisation used to "pull money" into programs from across the organisation, but now a more streamlined accounts management system is used to see how much each program actually costs. This system also ensures consistent quality standards across the organisation; regardless of how the program is funded, expectations of quality standards stay the same. Although programs are funded discretely, participants noted that flexible funding from trusts and foundations is used to "plug some of the gaps". Capacity building funding is also used "right across" the organisation to enhance professional development, supervision and training.

Although programs may be discretely funded, there is a sense of "cobbling together" the wrap-around services for the client. The organisation aims to provide services in a holistic way for clients. It is the organisation's general practice to engage clients in other specialist community services where possible, and to provide in-house services for those clients who are unable to negotiate external networks/resources and transition them to community supports over time. The organisation works with a complex group of clients, and in the organisation's experience they have seen better outcomes in terms of long term recovery if more services can be delivered in-house for complex clients. This said, the organisation aims to integrate into the community and partners with other services and co-locates to provide holistic and integrated care for clients.

Funding processes

The organisation uses a range of processes for securing and maintaining funding. It was noted that although the program logic of what the organisation wants to deliver is strategic and well-considered, the process of seeking funding from multiple sources is more "ad hoc" given the different trusts, foundations and government departments from which they seek funding.

The organisation actively seeks opportunities to tender from multiple government departments and philanthropic agencies. One participant noted that when preparing tender applications, the organisation generally already has "a good feel" for what the government will fund based on past experience. It was noted that the organisation is well positioned to receive funds to provide some of these services in the jurisdiction, given the limited number of residential rehabilitation treatment service providers in the jurisdiction and the infrastructure that it already has.

Tendering timelines were regarded as manageable, and participants were confident that the organisation had the skills and capabilities to prepare tenders and grant applications in a timely way. The organisation is focussed on a particular vision of holistic care provision, and as such chooses to tender only for funding which would enhance the core business of the organisation, including funding which broadens the availability of wrap-around services which support treatment for clients.

From a practical point of view, it was noted by one manager that program teams are configured in such a way to ensure that there is a team member who is a competent tender writer. Tender and grant writing was regarded as "a skill". Writing applications is regarded as part of the ordinary activity of teams: "it is a mindset within the teams".

It was also noted that the organisation invested significant time and energy into generating new ideas and innovations for trust and foundations' funding rounds.

It was suggested that going through a complete re-tendering process every 3 years, as is necessary with the Commonwealth funds, seemed "a bit unusual and over the top". Re-tendering was regarded as appropriate where it is "new money" or for new treatment programs, but if it is the Commonwealth's intention to continue the funding source and sustain organisations that are achieving well then re-tendering should not be necessary.

Participants noted that there was a "different playing field" for smaller and larger organisations in tendering processes, due to resources required for tendering. Competitive tendering was said to create an environment where bigger organisations grow and smaller organisations disappear: "it becomes very clear, very quickly, who's weak and who's strong". Smaller organisations do not routinely get invited to as many working groups and consultations, whereas larger organisations (such as the subject of this case study) get greater access to politicians and advisory groups. This

organisation is open to sharing the learnings gained through those meetings, but not all larger organisations are as open with other organisations in the sector.

Partnerships/consortiums

Working with consortiums was regarded as essential to bring about real change in a sector reform environment, and can generate "generosity" between organisations, but one participant noted that it would be "crazy" to be reconfiguring consortium arrangements every few years for tendering purposes.

The organisation which is the subject of this case study had already been leading a process to establish consortiums and partnership approaches, before the 'incentive' had been given through funding processes to create consortiums. As a result of this experience, the organisation had already generated learnings about sharing back office systems, and establishing governance processes. As such, when the state government reforms came in, the organisation already had a lot of experience with managing partnerships and as such was not as anxious as other organisations in negotiating this changing environment. It was noted by one participant that the organisation also has highly skilled ("unbelievably experienced") senior management staff, and that their management and governance experience means that the organisation is well placed to negotiate changing funding environments. There was awareness that other organisations in the AOD treatment sector may not have this skill-base to draw upon, which means that not all organisations are as adaptable and confident to survive and thrive in changing funding environments.

Participants reflected that some consortium arrangements had been successful in the past, but there is a chance in the future that the organisation could be involved in 8 or more consortiums and it may become difficult to monitor and manage all of those relationships and systems. It was suggested that there was a need for leadership within consortium arrangements to ensure clients are being served well. The organisation was careful not to partner with organisations who are not interested in change and quality improvement. It was also said that the sector needed to be conscious of fragmentation of resources – in some cases another 'partner' provider is not needed if additional services can be built into one organisation more efficiently. That said, issues of territoriality sometimes need to be resolved where one organisation seeks to protect their 'core business' rather than tendering with partners.

Participants mentioned some issues which had arisen with partner organisations through competitive tendering processes. It was suggested that integrity, confidentiality and ownership of information became sensitive issues in partnerships when tendering. Aligning policies and procedures between consortium partners is also challenging (e.g. ensuring that staff employed by different organisations who will be working together on the one program are not being paid at different rates, following the same policies and procedures around HR and service delivery, and streamlining reporting processes). Good probity processes need to be in place. One participant suggested that organisations needed to stay focussed on good outcomes for clients, not on inter-agency or jurisdictional politics. The focus should be on giving clients "seamless" and "better joined up" services.

Contract management

Over time the organisation has built up a single client and contract management system. This has streamlined reporting, particularly when clients are engaged in multiple programs across the organisation's activities. Interview participants noted that implementing a single electronic web based client management system across the organisation has been an improvement and said that

the system leads to greater integrated care and case coordination across services. Importantly for funding requirements, the system also produces reports for funders so "we're not double handling data". The system has been developed such that reports can be generated in different formats for different departments and funders. One participant noted that the sophistication of the system which had been developed was important not only for administration, but also for the delivery of integrated care for clients: "We work in a messy field, with complex people – there's going to be mess. It's just who carries the mess… a lot of the reforms in [the state] are trying to prevent the mess being experienced by the clients […] We carry the mess by having systems like this". The organisation's quality framework system is also integrated into an electronic management system, along with all its policies and procedures.

The management system also has a grants management component whereby all the deliverables of a funding contract are logged into the system so every time an acquittal report is due it can be managed and deliverables can be easily tracked. Given that the organisation is applying to over 100 trusts and foundations every year, and having 20-40 of those requests successfully funded, it was noted that it was essential to have systems for managing all these funding contracts at different stages. In one participants' opinion, the system makes managing the multiple funding environment possible.

Despite the sophistication and integration of the system developed by the organisation, it was noted by several participants that it would be beneficial for government departments to streamline funding reports and systems across the whole of government because reporting against multiple contracts with multiple government departments becomes "a nightmare". It was noted with frustration that every government department has a different standard contract format ("it is a waste of time"). It was suggested that the core part of government contracts should be the same, and only the schedule should change. There was the perception that there are a lot of inefficiencies that could be improved with the government contracting. Participants also noted with frustration that rarely do the funder's contract managers stay in their role for very long. Personnel changeover is disruptive, time consuming and is problematic for the continuity of relationships with funders.

Historically, most of the organisation's state government contracts have been on a rolling 3 year contract basis. It was suggested by participants that the state government had "poor and weak process for rolling over contracts". It was said that there was "very superficial" monitoring of targets and that the state rarely looked at the performance of services it funded. It was suggested that the organisation was not ever approached by the government funders to have conversations about the service/program; communication was only forthcoming if the organisation initiated conversations and was proactive. This process was regarded as "very easy for us, but really poor".

It was noted that funding processes used by the Department of Justice were more accountable and positive. The organisation provides quarterly quantitative and qualitative reports, and it was said that there are good expectations around outcome measurement. One participant said this process was "about right […] It is tax payers money, you want to be accountable for that". One participant with a long history of working in the sector suggested that for the majority of treatment organisations reporting in an accountable way should be "fairly straightforward", and that the minority of organisations who find it difficult to meet obligations should come under greater scrutiny (which would in turn create opportunities for new organisations to enter the market where some organisations are not performing).

One participant reflected that the AOD treatment sector has a "real can-do attitude"; services are able to hit the ground running quickly with new programs and the sector is used to getting start-up programs happening quickly. However despite the resilience of the sector, it was emphasised that

waiting on decisions regarding roll-over of contracts with existing funders is incredibly frustrating and problematic for organisations and especially for staff retention. It was said that informing services less than 3 months out regarding whether or not a contract would be rolled-over should not be permitted. Holding over decisions and giving short notice showed "disrespect" to organisations, and it was suggested that in these cases the funding should be rolled over for another year. In an environment where the continuation of funding is uncertain due to short notice decision-making, the organisation's staff will seek work elsewhere to preserve their income, and recruiting new staff is hard: "Staff can't wait that long, they are out looking for jobs now, so even if we get refunded the chances are most of the staff will have moved on anyway. So we then spend a lot of money advertising trying to recruit staff to keep the program going. That's a way of life, it happens with every program that gets refunded. We get told too late in the piece that we're going to get refunded, but we're back to square one in terms of staffing". It was noted that it is the clients who end up disadvantaged when good staff move on simply because they do not know if programs are being refunded. This uncertainty has a "huge impact on the ground". Speaking about one Commonwealth funded project (with a contract due to end in June), one participant said "If we lose enough of those staff, it is like running a pilot again. If the experience-base gets degraded to a point, it is very hard to build that back up". Similarly, participants spoke of examples where the organisation had been advised late in the financial year that the program funding would be rolled-over, but at a significantly reduced rate. As such, the program needed to be redesigned to allow the program to continue at the reduced rate of funding. In another example, the organisation received advice under the previous Labor Government that funding for one program would be rolled-over in the following financial year, but this advice was then reversed with the incoming Coalition Government and the future status of funding for that program is currently unknown. This reversal of was regarded as "appalling". It was suggested by participants that 6 months advance notice of contract roll-over would be ideal, to retain staff and maintain service delivery. Several participants emphasised that the lack of information about re-funding of the Commonwealth funded programs is a significant issue for the organisation at the moment.

Ideally, participants said that 3 or 4 years would be an ideal length for contracts. Anything less than 3 years was not regarded as enough time (it was said that 2 years is hardly even enough time to collect or document the learnings from the program and for 1 year contracts the focus becomes recruitment and then looking for future funding straight away). That said, participants said that contract length was an important accountability mechanism and that they would not like to see a poorly performing organisations funded for longer than 4 years. However, this depends on the monitoring systems throughout contract.

It was suggested that the ideal contracting arrangement would be one whereby the government used standard core contracts across departments (with only schedule changes), with 6 monthly written reporting which was then followed up with a meeting (e.g. a teleconference) to receive feedback (it was also suggested that a more streamlined approach to reporting requirements across government departments would be beneficial). Contract reporting arrangements with the Commonwealth were regarded fairly positively by the participants ("they actually read the reports") but it was noted that sometimes the Commonwealth could be can overly focussed on minutiae (which limited the organisation's flexibility to spend funds as they see fit to meet the program's outcome targets). There was sometimes a perceived tension between what clinicians regarded as important or relevant reporting information, and what the government requested as measures in reports.

It was said that having real relationships with contract managers is important, and that it was especially beneficial if contract managers can visit the program site so that they have a real understanding of what it is the program does so they can work together to work through any issues

that may arise during the contract period. It was also suggested that funders needed to have a greater understanding of the tight budget constraints not-for-profits worked within. Any move toward greater self-regulation or "earned autonomy" for organisations with a good track record of performance and compliance would be welcomed by this organisation, especially if this removed red tape and the cost of compliance. Fire safety compliance and risk attestations at a state government level are one example where this has been done. Spot checks would ensure organisations take this responsibility seriously.

One participant reflected upon a contracting process the organisation had gone through with the Commonwealth to illustrate some challenges. Residential rehabilitation programs are funded differently in every state and territory, and in this case the Commonwealth had adjusted the organisation's tender to align with state funding amounts (which was regarded as "really poor"). In this case, the organisation ended up refusing the contract offer from the Commonwealth as they were not happy with the process. The participant noted that there had been some "shock" when the contract was handed back to the Commonwealth, but the organisation used the situation to go through the budget and explain to funders how their service could not have been delivered with the funding the Commonwealth had offered. In this case, it was noted that it was great that the Commonwealth had been consulting the state (which is where the rehabilitation standard funding had come from) but there needed to have been broader consultation with the sector. It was suggested that to procure services successfully in Commonwealth competitive tendering processes, the Commonwealth need to "understand what you're funding and why" which requires consultation and good planning. Good planning is required to understand the mix of services available, as well as geographic need (e.g. focus on growth corridors). There is a need for the funding to "chase the demand" of where the need is, not simply continue to fund longstanding inner city and urban programs.

Funding models

In terms of funding models, it was suggested by one participant that some combination of block funding and activity based funding may be ideal. This combination would be beneficial as organisations need some centralised funding, but also need an incentive for through-puts. It noted that there needs to be rewards for the organisations that are putting in effort and doing innovative work. The question of how to incorporate outcomes was regarded as "really tricky" however, and it was noted that the organisation would not want to simply tie client or systems outcomes to the funding. However, having an outcomes framework at a catchment level or planning level to collect data and see that an impact is being made collectively at a community level would be positive. Such performance monitoring at the catchment level would provide more accountability and could identify programs that are working and organisations that are innovative. It was noted that in the AOD treatment sector there are so many components that connect to a client achieving a particular outcome, and as such 'outcomes' are complex to assess in AOD. But by collecting data and monitoring at a broader catchment level, it could be assessed whether some strategies are having an impact. Activity based funding is still important as it rewards effort. The possible "cherry picking" associated with outcomes based funding was regarded negatively, and fears around unintended consequences for complex clients were expressed. There was concern voiced around any funding model which meant that services would 'bend to' whatever the reporting outcomes may be.

It was also suggested that much of the rationale for competitive tendering could actually be shifted into the contract management space, so that rather than having to regularly tie up significant time and resources in re-tendering, performance could be more closely monitored through contract management. This way, if the contract management process reveals that organisations or programs are not performing, then the funds can be reallocated (rather than constantly forcing services which

are performing well to re-tender every 3 years). This would also alleviate some of the anxiety that goes with not knowing if a program is going to be refunded.

It was also suggested that after a program is established, a preferred provider model would be a better model for the continuation of Commonwealth funding. This would increase efficiency by minimising the data collection, acquittal and reporting requirements of competitive tendering. The rationale for this was that if organisations already have a good track record with the funder and are working within a quality framework, then the government should support that.

The role of Commonwealth funds (NGOTGP/SMSDGF) in relation to NGO providers

Participants suggested that the strength of the Commonwealth funding has always been that regardless of whatever strategy a particular state/territory government may be emphasising, the Commonwealth funding "fills in the gaps and some of the fallout". This could apply geographically, or in terms of particular populations, especially those difficult to reach (e.g. Aboriginal and Torres Strait Islander, CALD), or may encourage the development of niche projects that the state government may not want to take up (for this organisation, this included child and family programs, and residential programs in a state with a low number of beds per capita). The Commonwealth funding allows the organisation to provide 'wrap-around' services which produces better treatment outcomes. It was suggested that the intention to work towards program objectives is positive (that is, not just focussing on through-puts), as is the flexibility and scope offered by the Commonwealth funds. As one participant said, "if they want a holistic service that actually makes a difference, they need to provide some flexible funding around that. And the Commonwealth came in to do that".

A number of weaknesses were identified with the Commonwealth funds. These included issues encountered in tendering processes, the Commonwealth's lack of coordination with states and peak bodies, and the perception that funding "seemed hit and miss" due to a lack of consultation to check that the Commonwealth was choosing good programs. It was also noted that there had been a lot of communication issues between the Commonwealth's central offices and state offices. The Department of Health's request for interest earned on forward payments of funding was also regarded negatively (the interest rate requested is not available to the organisation through their retail banking arrangements). Fundamentally, short timelines, delayed processes, late payments and unknown outcomes were regarded as most problematic: "the anxiety that creates is immense". It was also suggested that competitively tendered government funding does not reward innovation or offer support for new/pilot project development.

Overall, the participants suggested that there is definitely a role for Commonwealth funding of the AOD treatment sector, and that AOD treatment funding is not just a state/territory issue. As one participant noted, "AOD is a health issue. It is clearly in the realm of Commonwealth responsibility, and it should be driven by evidence based policy and practice, and not moral debates." It was suggested that the Commonwealth funding provides checks and balances, in "big picture, gap-filling" ways. Commonwealth funding provides an extra level of protection for clients to ensure there are not significant gaps.

Case example: Organisation B

The aim of this case study was to document the experiences of an NGO in receipt of Commonwealth AOD treatment funding with a view to ascertaining the experiences and perceptions of: competitive tendering; management of multiple funding sources; funding reporting requirements; and strengths and weaknesses of current government processes. The NGO staff members interviewed for this case study (n=2) had been identified as having experience and expertise regarding the organisation's funding arrangements, and could speak knowledgeably about the subject matter under investigation. To maintain confidentiality and anonymity, the name of the organisation and the jurisdiction in which it operates will not be reported.

Description of the organisation and AOD treatment services

The organisation is located in an inner city area in one Australian capital city. The organisation provides primary health care and welfare services to marginalised inner city populations including homeless and disadvantaged men and women, many of whom have comorbid mental health and AOD issues. The participants consulted described the service as 'medium sized', and as engaging in health promotion, harm reduction and health education activities.

Within the broader activities of the organisation (which include accommodation services and holistic care and case management) the organisation runs two specific AOD treatment activities: an AOD counselling service (run by a clinical psychologist), and a capacity building program to enhance the capacity of staff and managers to more effectively work with clients who have comorbid AOD and mental health issues. This program includes training, training audits, and evaluation. Although these two services were described by participants as AOD treatment specific services, they noted the holistic nature of their services and that AOD treatment and harm minimisation are integrated across all of the organisation's activities (for example, through the case management model used within a crisis centre for clients with complex needs which operates using a harm minimisation model, and the organisation's AOD/HIV integrated care program).

The organisation is also a member of the state AOD peak organisation and is active in policy forums undertaken by the peak.

Funding

The organisation receives funding from multiple government departments including the state Department of Family and Community Services (for homeless service), the state Health Department (e.g. for rehab service), and the Commonwealth Medicare branch (for medical clinic for homeless people).

The two specific AOD treatment services are both fully funded by the Commonwealth; the counselling service by the NGOTGP and the capacity building program by the SMSDGF (both relatively small grants, each funded over three years). The organisation also receives income through client fees for other programs, and occasional donations corporate donations (but does not have any fee for service programs).

The organisation's programs are funded separately, by distinct pockets of money, and separate financial statements are produced for each funding agreement. Participants noted however that "While we don't cross over the funds, we certainly cross over the activities". To explain this, participants noted that clients participate across multiple programs within the organisation, although the client would not realise this due to the integrated approach of the organisation. The

organisation also works in an integrated way with other organisations and agencies to care for clients: "we all have to work together". Clients are referred to the organisation's AOD counselling service from other agencies as well.

The organisation maintains discrete funding streams for its various programs. The costs associated with accreditation and quality improvement activities are pulled from management fees and reserves which have been built up over the years.

Funding processes

Seeking funding

The organisation is often invited to tender, or may see open tendering opportunities through government websites and list servers. Participants noted that they look for funding opportunities which specifically fit the organisation's mission. Usually the CEO would write tenders (with input from staff), or sometimes a consultant will be engaged to write the tender (depending how big the application is and where expertise lies). Up until recently, the CEO was responsible for writing all the tenders and the reports.

Participants noted that competitive tendering processes generated "stress" and were "time consuming". The tendering process becomes the whole focus of CEO's work for that period, which takes the CEO away from other activities. Participants noted that timeframes for tenders are often short. They suggested that organisations should have at least 8 weeks to prepare a tender, and sometimes this is not the case.

Overall, participants said that the information provided by government in tendering processes is "usually ok" especially if a FAQ is provided on the website.

Participants expressed some concerns about how services are purchased by government through tendering processes – i.e. what's the basis of their decisions? There was a perception that tendering processes are now vastly different to how they have worked in the past, with the expectation that services produce "more outcomes for less money". In the past, when tendering for funding, the organisation would have considered "What's our capacity? What is our expertise?", but now the organisation has additional concerns: "Is there enough money in this tender to do what the government is asking us to do?"

Partnering

The organisation is a member of the inner city homelessness coalition, and noted that they are very happy to work with other agencies if that is required as part of the funding process (e.g. in the context of the current state reform being experienced by this organisation). Even where formal partnerships are not required, participants said that they may mention relationships with other organisations as part of the funding application to emphasise the strength of these relationships. Participants noted that in the past agencies have 'owned their clients'. This sense of 'ownership' no longer exists however: "They are homeless clients that require assistance from whichever agency can provide that assistance". There was the sense that competitive tendering processes will increasingly require formal partnering, not just the MOU arrangements which have existed in the past. Participants noted that "Government has the attitude that if you don't partner, you're not making the best of the dollars".

Although the participants spoke positively of partnerships, they also expressed some concerns about these partnering processes. It was suggested that because tendering timeframes are so short, agencies were forced into partnering with other agencies who may not share the same philosophy or standards of care. This was regarded as "a real problem" in cases where partnerships may be required as part of the tender but where the partnership may not be in the best interests of the organisation. Due to the short timeframes, participants said that "speed dating" partnerships were being established across the sector, which is not effective. It was suggested that smaller organisations have been forced to partner and just "grab someone" because of the short tendering timeframes. Participants said they had received last minute emails asking to 'partner', even if they have nothing in common with the other organisation's philosophy. Participants said that their organisation sought partners who share a similar philosophy to them. In this sense the tendering process forces partnerships, but does not encourage *quality* partnerships.

In discussing partnering, it was emphasised that quality and accreditation are very important. Agencies can only reform practices by bringing in a quality improvement system that is accredited. However, it was noted that accreditation is expensive for organisations, and needs to be funded adequately. It was suggested that much of the work and cost associated with accreditation and quality improvement has not been recognised by government.

Participants also noted that having multiple funders and multiple partners across programs can become "a nightmare to manage". Too many partners meant that the funding would not be viable as it dilutes the funding pool available to the organisation.

It was emphasised that good relationships and trust were needed, and that the partners needed to share quality standards.

Pre-qualification and accreditation in procurement processes

Participants said that a pre-qualification process is important and regarded favourably in a tendering process as a way of ruling services in or out. Participants mentioned that the state government was considering approaching agencies in some circumstances, but this process was not regarded by agencies as open and transparent. It was suggested that pre-qualification can be seen as a kind of selective tendering, but in this organisation's experience of the state process, just about every organisation who applied was pre-qualified. This was not seen to be an effective process. In this way, participants felt there had been no sense of quality in the procurement process.

Participants suggested that in the lead up to funding rounds there should have been an accreditation process or a review. In the case of the state reform, one participant suggested that the sector should have been consulted years prior to the reform, so that organisations could go through a process of qualification based on outcomes and capacity. It was suggested that in the four years leading up to the tendering process, organisations should be able to prove that their organisation can achieve the outcomes and have "got the points on the board". Participants noted that even as a small- to mid-sized organisation, they have achieved 'gold star' status in a number of areas which signals to other services that it can be done even in smaller services. Although accreditation can be lot of work at first, participants said that over time it became embedded in the practice of the service.

Reporting

Reporting is embedded within the operations of the organisation in that reports are routinely written by managers of the program (e.g. the psychologist) and then signed off by the CEO.

In discussing procurement and tendering processes, it was suggested that previous reports given to government by organisations should tell the government about an organisation's capacity and ability. Participants wondered how reports actually fed into the process in a tendering round; it was not clear whether reports are taken into account. Participants suggested that government should take the organisation's past track record into account in re-tendering processes. It was suggested that taking past history and reporting into account would encourage organisations to continue to build on good practice (accreditation was regarded as part of this process of quality improvement).

Participants noted that their state government funders give very little feedback on reports and the limited feedback had been received sometimes over 12 months later. Participants said they were very happy with the more detailed feedback they receive from the Commonwealth (which was regarded as "very thorough"). If sometimes the organisation does not agree with feedback, then there is room to discuss and resolve misunderstandings with the Commonwealth.

It was noted that reports are the primary way contracts are monitored (including financial reporting and audited accounts). Participants were pleased that the Commonwealth is open to rolling over small amounts of surplus funds; however the state funders do not permit this. Participants also said they were happy with their contract arrangements with the Commonwealth, and that local staff/project officers have always been "incredibly supportive". Although there had been some personnel change in local office (and some staff were better than others), on the whole the relationship is positive.

Contract length

In discussing contract length, it was noted that although the three year funding model is relatively workable, a five year model would be better and a "bit more substantial". However, participants were not in favour of just simply rolling over funding for organisations indefinitely because of the perception that "people can get slack" if they know the funding is coming in. Participants felt that without having to reapply for funds, a sense of complacency may permeate some services as there was "no incentive to look at your practice". Participants suggested that this is what has happened with the specialist homeless services which have just had funding roll over annually since 2010. In these participants' opinion, a competitive tendering process every 5 years would encourage good practice.

Probity and fairness

Participants said that they "want to see probity" and "that everyone is being treated fairly" in tendering and procurement processes. Probity was regarded as important because any wavering from this meant that the sector lost faith about who wins the tender.

Participants suggested that there was sometimes a mismatch between the tender process and the actual quality of the service delivered. It was noted that some organisations can write good tenders (or pay professionals to do so) but this does not demonstrate the actual service practice – which is why accreditation is regarded as important. It was suggested that the tendering process favoured organisations that used professional writers, even where the service practice may not be so good. Indeed, there was a sense was that some services who should not have pre-qualified in a recent tendering round did so because they "used the right language" not because they could deliver within their expertise. This created an unfair tendering environment. Participants suggested that funding should not be awarded based solely on the standalone tender document– accreditation and past track record should be part of the decision making process.

Participants also said that it was not fair for organisations to be given extensions to complete a tender. One participant said, "if you can't get your tender in on time, then that speaks to your organisation". Extensions were not fair to people and organisations who had worked hard to get it in on time. In some cases, organisations which had not pre-qualified had been allowed to apply at the last minute. Such exceptions are not fair for other organisations that met deadlines and worked within the process. In discussing recent state processes specifically, it was noted that there had been great negativity among the sector because of the perception that the government had been "changing the goal posts halfway through" - tender dates had changed, and last minute decisions were being made. Participants suggested that there should have been more consultation with the sector regarding how the process was to proceed.

Participants believed that the focus of funding processes should not be on the organisation, or about who gets the tender; the focus should always be about the clients. Participants noted that their organisation was careful to only tender for funding that is within their remit. They suggested that there needed to be a sense of "integrity" about organisations applying for funding within their remit and organisations need to ask "where do we fit as an organisation?" There is a sense that some organisations are going outside their expertise and trying to mitigate losses in tight funding environments by tendering more widely. Participants suggested that the current reform process in their jurisdiction was being seen by some organisations as an opportunity to "grab money". It was suggested that the rationale for this behaviour is that "we've got an iconic service we need to save" – participants viewed this approach negatively as it was not client-centred.

In procurement processes, there was a perception that preference was being given to larger organisations that could bring in-kind funding. Participants said that in-kind funding should not be a determinant in funding processes and that there needs to be fairness in the way funds are distributed. Funding organisations because they have significant in-kind donations is not a sustainable model – especially because donations are dwindling. Participants noted that these arrangements set up difficult relationships between agencies as well.

The role of Commonwealth funds (NGOTGP/SMSDGF) in relation to NGO providers

Participants said that the capacity building program which had been funded through the SMSDGF had been "amazing" for their organisation. They noted that up-skilling staff and evaluating programs has been incredibly valuable. The counselling service funded through the NGOTGP had also been an excellent program (although noting that it would be good to build a psychiatrist into this). The counselling service has intersected well with the organisation's medical clinic, as the organisation has been able to give clients mental health support through this program. The counselling service dovetails and 'taps into' the housing services offered by the organisation. In this sense, the Commonwealth funded AOD treatment programs complement and enhance the programs funded by the state – the state funding and the Commonwealth funding dovetail, in that the clients cross over. Participants suggested that these services stop 'clogging up' of hospital outpatient services, and give clients timely support rather than 'waiting' in health services. These support services within NGOs are essential for supporting vulnerable clients.

By maintain discrete funding for individual programs, if one source of funding was to cease participants felt that this would not restrict the overall service greatly. Staff positions are funded separately from the different funding streams, with designated positions attached to each funded program. Participants said that staffing was easier to manage this way. Even though all the programs intermix, the funding for each program stands alone. However, it was noted that the loss of any one source of funding would lessen the integration for the client. Although the funding does not cross

programs, the clients do. Clients get the benefit of multiple funding sources, even though in practice the funding streams are kept very separate within the financial arrangements of the organisation.

Participants spoke positively of the Commonwealth funding processes – they were pleased that they had been able to roll over funds and noted that the funds are reasonably flexible. It was noted that Commonwealth funding does not attract CPI (unlike state funding) and that this could be addressed.

Overall, participants emphasised that procurement processes need to be transparent, and standardised to some extent (whilst recognising the vast differences in the way the NGOTGP/SMSDGF funding pools are used). Consultation was also regarded as essential. Finally, participants emphasised that accreditation and quality standards are vital.

Case example: Department of Veterans' Affairs

The review of Alcohol & Other Drug (AOD) services being conducted for the Commonwealth is exploring a variety of funding models for alcohol and other drug (AOD) treatment. Funding options include block funding, fee-for-service funding and capitation. The processes for purchasing services include competitive tendering and preferred provider panels. This case study sought to explore in more detail one possible funding model, currently being explored by the Department of Veterans' Affairs (DVA). DVA's model of purchasing health care services evolved following the devolution of repatriation hospitals in the mid-1990s, and was developed with the aim of providing a wide geographic coverage of services, and in recognition of the increasing complexity of health care and the strong role for community care services.

Interestingly for the purposes of the present AOD review, the 2013-14 Budget announced changes to include an expansion of entitlement to DVA specific non-liability healthcare funding to now include alcohol and other drug treatment.

This case study aims to:
- Describe how the current DVA system works, and the strengths and limitations of this system;

- Consider how this system could be applied to non-DVA AOD and, in particular, examine issues regarding:

    - The selection of preferred providers for AOD treatment;
    - Management of the payment system (fee for service);
    - Geographic coverage.

Background

DVA currently provides a range of healthcare services to veterans and others entitled to treatment under three main pieces of legislation: the *Veterans' Entitlements Act 1986*, the *Safety Rehabilitation and Compensation Act 1988* and the *Military Rehabilitation and Compensation Act 2004* (see http://factsheets.dva.gov.au/factsheets/documents/HSV01%20Overview%20of%20Health%20Services%20available%20to%20the%20Veteran%20Community.htm).

In general, two pathways under which an entitled person may receive access to healthcare are:
1. Liability Pathway (where the Commonwealth has accepted liability for a condition(s) caused by service) which covers a range of healthcare needs; and

2. Non-Liability Pathway (including for those who have served on operations and some peace time service categories) for specific disorders: e.g. cancer, tuberculosis, PTSD, anxiety, depression. These conditions do not need to have service-causation established to access appropriate healthcare.

Help is also available through the Veterans and Veterans Families Counselling Service to a range of eligible current and ex-serving Defence members and their families.

The Veteran Mental Health Strategy was released on 27 May 2013 (Department of Veterans' Affairs, 2013) and provides a ten year framework for mental health care provision for current and future veterans and their families. The Strategy's stated purpose is to:
"Set the context for the provision of mental health services in the veteran and ex-service community and for addressing mental health needs;

Identify strategic objectives and priority actions to guide mental health policy and programs; and ensure the best possible outcomes for individual mental health and wellbeing."

The strategy underpins a commitment of $26.4 million dollars over four years (in addition to existing funding of $166 million per year) to expand the provision of mental health services to veterans (see budget: http://www.budget.gov.au/2013-14/content/bp2/html/bp2_expense-24.htm).

Under the budget measure there a range of new initiatives commencing in 2014, including an extension of the non-liability healthcare beyond the existing conditions to now include alcohol and other drug issues. The eligibility criteria will also be further extended to include more peace time service categories.

The new strategy recognises that alcohol and other drug issues may have an impact on the health and wellbeing of veterans and their families. From July 2014 eligible clients will be able to access free treatment for diagnosed alcohol and substance use disorders, without the need to lodge a compensation claim (Department of Veterans' Affairs, 2013, p. 17).

In addition to these changes to access to treatment, DVA continues to examine existing purchasing arrangements to ensure clients are provided treatment that meets their needs, including considerations of access, service settings, evidence-based treatments, safety and quality assurance.

DVA approach to market for AOD treatment

Current approach

DVA has a long established, standard system for how it pays for healthcare for veterans, through procurement arrangements (via tender) and agreements with providers. For example, DVA has entered into Hospital Services Agreements with private hospitals throughout Australia (for details see http://www.dva.gov.au/service_providers/hospitals/veteran_partnering/Pages/tier1hospitals.aspx). DVA is billed by the private hospital for each individual patient, generally at fixed, agreed costs (see fee schedules: http://www.dva.gov.au/service_providers/Fee_schedules/Pages/index.aspx). Where a health care provider accepts a DVA repatriation health card (Gold or White) for payment for treatment, the provider agrees to accept DVA fees and conditions for the services provided. This process is managed within DVA by the 'hospital contracting area'. DVA has also entered into agreements to provide mental health services through private hospitals (http://www.dva.gov.au/service_providers/hospitals/veteran_partnering/Pages/mentalhealth.aspx).

In November 2010, a simplified process for registration of allied mental health providers was introduced. Under this system of statutory registration, clinical psychologists, psychologists, social workers and occupational therapists who were registered with Medicare Australia to provide mental health services would automatically be able to provide allied mental health services to repatriation health card holders (see http://www.dva.gov.au/aboutDVA/publications/corporate/annualreport/2010-2011/Documents/perfrep.pdf). This meant that DVA was no longer required to approve individual service providers as long as the service met Medicare registration requirements.

Extension of service providers

DVA is currently examining purchasing arrangements for AOD treatment.

An option is a panel of providers to deliver AOD treatments, which are required to meet quality and accreditation standards, for instance Core Service Standards recently developed. Providers might be drawn from the government, NGO and/or private sectors, thereby enhancing access to services outside of hospital settings.

A panel arrangement would require consideration of fees, charges and quality standards[130]. A greater number of providers may offer increased accessibility for clients, and a good geographic spread of services is important.

A system for accrediting AOD services is also a key factor. AOD treatment providers may not necessarily be registered with Medicare, particularly services provided through the NGO sector. The challenge is how to select a panel of AOD treatment providers in the absence (at present) of a national accreditation system, and how to ensure the ongoing provision of quality services for clients.

To inform it's thinking, DVA will engage AOD treatment clinical consultants to provide advice on a set of 'Core Service Standards for Alcohol and Other Substance Use Disorder treatment service quality' which have recently been developed (see Appendix D) and advice on the development of a model for using the standards to assess treatment providers.

Reflections and implications for AOD treatment funding

A 'panel of providers' model for AOD services is akin to the notion of 'preferred provider'. The notion of 'preferred provider' has yet to be applied to the AOD NGO sector and is worthy of consideration for AOD treatment funding more broadly. A panel of providers could be used across multiple government departments seeking treatment services (notwithstanding the question of which agency may be best placed to assess and accredit quality treatment providers).

The length of contracts with the accredited 'panel of providers' may be a critical issue for sustainability, both in terms of continuity of service provision and for the organisations themselves. It is unclear how often new providers for panels would be sought (regularly or as a one-off expression of interest).

Another challenge within a preferred provider model is how to monitor standards, accreditation and quality over time.

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[130] As a guide, fee schedules for other current services are available on DVA's website:
http://www.dva.gov.au/service_providers/Fee_schedules/Pages/index.aspx;
http://www.dva.gov.au/service_providers/Fee_schedules/Pages/Dental_and_Allied_Health.aspx

Case example: Partners in Recovery

One aspect of Review being conducted for the Commonwealth pertains to exploring ways in which Mental Health services are purchased by the Commonwealth, with a view to examining how these processes might be applied to funding for AOD treatment. This case study describes how the Commonwealth approached the market in terms of establishing competitive tendering for Partners in Recovery (PIR)[131], exploring this process from the perspective of the Department.

What is PIR?

The *Program Guidelines for the engagement of PIR Organisations 2012-13 to 2015-16* (http://www.health.gov.au/internet/main/publishing.nsf/Content/37DB4B7B63BBE7C1CA257BF0001B7429/$File/pirguide.pdf) describes the aims of PIR:

> "The 2011/12 Federal Budget provided $549.8 million (over five years from 2011/12 to 2015/16) for the *Partners in Recovery (PIR): Coordinated Support and Flexible Funding for People with Severe and Persistent Mental Illness with Complex Needs* initiative. PIR aims to better support people with severe and persistent mental illness with complex needs, and their carers and families, by getting services and supports from multiple sectors they may come into contact with (and could benefit from) to work in a more collaborative, coordinated, and integrated way. PIR will facilitate better coordination of and more streamlined access to the clinical and other service and support needs of people experiencing severe and persistent mental illness with complex needs requiring a multi-agency response."

The objective of PIR is: "to improve the system response to, and outcomes for, people with severe and persistent mental illness who have complex needs by:
- facilitating better coordination of clinical and other supports and services to deliver 'wrap around' care individually tailored to the person's needs
- strengthening partnerships and building better links between various clinical and community support organisations responsible for delivering services to the PIR target group
- improving referral pathways that facilitate access to the range of services and supports needed by the PIR target group and
- promoting a community based recovery model to underpin all clinical and community support services delivered to people experiencing severe and persistent mental illness with complex needs." (see http://www.pirinitiative.com.au/about/overview.php)

The purpose of PIR is not to deliver services per se, but rather to provide coordination, integrated case planning and clinical collaboration through 'PIR organisations'. PIR organisations are described as "the mechanism that glue together all the services and supports within the region that an individual may require" (http://www.pirinitiative.com.au/about/piro.php). At the time of writing there are 48 organisations across 61 Medicare Local regions who have been funded to date to provide this function (most of the lead agencies are Medicare Locals but there are some exceptions: n=13).

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[131] The focus of this case study is on the tendering process. A case study providing an example of how Partners in Recovery (PIR) may work in practice to improve the way services across different sectors work together to improve consumer outcomes is available online through the Department of Health (http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pir-case-sys), which may also be relevant to AOD treatment service coordination. A second case study provides an example from the consumer perspective (http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pir-case-cons).

PIR organisations have access to a flexible fund to purchase services (although it is noted in the *Program Guidelines* that "it is important that in the main, PIR clients access services available within the existing network of service providers, rather than build a reliance on the flexible funding", p.9)[132].

What was the PIR tendering process?

A very specific approach to competitive tendering was used for PIR. The tendering process included a series of information sessions and workshops run by the Department, online videos, Q&A documents, and other communication materials. A website which provides resource materials and opportunities for networking, communication and engagement continues to be provided for PIR organisations (for PIR resources see http://www.pirinitiative.com.au/).

The extent of documentation and detailed support materials available to organisations throughout the tendering process is notable. Information sessions were filmed and PowerPoint presentations made available online (for five video sessions see: http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pir-sessvid). These sessions clearly articulated the rationale for the program, and explained to the sector and applicants both the intended target group for the program and the way the program would be rolled-out. A 35 page detailed question and answer booklet was also developed to complement the invitation to apply documents, to clarify any issues, and respond to common inquiries (see http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pir-qa).

It was noted that while the invitation to apply was technically open to any organisation, in practice the process encouraged only one applicant from each region (because the emphasis was placed on coordination of care across multiple organisations). Multiple applications were received in only a few regions.

The eligibility criteria for applications for funding were outlined in the *Program Guidelines*, p. 11-12:
- Suitably placed and experienced non-government organisations in Medicare Local regions, who can implement PIR in a way that best complements existing support and service systems and any existing care coordination efforts already being undertaken.
- For legal and accountability reasons, only incorporated, non-government health and welfare service providers are eligible to apply for funding. They could be funded by Commonwealth and/or State/Territory Governments, but would be governed independently, and be non-profit/charitable or for-profit or local community groups.
- Favourable consideration will be given to consortium applications. Consortium applications must identify the lead organisation to be contracted to the Department, and outline the role of each partner in the consortium. An authorised representative of the lead organisation must sign the application form, along with any representatives of any partner organisations.
- Joined up or multi-regional approaches will also be considered if it can be demonstrated such an approach is a more effective and efficient way to deliver PIR (if, for instance, the PIR target group population numbers in one region are too small to sustain a PIR organisation and the system of service delivery extends to adjoining regions).

The *Program Guidelines* specified that "[i]n general, only one PIR organisation will be funded in each Medicare Local geographic region" and that "Funding will be provided to support approaches which: identify a suitably placed and experienced non-government organisation to undertake the role of a

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[132] At the time of the key informant interviews, the PIR approach was still in the establishment phase, and it was expected that patients would start being seen from October 2013.

PIR organisation for that Medicare Local geographic region; and enable realistic achievement of PIR objectives within a region."

The coordinating role of PIR organisations is described in the *Program Guidelines for the engagement of PIR Organisations 2012-13 to 2015-16* (p.6):
> "It is intended PIR organisations will work at a systems-level and be the mechanism to drive collaboration between relevant sectors, services and supports within the region to ensure the range of needs of people in the target group are met. This will be achieved through the development of innovative solutions discussed and collectively owned by the PIR partners within the region. Support Facilitators will undertake the day to day tasks and develop the partnerships and relationships required at the individual level to support this."

Given the vision of PIR organisations as coordination and collaboration mechanisms, the tender documents emphasised the establishment of partnerships. The 'Invitation to apply and Instructions for Submitting Applications for PIR' (available at http://www.health.gov.au/internet/main/publishing.nsf/Content/E24E5964FDBC6C63CA257BF0001ACCD2/$File/invite.pdf, p.8) advised that:
> "The Department encourages organisations to form collaborations, consortia or other joint arrangements to deliver PIR within a region. For the purposes of PIR, members of a collaboration, consortium or other joint arrangement are defined as having an integral role in the delivery of the proposed PIR model."

The invitation to apply document required applicants to be explicit about the operation of partnership arrangements (the 'Essential requirements to be covered in applications' are outlined in the *Program Guidelines*, p. 13-15).

The invitation to apply document also specified that tenderers were required to have undertaken regional mapping beforehand to identify relevant services across sectors, and identify how the PIR organisation could best engage the services identified in the mapping. This again placed the onus on the tenderer to establish links and coordination, identify how partnerships would be established, and determine the capacity of partner organisations to undertake the commitments required of them.

Internally within the Department, modelling was used to assign PIR funding to each region based on a per capita funding amount for the population of the region which was then weighted to account for rurality and socioeconomic status. This planning formula offered transparency within the Department about how much funding would be allocated to each local area. This process also allowed requested funding amounts submitted by organisations to be balanced against the Departments allocations. Applicant organisations were expected to provide "a detailed demographic profile of the region, including identifying the number of people in the region expected to be in the PIR target group, projected client target numbers for each financial year, and articulate a model which will best meet the needs of the specified target group in that region". This approach also speaks to the question of where the 'planning' process takes place. In the case of PIR, the expectation was that tenderers would have a detailed understanding, demonstrated in their application, of the local needs.

Similar to the approach taken within the Medicare Locals system, the PIR approach acknowledges that local regions will differ. As such, one of the key principles of PIR is said to be 'Flexibility in roll out' (*Program Guidelines for the engagement of PIR Organisations 2012-13 to 2015-16*, p.4). Furthermore it is noted that, "[t]he range of sectors, services and supports to be coordinated

through PIR will reflect the existing suite of sectors, services and supports within the region that are required by the target group" (p.5).

Applications were assessed against the following criteria (which were outlined in the Invitation to Apply, the Program Guidelines, and Q&A documents):
- how well the Application's proposed PIR model meets the PIR initiative's aims and objectives;
- what the Applicant's ability is to implement the proposed PIR model within budget and timeframes, as well as abide by and meet all accountability and audit requirements (as described in the project plan and budget);
- whether the Application represents value for money;
- how the Applicant will work collaboratively with partners;
- how the Application's proposed PIR model will be communicated to all key stakeholders (as described in the communication strategy);
- what the level and proposed management of risk is associated with the Application's proposed PIR model (as described in the risk management plan);
- what the relevance and strength of the knowledge, skills, capabilities and experience of the Applicant is in achieving the proposed PIR model;
- what the capacity of the Applicant is to undertake all establishment phase activities and be ready to start accepting clients within three months of entering into contract with the Department; and
- what the readiness of the region is to start effectively implementing PIR (as demonstrated by the project plan, risk management plan and the partnership development strategy).

The tendering process resulted in three year funding agreements, with the lead agency then able to sub-contract as required.

Reflections on the tendering process

The tendering process ensured that partnerships were developed that suited the local regions/areas. Organisations were required to generate partnerships as part of the tendering process, rather than having partnership arrangements put in place as a result of directives. It was suggested by key informants to this case study that the process would not have worked if a lead organisation had been chosen *a priori* then instructed to find local partners. Feedback received by the Department from organisations suggested that this had been a positive process, and collaborative processes put in place by organisations during the application development phase have been sustained into the future.

Throughout the process, the sector was encouraged to be part of trying to create this new service model (rather than being seen as providers of services alone). It was suggested by informants to this case study that this too created a positive feeling across the sector.

It was also noted that this approach to tendering required great commitment (and time) from the Mental Health staff at the Department of Health, to ensure this process proceeded effectively. It was also noted that the service delivery model (program design) had been through numerous iterations and so was well understood, which meant that a detailed invitation to apply could be developed which comprehensively covered all key characteristics and issues.

It was noted that although there were benefits to the level of detail required in the applications (e.g. explicit descriptions of the partnerships, and regional mapping) the applications did not have page limits which meant that very long applications were received.

Lessons for the AOD treatment sector?

PIR provides a highly instructive example of an approach to market which may be worthy of consideration for AOD treatment funding.

In particular, the extensive information and support provided to tenderers by the Department throughout the process is notable. The approach used in the PIR tendering process is uncommon in this regard, and has not been characteristic AOD tendering processes to date. Although the level of support provided in the PIR process required time and dedication from the Department, the feedback received was positive and the standard of applications received reflected this added investment of resources.

The use of planning formulae in this case study is also instructive. The use of planning formulae offered transparency and generated capacity to calculate the funding to be allocated across regions. This transparency meant that applications could be more appropriately pitched and assessed.

This case study is also relevant for considering the way the Commonwealth purchases non-service delivery (or capacity building and coordinating) functions for the AOD treatment sector. In considering the aims of PIR (as expressed in the *Program Guidelines for the engagement of PIR Organisations 2012-13 to 2015-16*, p.4) it is clear that this approach seeks to address issues which are also relevant for AOD treatment services and clients. Indeed, the challenges associated with coordinating care to ensure that vulnerable clients do not 'fall through the gaps' when accessing multiple services across sectors are the same for AOD clients. Of particular relevance is PIR's emphasis on systematically facilitating coordination of services and building links between clinical and community care:

> "The ultimate objective of the initiative is to improve the system response to, and outcomes for, people with severe and persistent mental illness who have complex needs by:
> * facilitating better coordination of clinical and other supports and services to deliver 'wrap around' care individually tailored to the person's needs;
> * strengthening partnerships and building better links between various clinical and community support organisations responsible for delivering services to the PIR target group;
> * improving referral pathways that facilitate access to the range of services and supports needed by the PIR target group; and
> * promoting a community based recovery model to underpin all clinical and community support services delivered to people experiencing severe and persistent mental illness with complex needs.
>
> Through system collaboration, PIR will promote collective ownership and encourage innovative solutions to ensure effective and timely access to the services and supports required by people with severe and persistent mental illness with complex needs to sustain optimal health and wellbeing."

In this way, PIR creates a commitment to complex cases at the systems level. This is an issue of relevance in the AOD field, and provides a model for AOD services to provide coordinated and holistic care to clients. The funding, however, is directed towards the *coordination* of system responses for people with complex needs and not funding for service delivery per se. The PIR model builds a network of clinical collaboration, that is, it aims generate coordination across the service system within a local area. The competitive tendering process forced consortium arrangements and required organisations to generate partnerships (which have reportedly been maintained beyond the tendering process). However in thinking about lessons for AOD, it is worth noting that in the case of PIR this funding was newly allocated funding and was not provided at a cost to funding existing

service delivery, which meant the initiative was positively received by the sector. The information sessions explicitly emphasised that PIR was designed to complement, not replace or usurp, the existing service system.

It is interesting to compare the language and emphasis of the PIR tender documents, with those provided for the Substance Misuse Service Delivery Grants Fund (see http://www.health.gov.au/internet/main/publishing.nsf/Content/6A1EDE4D55F78EF3CA257BF0001 C11E4/$File/guide.pdf). Although 'building capacity' is said to be one of the primary objectives of the SMSDGF, cross sector partnership is not nearly as emphasised this this document as it is in PIR. The emphasis of SMSDGF is far more on funding individual service delivery, rather than facilitating coordinated care. This comparison highlights the divergence of these two approaches. This case study thus raises a key question: whether AOD treatment funds should be directed towards service delivery per se, or also provided for capacity building activities which aim to build a network of clinical collaboration across services.

Finally, the emphasis on partnership at the core of the PIR approach sits within the wider context of consumer and community engagement in health (Duckett & Willcox, 2011). As noted in other case studies (see the 'role of drug user organisations in supporting treatment' case study), the principles of participation have been better developed and integrated in the Mental Health sector. These principles need to be strategically and intentionally fostered within the AOD sector to ensure better engagement and improved health outcomes.

Case example: Victoria's Activity Based Funding Model for AOD services

Background

Our focus in this case example is the Victorian Government's Activity Based Funding (ABF) model that was released as part of a competitive selection process for AOD treatment providers (October 2013). This case example aims to describe the prior funding model in Victoria (unit costed episodes of care) and the context leading to the recent reform. We briefly outline issues related to the previous funding model as well as policy drivers shaping the new approach to funding. We then describe in detail the new ABF model being implemented in Victoria.

The Episode Of Care (EOC) funding model

What is an Episode of Care?

In 1994, sector reform in Victoria involved the introduction of a unit cost approach based on the delivery of specific units of care. When a client commenced in treatment, they would be involved in a Course Of Treatment (COT) that, if successful, would be counted as an Episode Of Care (EOC).

The Victorian Department of Human Services (VDHS) explained that,
> The Episode of Care was designed as an indicator of successful outcomes at the individual client level. It aims to develop performance measurement beyond the types of policy events measured previously, such as activities, throughputs, inputs and outputs, to at least indicate that the client has received a significant and desired outcome. (Victorian Government Department of Human Services, 2003, p. 1)

As stated above, treatment success was indicated by the achievement of one or more significant treatment goals.

Table 17.2 provides a summary of how the EOC construct has been defined, from its inception in the 1990s to 2013-14[133].

Table 17.2: Evolution of the EOC construct, from 1995 to 2014

When the EOC was introduced into the Victorian AOD sector, in 1995, it was defined as,
> The course of treatment that a client undergoes. An episode will consist of a number of contacts between the client and an A & D Worker and a number of related activities to ensure case management of the client and coordinated care. It is determined by the successful completion of a significant number of the goals in the Individual Treatment Plan. These goals should relate to the service type" (Victorian Department of Human Services, 1998, p. 1).

It was subsequently defined as,
> A completed course of treatment undertaken by a client under the care of an alcohol and drug worker which achieves significant treatment goals (Victorian Government Department of Human Services, 2003, p. 12).

Following a 2003 review, a revised definition was adopted. An EOC was understood to constitute:
> A course of treatment undertaken by a client under the care of an alcohol and drug worker which achieves significant treatment goals identified in the client's Individual Treatment

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[133] ie just prior to the implementation of reform for outpatient services.

Plan. The achievement of an Episode of Care requires the attainment of at least one significant treatment goal in accordance with the service-type specification (Victorian Government Department of Human Services, 2003, p. 12).

The 2010-11 policy and funding guidelines for drug services in Victoria states that the formal definition of an EOC is:

A completed course of treatment undertaken by a client under the care of an alcohol and drug worker, which achieves at least one significant treatment goal (Victorian Department of Health, 2010, p. 7).

How has the EOC construct been applied?

The EOC model was developed as "the fundamental unit aiming to measure or guide" three areas: service activity; service outcomes/quality; and service funding (Victorian Government Department of Human Services, 2003). In other words, the EOC was meant to fulfil multiple areas: what is being funded; to what benefit; and at what cost.

The EOC was an important intervention, in that it encouraged a focus on treatment outcomes and sought a degree of specificity regarding the volume and nature of treatments being delivered. It also provided clarity regarding total and episode related expenditure; with a stipulated price per EOC, by treatment type.

The 2003 review of the EOC suggested a number of improvements to the model, notably the articulation of treatment goals (from which clinicians would select) and the use of data as part of a "performance management system". Activity targets (number of EOC) would continue to be part of the service agreements (SA) between the Department and NGOs and it was "considered appropriate for the SA to specify a minimum number of episodes of care to be purchased from the provider" (Victorian Government Department of Human Services, 2003, p. 12). The unit cost for EOC would be retained, but revised to "enhance the meaningfulness and appropriateness of the EOC, the service targets and the unit cost" (Victorian Government Department of Human Services, 2003, p. 13).

Unit cost

It is worth noting the unit cost per treatment type and how these costs have been formulated. Table 17.3 shows the major categories of activity and the sub-activities (types of intervention provided in these categories), along with the price per unit of activity for 2010-11. Variations occur according to service location (metropolitan or rural) and client age (adult or youth). In addition, there are specific activities for Koori services.

Table 17.3: Victorian AOD services, unit prices, 2010/11
Source: (Victorian Department of Health, 2010)

Activity category and activity name	Sub-activity name	2010-11 Unit price (AUD)
COUNSELLING AND SUPPORT		
Counselling Consultancy and Continuing Care	Counsel Consult & Continuing Care	818.58
	Youth Counsel Consult & Continuing Care	818.58
	Extended Hours Capacity	1,024.00

Activity category and activity name	Sub-activity name	2010-11 Unit price (AUD)
	Post Rehabilitation	1,636.00
Koori Community Alcohol and Drug Worker	Koori Community Alcohol and Drug Worker	1,535.00
	Youth Koori Community Alcohol and Drug Worker	1,535.00
Mobile Overdose Response	Mobile Overdose Response Service (MORS)	5,359.00
Youth Outreach	Youth Outreach	1,357.00
Peer Support	Peer Support	514.06
WITHDRAWAL		
Home-based Withdrawal	Home-based Withdrawal	1,377.00
Rural Withdrawal	Rural Withdrawal	1,377.00
Outpatient Withdrawal	Outpatient Withdrawal	448.14
	Youth Outpatient Withdrawal	448.14
Residential Drug Withdrawal	Residential Drug Withdrawal - 12 Beds	2,395.00
	Residential Drug Withdrawal - 6 Beds	3,562.00
	Residential Drug Withdrawal - 4 Beds	7,274.00
Youth Residential Drug Withdrawal	Youth Residential Drug Withdrawal	7,639.00
RESIDENTIAL REHABILITATION		
Residential Rehabilitation	Adult Residential Rehabilitation	12,387.00
AOD SUPPORTED ACCOMMODATION		
Alcohol & Drug Supported Accommodation	Alcohol & Drug Supported Accommodation – Metro	4,560.00
	Alcohol & Drug Supported Accommodation – Rural	6,079.00
	Rural & Metro Drug Diversion	4,560.00
Women's Alcohol & Drug Supported Accommodation	Rural Women's Alcohol & Accommodation	6,079.00
	Women's Alcohol & Drug Supported Accommodation	4,560.00
Youth Alcohol & Drug Supported Accommodation	Metro	4,560.00
	Rural	6,079.00
KOORI RESOURCE CENTRE (SOBERING-UP, SUPPORT SERVICES)		
Koori Community Alcohol & Drug Resource Centre	Koori Community A & D Resource Centre - Model 1	559.09
	Koori Community A & D Resource Centre - Model 2	1,727.00
	Koori Community A & D Resource Centre - Model 3	1,727.00
PHARMACOTHERAPIES		
Specialist Pharmacotherapy Program	Community Pharmacotherapy Service	2,485.00
	Specialist Pharmacotherapy Service	2,485.00

The approach to funding was explained as follows:

> The model acknowledges that not all courses of treatment (COTs) will result in a significant treatment goal being achieved, and this is taken into account in both unit prices set and targets expected. Unit prices are based on one of the following approaches for:

- an equivalent full time worker (38 hours per week);
- a residential service whose outputs are separations per bed per annum based on average lengths of stay;
- a service where a team of workers may be involved in order to deliver the required Episodes of Care; and
- other services (Victorian Department of Health, 2010, p. 7).

In addition to unit prices, indicative amounts of EOC per FTE / bed separation were provided for 2010-11. For example, the activity level performance target for an equivalent 1 FTE of adult counselling consultancy and continuing care (CCCC) was 110 EOC. Adult residential withdrawal involved 54 bed separations per annum, with an average 6-day stay and a range from 4 to 8 days (within a 12-bed facility) (Victorian Department of Health, 2010).

Summary reflections

The EOC model had multiple purposes, as noted above. For example,

a. The funder (government) wanted clarity regarding the number of activities it was purchasing. This was possible, although data accuracy and meaningfulness was problematic. (Particularly early on, when some service providers did not understand the concept well and faced challenges in use of the Alcohol and Drug Information System (ADIS)).

b. For clinicians and clients, an individualised approach to treatment was needed and diversity in the type and intensity of activities within the set treatment types was possible.

c. The funder wanted control and clarity over program and total expenditure. This was achieved, given the set unit cost.

d. There was policy interest in extracting outcomes data from ADIS and this task was made easier with the introduction of stipulated significant treatment goals, which could constitute outcomes. However, there many possible significant treatment goals and they were not necessarily consistent with conventional measures of therapeutic outcomes, as used in studies of treatment effectiveness. (Please note that the goals were not designed for this purpose, but to maximise the scope for individualised treatment and associated plans).

e. Services sought predictability regarding funding, to enable a sustainable workforce. This was possible within the unit costed model however there was limited flexibility to change funding arrangements; for example, by arguing for additional funds or to amend EOC targets in the context of impacting factors (e.g., staff shortages).

f. Services were able to identify the staffing profile possible to provide a service.
g. It was not clear whether the unit costs included an allowance for management, administration, or workforce development.

The 2011 AOD management review

In late 2011, the Victorian Auditor-General's Department published a review entitled *Managing drug and alcohol prevention and treatment services* (Victorian Auditor-General, 2011). The review was scathing in its assessment of the policy inaction regarding sector change and improvement in the years following major reform in the early 1990s. The report authors noted that:

- Regular review and refinement of prevention and treatment is necessary, "to adapt to changing community needs" and maximise the chances of program success;

- In the years following the establishment of the new community-based alcohol and drugs sector, "the problems with treatment services that the program was designed to overcome have not been resolved"; and
- "The department has no assurance that the service system objectives of effective case management and continuity of care for clients and consistent, high quality services, are being achieved". (p. vii)

Further, and with particular relevance to this case example on funding, "the episode of care funding and performance measurement model, recognised as flawed since 2000, has not been satisfactorily dealt with" (p. viii).

Briefly, the Victorian Auditor General's report (2011) identified the following problems with the approach to funding:

- The inadequacy of the unit price; failure to review and update price.
    - Each EOC has a set unit price which is historically based. Due to changes over time, unit prices have lost their relationship with the real costs of service delivery, p. ix.
    - Unit prices for treatment services have not been regularly reviewed to keep pace with increasing client complexity and costs of service delivery, p. 9.
- Treatment fragmentation; as units of service were in focus (not continuing care).
    - The EOC service model which links funding and service performance to the achievement of EOC targets effectively promotes fragmented service responses to clients. The EOC model does not encourage service providers to keep clients engaged and to provide them with long-term support through effective case management and continuity of care, p. 25.
- A built-in incentive to manipulate the performance monitoring system to meet funding targets, in the context of under-costed units of care.
    - There are weaknesses in the primary indicator of performance used by the department to fund and monitor the AOD system, the episode of care (EOC). These affect the department's capacity to adequately capture the performance of services and create an incentive for service providers to manipulate or 'game' the performance reporting system. This led to around 40 per cent of service providers recording multiple continuous EOCs for the same client in the same treatment type during 2009–10, p. 40.[134]

While the Auditor General's Department acknowledged the good work being undertaken, by dedicated services that operate in a complex and challenging environment, their concerns were essentially about the negative effects on continuity of care and performance data arising from inadequate pricing and reporting. Recommendations pertaining to the EOC funding model did not suggest it should be abolished, but rather improved, to update the unit prices and revise reporting requirements to address weaknesses in the use of the episode of care (Victorian Auditor-General, 2011, p. 9). The review findings provided a major impetus for reform discussions (which had been going on for some years) to be enacted. Associated policy developments meant the reform became part of a much bigger program of change. Our attention turns to the current reform agenda as it relates to changes in the approach to funding AOD services in Victoria.

Reform

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[134] This finding is complex, in that a continuous program of care would necessarily involve sequential episodes (although not always involving the same treatment type). Re-episoding may therefore indicate an appropriate approach to service delivery. Consistent with this perspective, the report authors noted that, "there may be clinical considerations for closing and reopening an EOC due to the chronic and relapsing nature of addiction, however, these considerations can be compromised by the imperative for agencies to meet their EOC targets" (p. ix).

The call for submissions for outpatient treatment in Victoria includes a new approach to service funding; "a new activity based funding model that will enable flexibility in the development and delivery of services at the local level" (Victorian Department of Health, 2013a, p. 5).

Funding is distributed by five service types, as shown in Table 17.4.

Table 17.4: Victorian funding distribution by service type
Source: Victorian Department of Health, 2013, Appendix 2, pp. 7-11

Service type	AUD	%
Intake and assessment	13,682,000	34
Care and recovery coordination	5,435,000	13
Counselling	17,262,000	42
Non-residential withdrawal	3,541,000	9
Catchment based planning	768,000	2
TOTAL	40,688,000	100

Funds distribution is also organised according to Victoria's 8 health regions, which are divided into 16 service catchments; 9 in metropolitan Melbourne, and 7 in the non-metropolitan area. Funding is distributed by catchment and amounts are determined on the basis of catchment population and current service provision. There is a higher level per capita for rural catchments (Victorian Department of Health, 2013a).

In addition (with separate funding arrangements), there is a statewide centralised intake and assessment service, an online statewide bed vacancy register, and the mandated use of an *Adult Alcohol and Drug (AOD) Screening and Assessment Tool*. Five new area based pharmacotherapy networks are being established (through a separate funding stream) and an outcomes-focused performance management framework is in development (Victorian Department of Health, 2014).

The *Drug Treatment Activity Unit (DTAU)*

Whereas the EOC involved a specific price per service type, the 2014 reform of the AOD sector uses the Drug Treatment Activity Unit (DTAU), which is a single price common counting tool. The price of all funded activities is expressed as a multiple of this unit price. For 2013-14, the DTAU price is $644 (Victorian Department of Health, 2013a). Adjustments will be made prior to funding agreements for 2014-15.

A weighting is attached to each activity to determine the activity price. For example, the weighting for 'intake and referral – phone contact (completed referral)' is 0.091, meaning that the activity price is $644 x 0.091 = $58.60. In another example, the weighting for 'counselling – standard (course of counselling)' is 0.91, meaning that the activity price is $644 x 0.91 = $586[135]. It is important to note that prices are for completed activities[136] and that the prices are intended to cover direct costs, fixed costs and overheads (Victorian Department of Health, 2013a).

DTAUs include loadings for Aboriginal (30%) and forensic (15%) clients.

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[135] For details of the unit price for each service type, refer to Victorian Department of Health, 2013.
[136] That is, completed referrals, comprehensive assessment and initial treatment plan, course of coordination / counselling / withdrawal.

For some service types, there are different levels of pricing to account for variations in the mode of delivery (phone, face to face, via internet, for intake and referral) and the intensity of treatment ('standard' and 'complex'[137], involving counselling and withdrawal). The catchment-based planning function is a block grant.

The volume of DTAUs has been calculated based on the total resources assigned to each catchment and current met need (i.e., 2012-13 client numbers for the treatment streams included in Stage One). Providers will be able to vary the mix of activities, as only 80 per cent of their total allocation of DTAUs will be tied to specified activities. The remaining 20 per cent will be available for flexible use across all activity types delivered by the service, "as long as the total mix of services delivered by that 20 per cent equates to an agreed volume" of DTAUs, (Victorian Department of Health, 2013a, p. 20).

Table 17.5 provides two examples of the approach to funding for two of Victoria's health regions. The information is separated by catchment and by activity type. Funds distribution is shown by DTAU and by dollar amount. The total funding (Stage One activities only) for these catchments is shown in the final column.

Table 17.5: Funds distribution by DTAUs and dollar amounts, for catchments in one metropolitan and one rural region in Victoria
Source: Victorian Department of Health, 2013, Appendix 2

Region / Catchment	Intake & Assessment	Care & Recovery Coordination	Counselling	Non-Residential Withdrawal	Catchment Based Planning	Total Funding
Southern Metropolitan Melbourne Health Region						
Bayside	1,592 DTAU $1,025,000	633 DTAU $407,000	2,008 DTAU $1,293,000	412 DTAU $265,000	N/A $48,000	$3,039,000
South-Eastern Melbourne	1,842 DTAU $1,186,000	732 DTAU $471,000	2,324 DTAU $1,496,000	477 DTAU $307,000	N/A $48,000	$3,509,000
Frankston-Mornington Peninsula	903 DTAU $582,000	359 DTAU $231,000	1,140 DTAU $734,000	234 DTAU $151,000	N/A $48,000	$1,745,000
Gippsland Health Region						
Gippsland	1,938 DTAU $1,248,000	770 DTAU $496,000	2,445 DTAU $1,574,000	502 DTAU $323,000	N/A $48,000	$3,689,000

Prices for these activities are as follows:

- Catchment-based intake assessment activities involve three different modes of contact as well as the development of a comprehensive assessment and preliminary treatment plan:
  - Intake and referral – phone $58.60 per completed referral

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[137] Complexity will be determined through the comprehensive assessment, which will be conducted as part of the intake and assessment function. Service providers will receive the complex price only when clients have been assessed as complex through that assessment process. There is scope for reclassifying between standard and complex if a client's clinical requirements change significantly during the treatment episode, (Victorian Department of Health, 2013a, p. 18).

- Intake and referral – face to face $58.60 per completed referral
- Intake and referral – via internet $46.40 per completed referral
- Care and recovery coordination, involving "a course of coordination of up to 12 months duration" (Victorian Department of Health, 2013, Annex 1, p. 15) $1,431.00 per course of coordination
- Counselling, incorporating "face-to-face, online and telephone counselling for individuals and families, as well as group counselling and day programs", which are classified as standard or complex and can range from a brief intervention to extended periods:
  - Standard $586.00 per course of treatment
  - Complex $2,198.00 per course of treatment
- Non-residential withdrawal
  - Standard $546.80 per course of treatment
  - Complex $1,367.90 per course of treatment

An outcomes focus?

The Advertised Call for Submissions (Victorian Department of Health, 2013b) includes "a summary of indicative types of outcomes the Victorian Government is seeking to achieve for people with an alcohol and drug problem through the delivery of accessible, efficient, effective and responsive alcohol and drug treatment services". Indicative outcomes and ways that benefit might be measured are included in the Advertised Call for Submissions for illustration. The outcome domains are: effectiveness, efficiency and sustainability, responsiveness, accessibility, continuity, and safety. For example, the outcome domain of effectiveness has ten indicative outcomes, and each of these outcomes has one or more means of measurement. An extract is shown in Table 17.6.

Table 17.6: Extract from the indicative outcomes framework accompanying the Advertised Call for Submissions regarding AOD treatment service provision, Victoria, 2013
Source: Victorian Department of Health, 2013, Annex 1, pp. 5-6.

Outcome domain	Indicative outcome	Ways benefit might be measured
Effectiveness	AOD taking behaviours of clients stabilised, improved or ceased	Reduced frequency and/or level of AOD use Increased protective behaviours associated with AOD use
	Improved quality of life status	Client reports better/greater satisfaction with living conditions

The Victorian Department of Health notes that "alcohol and drug treatment services will be required to meet the accountability and reporting requirements set out in a new outcomes - focused performance management framework. This framework will be developed in 2013-14 in consultation with stakeholders and will include further development of these outcomes" (Victorian Department of Health, 2013a). In the March 2014 communiqué from the Minister's Office, it was noted that the appointment of a contractor to develop the framework was almost finalised (Victorian Department of Health, 2014).

Conclusion

Victoria has used some form of unit price to purchase AOD services since the mid-1990s. Shortcomings of the EOC construct are principally around its application and the need for rigorous and timely reviews and updates to ensure such a highly articulated approach marries well with the cost of services and sector developments such as new service types and changing client need.

Arguably, the approach to purchasing services should sit alongside a process for measuring outcomes – without confusing the two.

The introduction of ABF to Victoria, with a single unit price and total funds set by catchment, brings a level of transparency and clarity regarding what is being purchased and for how much. The level of articulation with the actual cost of service delivery is not apparent and it would be prudent to schedule in reviews and adjustments over time. Importantly, the introduction of the unit price is being accompanied by major structural reforms (e.g., catchment based planning, reduced service types, an indicative outcomes framework, centralised intake and assessment). Major change is difficult and unravelling the advantages and shortcomings of the new model within this context will be challenging. Nevertheless, the ABF model provides a structure that can easily accommodate adjustments each year (i.e., based on CPI, professional agreements, and so on) and allow for changes in service types. Further evolution of ancillary elements of good sector planning will have an integral relationship with the success of this approach to purchasing services.

Case example: the role of drug user organisations in supporting treatment

In this case study, we turn our attention to the notion of 'supporting treatment'. There are many organisations and services within the AOD sector that play a particular role in supporting people who use alcohol and other drugs to reduce the harmfulness of their substance use, and to encourage and support access to treatment. These services and organisations exist alongside the formal treatment service system but perform an essential role in facilitating entry to treatment. The Medically Supervised Injecting Centre in Sydney is one such example. Many needle syringe programs and outreach workers also perform harm reduction and treatment support functions, as do some of the state and territory peak bodies. The Association of Participating Service Users (APSU) is another example of an organisation which provides a number of support functions for people who are engaged in treatment.

Within this broader context, for the purposes of this case study we have chosen to focus on one particular group of organisations that provide supporting treatment functions. The following case study provides an in-depth investigation of peer-based drug user organisations which work with and for marginalised populations of people who inject drugs, and describes the role they play in supporting treatment. We acknowledge that peers may be actively engaged in many alcohol and other drug services and organisations, for example as peer-workers or treatment consumer representatives. As such, this case study of only peers through drug user organisations is not generalisable across the breadth of organisations which support treatment, but rather is illustrative of the role played by one specific group of organisations who support treatment within their charter of representing people who inject drugs.

The focus of this case study is on how peer-based drug user organisations support AOD treatment in Australia, and the associated challenges regarding funding and funding processes for drug user organisations as treatment support providers. We begin by providing the context for our analysis, and then describe six activities that the drug user organisations consulted in this case study identified as core supporting treatment functions. We then describe the associated challenges identified in the case study: funding; contracting and organisational viability; reporting and monitoring; health policy context; and acceptability of the role of drug users in supporting treatment.

Context

There are three key issues which provide the context for this case study: the role of consumer participation in health care as an overarching principle; the effectiveness of consumer participation and peer-based interventions; and, specifically for the drug treatment sector, the marginalisation and stigmatisation of people who inject drugs.

There is an extensive literature on consumer[138] participation in health care. Examples of different models and approaches to consumer engagement in health policy have been documented across developed nations (Tritter & McCallum, 2006). Consumer participation is regarded as a fundamental part of an accountable health system (Duckett & Willcox, 2011; Victorian Auditor-General, 2012).

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[138] We note the term 'consumer' is sometimes used interchangeably in the AOD sector to describe people as consumers of drugs, and also people as consumers of drug treatment and other health care services. 'Consumer participation' in the AOD context is also sometimes used to describe the participation of people who use drugs in policy and public debate, as well as to describe participation in health and treatment service settings. The focus of this Review is on treatment, and as such we use the term 'consumer' in this case study with reference to people who access drug treatment and other health care services (which is not to say that the right to participation in policy and health care decision-making by treatment service consumers is necessarily distinct from the right to participation by people who use drugs).

Consumer participation may be understood broadly along a scale ranging from information, to consultation, partnership, delegation and control (Duckett & Willcox, 2011). Consumers participate, for example, through independent health complaints offices which are legislated in every state/territory (e.g. Office of the Health Services Commissioner, Vic; Office of Health Review, WA; Health Care Complaints Commission, NSW). Through advocacy and representation on committees and advisory bodies, consumers can contribute to decision-making about clinical standards, policy developments, and within health care agencies. Indeed, 'Partnering with consumers' is included in the ten National Safety and Quality Health Service Standards (Australian Commission on Safety and Quality in Health Care (ACSQHC), 2011) and since 1 January 2013 health service organisations across Australia (including public hospitals) have been accredited to these standards. The principle of consumer participation in local services is also reflected in the National Standards for Mental Health Services, with the expectation that services "will involve consumers in the planning, implementation and evaluation of services, and that consumers will be active participants in the assessment and treatment planning that directly affects them" (Department of Health and Ageing, 2013).

The reason consumer participation is not only encouraged but in many instances mandated, is because evidence shows that engagement with consumers produces better quality health services, greater accountability and opportunities for continuous improvement (Duckett & Willcox, 2011). Moreover, consumer participation has been shown to improve clinical outcomes and experience of care, as well as offer operational benefits in delivering care (Australian Commission on Safety (Australian Commission on Safety and Quality in Health Care (ACSQHC), 2011, p. 23).

In parallel to the broader movement towards consumer participation in health, peer-based drug user organisations have been established. A special issue of the journal *Substance Use & Misuse* (Latkin & Friedman, 2012) focused on the successful programs and roles of drug user organisations in promoting the goals of public health internationally, including increasing access to drug treatment. This international publication noted Australia's position as a world leader in the establishment and maintenance of peer-based organisations since the 1980's, and that the Australian Injecting and Illicit Drug Users League (AIVL) has "served as a major resource for efforts to organize globally throughout this period" (Friedman, Schneider, & Latkin, 2012, p. 569). Australia's peer-based drug user organisations emerged in the 1980's in response to the global HIV/AIDS crisis and subsequently gained government funding for programs and drug treatment support activities (Australian Injecting and Illicit Drug Users League (AIVL), 2012). The significant contributions of drug user organisations to drug policy in Australia have been documented through the 'TrackMarks' national consultation and research project (Australian Injecting and Illicit Drug Users League (AIVL), 2012).

People who inject drugs are a highly stigmatised and marginalised population and often experience discrimination when accessing essential health care and social services (Australian Injecting and Illicit Drug Users League, 2011; Lloyd, 2010; Rowe, 2007). On top of the socioeconomic disadvantage experienced by many people who inject drugs, potential treatment seeking clients are further marginalised by virtue of their criminalised status as a person who uses drugs. This creates increased barriers to health care which may not be experienced by other people when accessing services. Although the criminalisation of drug use is a complex barrier, it should not prevent people who use drugs from accessing, participating and having a voice in their own health care (Lancaster, Ritter, & Stafford, 2013). The criminalisation and stigmatisation of illicit drug use therefore has implications for provision of health care and treatment seeking, which is where drug user organisations play a key role in countering this power imbalance by supporting engagement with the treatment system and actively representing the interests of their marginalised constituents in health care and policy settings.

Australia's drug user organisations

The role of Australian drug user organisations is broad. The Australian Injecting & Illicit Drug Users League (AIVL) is the national peak organisation for the State and Territory Drug User Organisations and represents issues of national significance for illicit drug users (Australian Injecting and Illicit Drug Users League, 2014). AIVL and its state based member organisations focus on injecting drug use due to the higher level of harm and marginalisation experienced by people who inject drugs, while also seeking to address issues relating to all illicit drugs more broadly (Australian Injecting and Illicit Drug Users League, 2012). The aims, objectives and functions of drug user organisations include: addressing and representing the health needs of people who use illicit drugs and people on opioid pharmacotherapies through a health promotion and disease prevention approach; preventing the transmission of blood borne communicable diseases such as HIV/AIDS and hepatitis C among people who inject illicit drugs; promoting the provision of high quality, accessible and relevant services to people who use illicit drugs and people on opioid pharmacotherapies throughout Australia; as well as promoting and protecting the health and human rights of people who use illicit drugs and people on opioid pharmacotherapies (Australian Injecting and Illicit Drug Users League, 2012, p. 3).

Australia's drug user organisations are funded by the Commonwealth, as well as state and territory governments. AIVL is a recipient of both SMSGDF and NGOTGP funding. Additionally, three of the state and territory drug user organisations consulted for this case study receive NGOTGP funds, and one organisation receives funding from the SMSDGF.

For this case study, the focus is on peer-based drug user organisations and understanding the role they play in supporting the availability of, accessibility to, and effective delivery of drug treatment services, particularly for their constituent group of people who inject drugs.

Supporting treatment functions
1. Creating treatment access and entry points

Through consultation with eight drug user organisations across Australia[139], we identified five roles/activities that drug user organisations undertake in supporting treatment:

2. Client complaints handled
3. Provision of peer-based treatment interventions

4. Advocating for better treatment policies
5. Workforce development and capacity building

Each of these are described in turn (while noting that some functions overlap).

1. Creating access and entry points to treatment

One of the functions of drug user organisations is providing information to people who use drugs about available services and assisting their constituents to navigate the system. Given drug user organisations' unique position of interacting with people who use drugs on a continual basis, they can, over time, encourage and support initial access to treatment.

Drug user organisations spoke of the multiplicity of "every day functions" which focussed on community and peer engagement to connect people who use drugs with their organisation and therefore services. Pathways into treatment are facilitated by drug user organisations using a holistic approach to provision of services, information and care. In the consultation, engaging people in

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[139] The drug user organisations consulted for this case study were representatives from: AIVL, CAHMA, SAIN, WASUA, NTAHC, QuIHN, QuIVAA and NUAA. Not all of these organisations receive Commonwealth and/or state/territory funding. HRV was not able to attend.

treatment or "getting people to a point where they want to decrease or stabilise their drug use" was described as an important function and closely integrated into many of the programs and activities undertaken by drug user organisations. By first engaging people who use drugs as peers through the organisations' outreach work or low-threshold services (such as NSPs), drug user organisations could then "piggy back" other services onto their role and thus facilitate pathways for people into treatment. In WA for example, WASUA employs a Drug Treatment and Referral Service worker to provide counselling and treatment referral services to clients who are engaged through many of WASUA's activities, and especially through their NSP (WASUA, 2012). As WASUA (2012) note "The ability of the […] worker to engage with clients in an outreach capacity, outside normal working hours, and with minimal waiting time has made this service very attractive for many consumers who often face many weeks of 'waiting' due to extensive waitlists of many treatment services." Supported referrals and case management of clients form the basis of WASUA's program. This service provides referrals to AOD treatment centres, as well as accommodation agencies, legal services, and other specialist health and consumer services. The service also provides transport and advocacy support, GP liaison and support to address multiple needs in the client's life. This is especially important for clients who may require more complex service provision. In these cases WASUA has developed a "shared care" model with other stakeholder organisations, with memorandums of understanding established to build partnerships and referral pathways with suitable organisations including mental health services. As this WA example highlights, drug user organisations not only provide initial access points through outreach services, but also support continued engagement (retention) in treatment using a holistic and flexible approach.

Engaging people in treatment also involves reducing and negotiating barriers to treatment. There are multiple barriers to treatment for people who use drugs, and drug user organisations argued that they are well placed as skilled professionals and peers to help people negotiate and overcome those barriers. This is because the drug user organisations' model of peer engagement is built on strong connections into communities of people who use drugs, relationships, mutual understanding and trust.

Low threshold needle and syringe programs[140] are provided by drug user organisations. These harm reduction services dovetail with the supporting treatment function as they create avenues for regular engagement, relationship building and advice. Such services allow drug user organisations to be responsive to priority needs. Drug user organisations suggested that their NSP clients "get more" than they would at other NSP services, as drug user organisations have an integrated approach to engagement, relationship building, information provision and peer education beyond the scope of a traditional NSP.

As peers on the ground, drug user organisations noted that they are well positioned to share knowledge and assist people who use drugs to navigate the system. Drug user organisations understand the complex treatment system and are able to explain it to peers in a non-judgmental way. As was noted in the consultation, "clinical language is alienating" and "the conversation is different when it's delivered by peers". Systems of treatment entry and available services are constantly changing. Drug user organisations said that they remain up-to-date with service systems, requirements, access and entry points. In addition to one-on-one peer-education, drug user organisations publish resources about treatment which are distributed online and through their services. For example, in NSW NUAA has published an easy to understand, pocket-sized resource entitled 'If I knew then what I know now: a user's guide to pharmacotherapy' and provides further

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[140] NSP are outside the scope of the Commonwealth review, however as the provision of NSP services can lead directly to treatment engagement, they are noted here as part of the continuum of services where drug user organisations springboard from their NSP service to engagement and facilitation of formal treatment entry.

resources on their drug treatment information webpage (http://www.nuaa.org.au/index.php?option=com_content&view=category&id=9&Itemid=26).

The way treatment access points are integrated into the everyday activities of drug user organisations highlights the importance of long-term relationships with people who use drugs, which are developed by drug user organisations over time. Trust and credibility (as peers) facilitates the ability of drug user organisations to encourage treatment access.

2. Client complaints services

Drug user organisations provide a variety of treatment client complaints mechanisms, dispute resolution and mediation services. For example, the 'Pharmacotherapy, Advocacy Mediation and Support'(PAMS) Service is a state-wide telephone service run by the local peer-based drug user organisation Harm Reduction Victoria (HRV) and funded by the Victorian Department of Health. PAMS provides confidential telephone-based information, support, advocacy, referral and mediation for opioid pharmacotherapy consumers and their direct service providers on any pharmacotherapy client related issue in Victoria (Harm Reduction Victoria, 2014). The two main goals of PAMS are to ensure program continuity for people engaged in pharmacotherapy and to facilitate access to programs for people wishing to enter treatment. The goals of the program are achieved by: providing a pro-active, crisis-oriented service that works towards resolving pharmacotherapy consumer related problems and concerns; advocating on behalf of Victorian pharmacotherapy consumers and potential consumers at a local, state and national policy level; and working closely with pharmacotherapy service providers to assist them in maintaining collaborative and professional working relationships with their clients (Harm Reduction Victoria, 2014). Similar services are run by peer-based drug user organisations in Queensland, WA and ACT (e.g. QPAMS in Queensland: QuIVAA, 2014; and ORPACS in WA: WASUA, 2012), although some jurisdictions do not have this service[141].

Drug user organisations noted in the consultation that the mediation services offered through these individual client support services were critical, for example negotiating pharmacy debt for dispensing fees, or contact with family and child protection services, housing or courts. These telephone complaints services are also a significant resource for people in rural and remote areas, who are more isolated and regularly encounter issues accessing prescribers and need to travel significant distances to dispensers (WASUA, 2012).

The provision of mediation and complaints services by drug user organisations is in accordance with the charter of consumer participation mechanisms offered by independent health complaints offices (see context above). The provision of these services improves the likelihood that an individual will stay in treatment which thus contributes to positive health outcomes.

3. Provision of peer-based treatment interventions

The position of drug user organisations as peers means they are well placed to provide a variety of peer-led treatment interventions. Participants in the consultation argued that there are certain models of peer education and treatment support which cannot be delivered by other AOD workers or treatment services. It was suggested that while other services may speak the language of peer-based intervention, from the drug user organisations' perspective the key is that peer education and treatment support is "done *with*, not done *to*" their communities. This model of peer-led treatment intervention is highlighted in several examples across the organisations' operations.

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[141] It should be noted that such a service is not available in NSW.

Peer education programs bridge the gap between active drug use and clinical interventions by accessing harder to reach clients, increasing knowledge, building capacity, and promoting attitude and behaviour changes (QuIHN, 2014). In Queensland, for example, QuIHN runs peer-education training programs which "aim to support people who inject drugs in Queensland to effectively pass on information about harm reduction and blood borne virus prevention practices throughout their own peer networks." These programs are designed to complement other service provision undertaken by the organisation, including NSPs, treatment services, welfare and health care programs. Similar programs operate in other states and territories (e.g. the PeerLink program run by NUAA's Community Mobilisation Team which has run courses throughout NSW: http://www.nuaa.org.au/index.php?option=com_content&view=article&id=177&Itemid=60).

Some drug user organisations aim to provide a 'one stop shop' which gives their constituents access to counselling, health nurses, outreach, support and advice services. As described above, WASUA provides a range of treatment support services which complement their other activities, following a social holistic model (WASUA, 2012). In the ACT, CAHMA provides a Peer Treatment Support Service which includes: education and information about the range of treatments available; personal assessment to ensure treatment suits the individual's needs; referral to treatment services; support, case management and access to counselling for people engaged in treatment; information about new treatments available; and dispute resolution services (see http://www.cahma.org.au/TSS.html).

In our consultation, participants suggested that in context of limited pharmacotherapy treatment places and waiting lists, people wishing to cease or reduce their drug use may need other forms of support to "get by". Drug user organisations provide information about a range of options, including home-based withdrawal support (see for example the resources provided on NUAA's website: http://www.nuaa.org.au/index.php?option=com_content&view=article&id=39&Itemid=27).

Overdose prevention and management education programs are also provided by drug user organisations. In the ACT and WA, the respective state and territory governments have funded CAHMA and WASUA to run peer-led programs where naloxone is provided on prescription to help prevent the morbidity and mortality associated with opioid overdose (an issue of significance for people who inject opioids as well as people engaged in pharmacotherapy treatment).

Participants argued that often peer-led treatment services run by drug user organisations provide a degree of flexibility not necessarily readily available in other drug treatment services. This includes the hours of operation, the mode of information/education delivery, and the locations where these services are delivered. The combination of formal skills and direct personal experience embedded within drug user organisations' staff and services was regarded as an "unbeatable combination" in delivering treatment services and interventions. It was this combination which was deemed a crucial asset to develop relationships with people who use drugs who may not be readily accessed by other treatment services because, as peers, drug user organisations are better placed to get out into their community. It was also suggested that the combination of formal training and personal experience meant that workers within drug user organisations were motivated differently, often working after-hours for peers (not understood as 'clients') to piece together holistic care, organise appointments, access those who are perceived to be the best doctors and services to help peers get the best care and achieve the best outcomes. This motivation was said to be borne from a different level of personal understanding: "we know what it will mean on a physical and emotional level if that person doesn't get their dose". As such, drug user organisations argued that they occupy a specialist position within the AOD sector in the delivery of treatment support services, with their roles and functions explicitly targeted at a particular "underserviced and marginalised group".

4. Advocating for better treatment policies

At the policy and treatment service system level, drug user organisations participate as representatives of their constituents on advisory committees and have participated in the development of clinical guidelines. Actively representing the rights and interests of both people who use drugs and of treatment consumers is regarded as a core activity for many drug user organisations.

Several jurisdictions have established pharmacotherapy "action groups" comprised of volunteer treatment consumers who meet regularly in order to coordinate consumer input into treatment guidelines and other consultations. The activities of these groups includes: review of clinical guidelines; referral of individuals into treatment; policy development work; participation in formal government advisory bodies. In cases where these groups feed into formal government committee processes this ensures consumer participation, consistent with healthcare principles. The drug user organisations regard these action groups as playing an important role in "empowering people" through "people being involved" and by generating opportunities for engagement, mentoring and capacity building. Most importantly, the "action groups" provide an avenue for two-way communication between higher level government committees and treatment consumers, and as such treatment consumers can see how discussions at the "action group" level has been fed into policy discussion and brought about change.

The input of people who use drugs and of treatment consumers into clinical policies can result in important changes to clinical regimens. In the consultation with drug user organisations, two examples were given relating to the pharmacotherapy maintenance program - the guidelines around take-away dosing, and urine drug screening. Other instances where drug user organisations have played a significant role in influencing drug policy and treatment practice have been documented in the 'TrackMarks' report (Australian Injecting and Illicit Drug Users League (AIVL), 2012). For example, during the ACT review of pharmacotherapy guidelines in 2009/2010, CAHMA and consumer representatives argued for "greater flexibility, more respect to be shown for consumers within treatment settings and better mechanisms for dispute resolution" which led to substantial improvement to the guidelines (Australian Injecting and Illicit Drug Users League (AIVL), 2012).

5. Workforce development and capacity building

Drug user organisations play a key role in workforce development and capacity building across the AOD sector. In Queensland, for example, QuIHN's Health Promotion team provide workforce development training that is targeted at health and human service professionals and others working with people who inject drugs so as to increase knowledge throughout the health sector (QuIHN, 2014). In addition to training and workforce development activities within specific jurisdictions, drug user organisations are also active participants at sector meetings and conferences (such as the Australasian Professional Society on Alcohol & other Drugs).

A variety of resources have been developed by drug user organisations to help meet the needs of services, GPs and pharmacists (especially those new to prescribing opioid pharmacotherapy maintenance). In NSW, NUAA has developed a series of modules for the AOD treatment sector and the Blood Borne Virus sector which cover consumer participation, building better relationships and harm reduction (see http://www.nuaa.org.au/files/Reports/Evaluation_WDP_2009.pdf). The drug user organisations provide a unique window into the lived experience of people who inject drugs, which enables clinicians to be better trained, and have greater awareness of issues with this population group.

Another key activity has been capacity building within the sector to facilitate greater consumer involvement (an activity which overlaps with advocating for better treatment policies, as above). One consumer participation project (the "Change Project" in NSW) was said to have generated significant culture change within the services it targeted including increased quality of treatment delivery, better experiences for service workers, and a more positive experience for treatment consumers at the service.

Research has also been undertaken by AIVL to inform the development of resources to ensure consumer input into treatment services. The 'Treatment Service Users Project' (Australian Injecting and Illicit Drug Users League (AIVL), 2008, 2011) aimed to describe the current arrangements for consumer participation and to determine the extent of support for consumer participation in the planning and delivery of drug treatment services in Australia. The phase one report found that unlike in the mental health sector, there are few examples of consumer participation policies within the drug treatment sector and a lack of understanding within the sector about the meaning and practice of consumer participation. It was also shown that communication gaps about opportunities for engagement exist between treatment providers and consumers. Following these initial findings, the second phase of the project involved a peer-driven action research project which aimed to refine and implement the model of consumer participation in drug treatment services which had been developed, and evaluate its implementation (Australian Injecting and Illicit Drug Users League (AIVL), 2011). These two reports have been a valuable resource for consumer participation in the Australian drug treatment sector and provide one example of how drug user organisations have contributed to capacity building within the sector.

Challenges associated with providing these treatment support functions

There were a number of challenges identified by the drug user organisations in undertaking these various supporting treatment functions. These include:
- Funding
- Contracting and organisational viability
- Reporting and monitoring
- Health policy context
- Acceptability of the role of drug users in supporting treatment.

Each of these is discussed in turn, even though many of the challenges are inter-related.

1. Funding

While some of the services and activities listed above are directly funded, many are not funded. Notably the fourth (advocating for better treatment policies) is unfunded. At a national level, none of the advocacy and consumer participation activities undertaken by the drug user organisation peak are funded by government. For example, AIVL's representation on the Review Advisory Committee is not a funded activity for AIVL. Likewise engagement with various state clinical policy committees is unfunded. This commitment is substantial. In the ACT, for example, CAHMA workers sit on a range of committees which meet regularly including (but not limited to): the Alcohol, Tobacco and Other Drugs Association (ATODA) Board; the ATODA Executive Officers Group; the ATODA Workers Group; the Alcohol, Tobacco and Other Drug Strategy Evaluation and Implementation Committee; Alcohol and other Drug Program Quality and Safety Committee; Alcohol and other Drug Program/CAHMA Joint Health Promotion Working Group; Canberra Sexual Health (CaSH) Network; Community Corrections Committee; Co-Morbidity Grant Recipients Group; Co-Morbidity Strategic Working Group; Drug Action Week Planning Committee; General Practitioners Engagement Working Group; NSW Users and AIDS Association Consumer Participation Project reference Committee; Opiate

Treatment Advisory Committee; Pharmacotherapy Advocacy and Action Team; and the Women and Prisons Group (see http://www.cahma.org.au/represent.html).

In discussing consumer participation, drug user organisations noted that without dedicated funding to sustain these activities, the ability of drug user organisations to continue to perform these functions was severely limited. Significant resourcing pressures are created. The expectation that drug user organisations continue to engage in consumer participation work without funding is not a sustainable model. There was frustration expressed that consumer participation activities were not funded from available treatment funding programs despite the recognition that the outcomes from this work were overwhelmingly positive.

Most of the drug user organisations rely on funding from multiple sources and their flexibility and adaptability was regarded as a strength for their survival. However the lack of core funding was regarded as a significant vulnerability for these organisations; should one funding source cease, the viability of the organisation is at risk. In discussing funding arrangements, some of the drug user organisations emphasised the ways that they "patch" funding together from various sources including commonwealth and state funding to create a one-stop-shop for their constituents. The risk associated with this "patchwork" funding model is that if one funding source ceases or is reduced, then the viability of complementary services is jeopardised. For example, the low threshold needle and syringe programs offered by drug user organisations are regarded by funders to be a separate activity, even though these harm reduction and peer-education services dovetail and complement treatment support activities as they create avenues for regular engagement, relationship building and advice. It was argued that a 'critical mass' of staff and resourcing is essential.

It was noted that the formal complaints services (such as QPAMS and PAMS[142]) were high intensity, under resourced services often involving significant contact time and extraordinary commitment by peer-workers. Indeed, much of the flexibility lauded in these programs is available due to the dedication of peer-workers, not due to funding which sustains this level of engagement.

It is interesting to reflect on the way in which government(s) fund and support Aboriginal Community Controlled Health Organisations (ACCHOs), given the similarities in approach and purpose between ACCHOs and drug user organisations. See text box below for a brief discussion of this.

2. Contracting and organisational viability

Length of contracts was a significant issue raised in the context of "patch work" funding and the need to maintain a critical mass of staff to ensure the viability of the organisations. Ideally funding contracts of no less than 5 years were preferred by drug user organisations, with options for roll-overs where the service is functioning well. Contracts of 5 years or more would enable capacity building, continuity of programs and more secure environments to maintain a critical mass of staff, all of which would better ensure organisational viability.

Within competitive tendering processes, drug user organisations could be seen as "sole providers" for many services and functions; given that they are arguably uniquely placed to provide the supporting treatment role from a peer-based perspective. Participants expressed a fear that unless this unique and important position is recognised and valued by funders, drug user organisations as smaller and less resourced organisations will not be competitive in a tendering process. A noted above, although other services may use the "language" of peer engagement, the drug user

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[142] It should be noted that such a service is not available in NSW

organisations argued that they are uniquely tied to communities of people who use drugs, and this is their core function (not a side-function of another business or service model).

Consortium arrangements were regarded with suspicion by drug user organisations, the perception being that lead agencies disproportionately benefitted from such arrangements. Such arrangements were also perceived to entrench the weaker position drug user organisations, compared to other more powerful agencies in these arrangements. Consortium arrangements were regarded to only be appropriate in situations where the power was shared equally amongst organisations and all organisations shared equal standing in the community. The stigmatised position of people who use drugs, and also the peer-based organisations who represent them, make this difficult.

3. Reporting and monitoring

Drug user organisations recognised the importance of reporting for accountability, and hoped that reports prepared would be used for planning or add value to planning processes around future funding (there was the perception that this was not the case).

Reporting and monitoring requirements were reported as onerous for drug user organisations given the multiple sources of funding. Drug user organisations in some jurisdictions had begun to move towards verbal reporting. Although verbal reporting reduces administrative time in preparing reports, there were fears that verbal reporting reduced transparency and organisations were not given the time to report all activities undertaken. There was a perception that this may be "dangerous" if there were ever a dispute over funding. The preferred model for these organisations would be a combination of annual written reports and regular verbal "catch up reports" throughout the year.

The lack of regular site visits by funders was regarded to be a significant problem by some jurisdictions, with the perception that funders were detached from the everyday activities of the organisations and therefore may not understand their value. Moreover, building relationships with funders was difficult given turnover of personnel in government roles and often the lack of specialist content knowledge. There was a perception of lack of institutional memory or poor information retention by government.

4. Health policy context

The health policy context more broadly was identified by drug user organisations as presenting challenges to their function as treatment support providers. Unlike mental health where the importance of consumer engagement is written into charters and strategies, it was noted that the current National Drug Strategy document lacked explicit support for and recognition of the importance of consumer participation. Participants also reflected on the differences between the National Drug Strategy and the BBV Strategy; they perceived that the BBV strategy was more explicit in its funding commitments and required state/territory sign-off (through COAG) such that states/territories were then leveraged to supply funding. Their perception was that this was not the case for the National Drug Strategy. As one participant stated, there was "no leverage to get states/territories to act on consumers' needs".

There was concern expressed that some stand-alone drug treatment consultation committees and reference groups were being folded into mental health portfolios, which limited opportunities for engagement and discussion of pharmacotherapy treatment in particular at the government level given the multiple priorities needing to be addressed in each meeting.

5. Acceptability of the role of drug users in supporting treatment

Participants argued that the capacity building and advocacy roles played by drug user organisations are essential for ensuring consumer participation across the drug treatment sector. It was noted by the drug user organisations that unlike mental health where consumer participation is valued and normative practice at all levels of service delivery and policy deliberation, in the AOD sector drug user organisations are frequently left out or disregarded.

Because consumer participation is not embedded or mandated practice in the AOD treatment sector (as the Treatment Service Users research showed: Australian Injecting and Illicit Drug Users League (AIVL), 2008), there continues to be uncertainty and ideological debate about who should do consumer engagement. This undermines the legitimacy of drug user organisations as expert and experienced providers. The drug user organisations asserted that they are best placed to lead and implement consumer participation programs, build capacity amongst peer-workers and volunteers, and liaise with services. In the consultation, an example was given of one LHD in NSW which was employing a part-time consumer representative themselves within the treatment service, rather than partnering with NUAA to oversee consumer engagement. It was emphasised in the consultation that "this is not [the LHD's] job", and that such arrangements create power imbalances within the service in the absence of the drug user organisation's experience and support. This example highlights the importance of independent support (in accordance with the healthcare literature, where consumer participation mechanisms are generally legislated and independent from the healthcare policy and provider system).

As noted in the context above, the AOD sector is yet to have an agreed and shared language around 'consumers', 'drug users', 'treatment service users' and so on. This lack of agreed terminology (and often lack of person-centred language) creates confusion when talking about 'consumer participation' between consumers of drugs and consumers of treatment. The language of 'consumer' has been borrowed from the mental health sector (which distinguishes between carers and consumers) but from drug user organisations' perspective "the words don't work for AOD". Connected (but not limited to) the issue of appropriate use of language are underlying issues of stigma and discrimination encountered by drug user organisations (and more broadly, the people they represent). Indeed, the word 'consumer' does not covey the expertise required to fill the significant roles performed by drug user organisations, peer-workers and volunteer representatives. One example from the consultation is the highly skilled and dedicated peer-workers who staff the PAMS telephone service. These peer-workers have a depth of expertise and dedication, borne from both training and personal experience. Participants argued that the roles performed by consumer representatives and peer workers are specialist and cannot be performed by "just anyone off the streets".

Drug user organisations felt that there was little appreciation of the expert voice that experience brings, and a lack of understanding or respect for the specialist nature of their role by the AOD treatment and policy sector. Drug user organisations frequently encountered discrimination in the course of doing their job representing their constituents. There was a view that drug user organisations are perceived as being "not palatable", "not expert", "not evidence-based" and "unpredictable" by services and policy makers, despite their decades of effective engagement. Drug user organisations frequently encountered "disrespect and moralism" when sitting on advisory groups and committees. This discrimination was understood to stem from the stigma associated with drug use (and injecting drug use particularly) within society, and affected drug user organisations as a whole.

Text box: ACCHO and Drug User Organisations – striking similarities

Drug user organisations are arguably similar to Aboriginal Community Controlled Health Organisations (ACCHO's) who are embedded within the community, constituted from that community and have the capacity to deliver services because of the community-controlled nature of the organisation. Drug user organisations are likewise intimately tied to their constituent community (people who use drugs) and provide services from this peer-base.
ACCHOs are controlled by, and accountable to, Aboriginal people in those areas in which they operate. ACCHOs aim to deliver holistic, comprehensive and culturally appropriate health care to the community that controls it.

NACCHO's guiding principles are:
- The National Aboriginal Health Strategy (1989) definition of health.
- The Aboriginal concept of health as holistic.
- The right to self-determination.
- The impact of history in trauma and loss.
- The need for cultural understanding.
- The recognition of human rights.
- The impact of racism and stigma on Aboriginal People's lives.
- The recognition of the centrality of kinship.
- The recognition of diverse communities and different needs.
- The strengths of Aboriginal Peoples.
- The right to have universal access to basic health care.
- The need for high quality health care services.
- The need for equitable funding for health care.

See more at: http://www.naccho.org.au/about-us/vision-and-principle/#sthash.ciYBnHOl.dpuf

There are striking similarities between these principles and the fundamental approach of ACCHO's and those of drug user organisations. Drug user organisations are controlled by, and accountable to people who use drugs. The ACCHO principles (listed above) resonate strongly with drug user organisations, including the right to self-determination, the impact of marginalisation and stigma, the importance of equity and quality in health care and acknowledgement of the diversity of communities and needs.

It is Commonwealth government policy to support and facilitate ACCHO's provision of alcohol and other drug treatment. The drug user organisations are in a similar position in Australia, but at present are not recognised in the same way as ACCHO services.

Case example: Sector capacity building and the role of AOD state/territory peak bodies

Context

Peak bodies play an important role in the health and welfare sectors across Australia. Core roles and responsibilities are generally described as[143]:

- Policy development and advice
- Sector consultation and coordination
- Sector advocacy and representation
- Information dissemination
- Promoting and facilitating partnerships
- Sector capacity building
- Research.

The importance of peak bodies has been reinforced by the Productivity Commission (2010) which recommended that governments review their support for sector development and strengthen strategic focus, including on:

- "developing the sustainable use of intermediaries providing support services to the sector, including in information technology;
- improving knowledge of, and the capacity to meet, the governance requirements for not-for-profits organisations' boards and management;
- building skills in evaluation and risk management, with a priority for those not-for-profit organisations engaged in delivery of government funded services" (Recommendation 9.2).

Each state/territory in Australia has an alcohol and other drug (AOD) peak body. Some have a long history, others are more nascent. The role that each state/territory peak plays varies but there are some basic commonalities in mission and purpose. In summary, the main purpose of AOD state/territory peaks is to advance and support the non-government drug and alcohol sector to reduce alcohol and drug related harms to individuals, families and communities. This is achieved by:

- sector capacity building;
- workforce development;
- information management and data collection;
- advocacy; and
- governance and management support.

One particular role that the state/territory AOD peaks have played is in relation to capacity building. Capacity building had been explicitly funded under the Improved Services Initiative (ISI) with a focus on comorbidity. This is now broadened out under the SMSDGF into capacity building for complex needs and comorbidity[144]. This particular function, funded through the SMSDGF open competitive grants round in 2012, is currently being evaluated by David McDonald of Social Research & Evaluation. The evaluation is due to be completed by December 2014, but results thus far indicate that the peaks undertake many diverse capacity building activities and strategies (see copy of the interim report, attached Appendix E).

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[143] See also the NSW Grants Management Improvement Program (GMIP) Taskforce Report (2012) which reviewed and discussed the role of Peak organisations in aligning Health program areas with Peak organisations. It identified the following key roles: Capacity building contributing to NGO sector development; Data management support; Workforce development; Policy development and advocacy; Consultation Research; Promoting partnerships and cooperation; Provision of advice, information and services support; and Demonstrating leadership and innovation.

[144] Agencies other than AOD peak bodies also submitted applications and were funded for capacity building activities in the 2012 funding round.

Sector capacity building

We interviewed the AOD state/territory peak bodies, asking them to reflect on their role in providing capacity building and supporting the Commonwealth's investment in AOD treatment. The responses centred around three main themes:
1. Sector coordination, networking and linkages within and between agencies, and government portfolio's;
2. Support for government implementation (e.g. interpreting national priorities);
3. Support for effective service delivery[145].

1. Sector coordination, networking and linkages

The peaks identified the importance to a national funder of effective and efficient sector coordination and networking. Investment by a national funder in purchasing services, where those services are well networked with others in their state/territory provides the opportunity to maximise clinical learning, to ensure consistent and reliably high quality service delivery which is informed by an understanding of what constitutes good practice, as well as clarity around how each service fits within and contributes to the larger AOD and health and welfare systems (and thus avoids unnecessary duplication of effort).

One example is the regular *Infosessions* held by the Alcohol, Tobacco and other Drugs Council of Tasmania (ATDC). Every six to eight weeks, ATDC hosts a 60 – 90 minute session for sector workers on contemporary AOD topics, presented by specialists working in Tasmania. Topics are determined by feedback from the sector on what they require (e.g. understanding pharmacotherapy: how opiate substitutes work on the body, how they interact with other drugs, physical and mental side effects and issues for collaborative care). Question and answer time, as well as coffee/tea after each session provides informal networking for sector workers, which have been shown over time (through event evaluations) to increase communication between agencies.

Because AOD crosses a number of services areas, such as mental health, homelessness, child welfare etc., the peak s afford the opportunity for the specialist AOD agencies to be better networked with other agencies working with the same client group.

One example is the Community Mental Health and Drug and Alcohol Research Network (CMHDARN), established by the Network of Alcohol and other Drugs (NADA) and the Mental Health Coordinating Council in NSW, which aims to build the capacity of services to engage in research and develop more strategic and long term relationships with researchers. In 2012/13, CMHDARN facilitated 4 research forums and 2 reflective practice webinars, provided 16 research-seeding grants, distributed two CMHDARN Yarn newsletters and had 951 individuals accessing the CMHDARN website (www.cmhdaresearchnetwork.com.au).

Across government portfolios (e.g. Heath, DSS, Corrections), the peak body can provide the opportunity to represent the sector, raise the profile of AOD treatment in other government departments, liaise between portfolios, and then feed that back to service providers.
One example is the participation of the Association of Alcohol and other Drug Agencies NT (AADANT) in the recent public hearings in the NT for the Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities, currently being undertaken by the House of Representatives Standing Committee on Indigenous Affairs. AADANT undertook a sector survey on the Inquiry's

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[145] It is difficult and probably unnecessary to precisely disentangle capacity building activities from some of the other service support functions.

Terms of Reference and presented the findings to the Standing Committee. A record of the proceedings will be shared with the sector.

An important feature of the peaks raised in our consultation is that they are networked themselves across Australia, thus facilitating national learning. That is, the peaks are a collaborative group themselves.

One example is the peak bodies in each jurisdiction, in collaboration with the National Centre for Education and Training on Addiction (NCETA), facilitated and hosted a national Improved Services Forum in South Australia in 2010. The forum was attended by organisations who received funding from the Commonwealth for the Improved Services Initiative. The forum provided a valuable opportunity for information sharing, particularly around innovations in practice approaches in providing services for people with complex needs.

The jurisdictional peak bodies provide opportunities for the specialist AOD sector workforce (as well as related sectors and government agencies) to come together to discuss practice issues and emerging trends in the population seeking AOD treatment. This has a number of positive effects across the individual worker, agency, sector and client perspectives, by ensuring service providers are aware of the manner in which their practice fits within the broader health and welfare system, as well as keeping up to date with the evidence base, as it develops.

2. Support government implementation

In the consultation, the peak bodies identified a number of activities, functions and roles that peaks can play in relation to supporting government implementation. One example given was that peaks can interpret national priorities, ensuring the service providers have a full understanding of government's intentions and purpose. The role to "support government reform" was also raised, and included, for example assisting with consortium facilitation processes.

The Alcohol, Tobacco and other Drugs Association ACT (ATODA) has been a key support to the ACT and Federal Governments regarding tobacco reform. This has included the establishment of the Under 10% Project (www.under10percent.org.au) that aims to improve the health and wellbeing of the Canberra community by strengthening tobacco management practices in health and community sector workplaces that support disadvantaged people. The program (which is early in its development) has supported more than ten health and community services to develop and implement tobacco management policies and practices.

A second area in supporting government implementation was in relation to communication amongst service providers, and between service providers and government. Peaks are well positioned to be a central point of contact for agencies funded by Commonwealth.

A good example of this is the work the peaks have undertaken to support the national Review projects currently being undertaken on behalf of Commonwealth. Each peak has facilitated the rapid assessment process for the national Review project in their jurisdiction, which included arranging for the Review team to meet with AOD agencies. In addition, the peaks have been able to provide important advice to the team developing the Quality Framework for Commonwealth-funded AOD agencies, including current levels of engagement with quality standards in the sector, the appropriateness (or otherwise) of specific practice guidelines, and practical issues around implementation (which vary across jurisdictions).

Peaks may also play an "early warning" role for funders, helping to identify and communicate emerging priority topics or populations of concern. In this way, peaks can act as "sentinel canaries" for government, due to their close contacts with local services on the ground. For example, the ATDC conducts regional consultations and meetings with the membership to identify new and emerging issues. At one such forum, it was identified that a change in the delivery of sexual health services had led to an apparent increase in the number of young people presenting to the local NSP who reported the presence of an STI. As a member of the Hepatitis and HIV working group, the ATDC was able to raise this issue with those managing sexual health services in the state.

Another role for peak bodies is in gathering and synthesising the views of service providers to then feed into national planning and priority setting processes. As representatives of the NGO sector, peaks are well positioned to obtain and synthesise the views of AOD workers and agencies for the Commonwealth.

For example, the Victorian Association of Alcohol and other Drug Agencies (VAADA) has facilitated a number of consultations on a range of issues relating to the state government's planned recommissioning of AOD services in the state, including proposed changes to treatment types, funding models, client management systems and treatment principles. This will be followed up by a range of forums and other supports to the sector after the formal recommissioning process has been completed to ensure system integrity is not unduly compromised during the change management process.

The peaks are also well positioned to develop and refine data collection tools, and synthesise and disseminate this information. For example, the Qld Network of Alcohol and other Drug Agencies (QNADA) provides support to the sector to collect the national minimum data set (NMDS), which includes a telephone assistance line for workers. Through this service, QNADA identified a gap in the NMDS relating to the principal drug of concern codes for synthetic cannabinoids. This issue was raised with the Queensland representative on the AODTS-NMDS working group and a classification code for synthetic cannabinoids was added for the 2012-2013 collection.

The peaks are uniquely placed to observe trends in both patterns of drug use and changes in the treatment seeking population as they emerge, which is shared across jurisdictions via a monthly teleconference of CEO/EO's. In this way, the peaks are able to provide early information to governments of all levels around emerging trends, potential issues and the fidelity of policy implementation, which provides a level of protection to ensure limited funding pools are directed for maximum benefit.

3. Support effective service delivery

The peaks articulated a particular role in supporting effective treatment. This could occur through the peak's role in capacity building, workforce development, training, and education. The peaks' role in knowledge dissemination, knowledge transfer was highlighted.

For example the Western Australian Network of Alcohol and other Drug Agencies (WANADA) was instrumental in developing the first internationally recognised set of standards specific to the AOD sector, the Standard on Culturally Secure Practice. This Standard is the culmination of 12 years of sector development work, which commenced with consultation with sector workers, managers, service participants and government to develop a quality framework. The implementation of the framework was supported by WANADA across the sector (including AOD programs funded by OATSIH and the state Office of Aboriginal Health). In 2010, the framework was reviewed and updated with a particular additional focus on cultural security and is now a registered accreditation

standard with the Joint Accreditation System of Australia and New Zealand. In addition, there is now recognition of the value of continuous quality improvement across all AOD services in WA, including 'industry specific' application of evidence based practice. Services in the NT, Qld and SA are currently working with the Standard to shape their service delivery.

Peaks act as conduits to define what is meant by 'good quality' in the AOD treatment system and contribute to improved quality of AOD treatment through developing capabilities at an institutional or organisational level.

The SA Network of Drug and Alcohol Services (SANDAS) provides support to its members in adopting and implementing quality improvement approaches, frameworks and standards relevant to organisational strengthening and the services they provide. In 2013 SANDAS partnered with SACOSS to establish the NGO finance and quality improvement officer network. This network plays a role in systems and contractual aspects of capacity building and provides a forum for both state and Commonwealth funding bodies to more effectively and efficiently communicate and implement changes and seek feedback for their own quality improvement needs.

In much the same way that peaks can provide governments with early information on emerging trends, they are also uniquely placed to provide support to the specialist treatment sector to deliver services which are evidence informed and reflective of good practice.

Extent of 'sector' representation, and role of state/territory funding

The above analysis provides an outline of roles that peak bodies have identified that they currently play or could play in the future. The examples given have been provided by the peaks.
The extent to which the current AOD state and territory peaks have the relevant agencies as members is an important consideration. Examination of the list of agencies which receive NGOTGP and SMSDGF (see Tables 17.7 and 17.8 below) demonstrates that approximately 80% are members of one of the state/territory peak bodies.

List of NGOTGP and SMSDGF funded agencies and their relationship to state and territory AOD peaks

Table 17.7: NGOTGP funded agencies and membership of peak body

List of agencies sourced from:
http://www.health.gov.au/internet/main/publishing.nsf/Content/drugtreat-ngotgp-org

	Member of a peak body (Y/N)
Australian Institute of Health and Welfare	NA
Australasian Therapeutic Communities Association	NA
Eastern Health (Turning Point)	Y
NSW and ACT	
Aboriginal Medical Services Cooperative Limited	Y
ACON Health Limited	Y
Australian Injecting & Illicit Drug Users League (AIVL) Incorporated	Y
Alcohol & Drug Foundation of NSW	Y

	Member of a peak body (Y/N)
Assisting Drug Dependents	Y
Bridges Incorporated	Y
Calvary Health Care Riverina Limited	Y
Community Restorative Centre	Y
Eleanor Duncan Aboriginal Medical Service (EDAMS) auspised by Yerin Aboriginal Health Service Inc	N
Family Drug Support	Y
Kamira Alcohol and Other Drug Treatment Services Incorporated	Y
Karralika Programs Inc (Solaris Therapeutic Community)	Y
Kedesh Rehabilitation Service Ltd	Y
Manly Drug Education & Counselling Centre	Y
Mission Australia	Y
Namatjira Haven Ltd	Y
Ngaimpe Aboriginal Corporation	Y
Odyssey House McGrath Foundation	Y
Peninsula Community Centre Incorporated	Y
The Buttery Ltd	Y
The Drug and Alcohol Multicultural Education Centre (DAMEC) Inc	Y
The Haymarket Foundation Limited	Y
The Lyndon Community	Y
The Salvation Army (NSW) Property Trust	Y
The Station Ltd	Y
The Ted Noffs Foundation	Y
The Trustees of the Society of St Vincent de Paul (NSW)	Y
Toora Women Inc	Y
Watershed Drug and Alcohol Recovery and Education Centre Incorporated	Y
We Help Ourselves (WHOS)	Y
Weave Youth Family Community Inc	Y
Weigelli Centre Aboriginal Corporation	Y
Women's Alcohol and Drug Advisory Centre (WADAC) Incorporated	Y
Youth Off the Streets	Y
Northern Territory	
Amity Community Services Inc	Y
Catholic Church of the Diocese of Darwin Property Trust trading as	Y

	Member of a peak body (Y/N)
CatholicCare NT	
Council of Aboriginal Alcohol Program Services (CAAPS)	Y
Drug and Alcohol Services Association Alice Springs Incorporated	Y
Forster Foundation for drug rehabilitation (Banyan House)	Y
Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council Aboriginal Corporation (NPYWC)	N
Northern Territory AIDS and Hepatitis Council (NTAHC)	Y
Queensland	
Alcohol and Drug Foundation Queensland (ADFQ)	Y
Bridges Aligned Service Inc	Y
Brisbane Youth Service Inc	Y
Central Queensland Indigenous Development Limited (CQID) Ltd	N
Community Services Tablelands Inc	Y
Congress Community Development and Education Unit	Y
DRUG ARM Australasia	Y
Fresh Hope Association Incorporated	Y
Gold Coast Drug Council (GCDC) Inc	Y
GoldBridge Rehabilitation Services Inc	Y
Mater Misericordiae Health Services	Y
North and West Queensland Primary Health Care Association Incorporated	N
Ozcare	Y
Queensland Injectors Health Network (QuIHN) Ltd	Y
Royal Flying Doctor Service of Australia (Queensland Section)	Y
Teen Challenge Care (Queensland) Ltd	Y
The Corporation of the Synod of the Diocese of Brisbane	Y
The Salvation Army (QLD) Property Trust	Y
We Help Ourselves (WHOS)	Y
Youth Empowered Towards Independence (YETI)	Y
South Australia	
Aboriginal Drug and Alcohol Council (ADAC) SA	NA
Baptist Care (SA) Inc	Y
Catholic Church Endowment Society	Y
DRUG ARM Australasia	Y
Hepatitis SA Inc	Y

	Member of a peak body (Y/N)
Mission Australia	Y
Northern Area Community & Youth Services Inc	Y
Nunkuwarrin Yunti of SA Inc	Y
Offenders Aid & Rehabilitation Service SA Inc	Y
The Salvation Army (SA) Property Trust	Y
Umoona Tjutagku Health Service Aboriginal Corporation	Y
Uniting Care Wesley Adelaide Inc	Y
Vietnamese Community in Australia / SA Chapter Inc (VCASA)	Y
Tasmania	
Anglicare Tasmania Inc	Y
Community Connections	Y
Holyoake Tasmania Inc	Y
The Salvation Army (Tasmania) Property Trust	Y
Youth and Family Focus Inc	Y
Victoria	
Anglicare Victoria	Y
Australian Vietnamese Women's Association	N
Barwon Medicare Local	N
CatholicCare Archdiocese of Melbourne	Y
EACH Limited	Y
Eastern Health	Y
Flat Out Inc	Y
Gateway Community Health	Y
Glastonbury Community Services	N
Grampians Community Health	N
Inner South Community Health Service Ltd	Y
Jesuit Social Services Limited	N
Knox Community Health Service Limited	N
La Trobe Community Health Service	Y
MacKillop Family Services Ltd	N
Merri Community Health Services Ltd	N
Mitchell Community Health Service Ltd	N
Ngwala Willumbong Cooperative Ltd	N
North Yarra Community Health	Y

	Member of a peak body (Y/N)
Odyssey House Victoria	Y
Peninsula Health	Y
Primary Care Connect	Y
Self Help Addiction Resource Centre (SHARC) Inc	Y
Sunbury Community Health Centre	Y
Sunraysia Community Health Services Ltd	N
TaskForce Community Agency Inc	Y
The Salvation Army (Vic) Property Trust	Y
The Western Region Alcohol and Drug (WRAD) Centre Inc	Y
UnitingCare ReGen	Y
VincentCare Victoria	Y
Windana Drug and Alcohol Recovery	Y
Youth Support and Advocacy Service (YSAS)	Y
Western Australia	
Aboriginal Alcohol and Drug Services (AADS)	Y
Agencies for South West Accommodation Inc (AccordWest)	Y
DRUG ARM WA	Y
Holyoake (The Australian Institute for Alcohol and Drug Addiction Resolutions)	Y
Mission Australia	Y
Palmerston Association Inc	Y
The Salvation Army (WA) Property Trust	Y
Western Australia Council on Addictions Inc	Y
Western Australian Substance Users Association Inc	Y
Women's Health Care Association Inc	Y

Table 17.8: SMSDGF funded agencies and membership of peak body

List of agencies sourced from:
http://www.health.gov.au/internet/main/publishing.nsf/Content/drugtreat-fund-org

	Member of a peak body (Y/N)
Australian Drug Foundation	N
Aboriginal Health and Medical Research Council	NA
Aboriginal Medical Service Co-operative Limited	Y

	Member of a peak body (Y/N)
Aboriginal Medical Service Western Sydney Cooperative Ltd	Y
ACON Health Limited	Y
Alcohol Tobacco and Other Drug Association (ATODA) Australian Capital Territory Incorporated	NA
Assisting Drug Dependents	Y
Australian Injecting & Illicit Drug Users League Incorporated (AIVL)	NA
Benelong's Haven Limited	Y
Blue Mountains Drug and Alcohol Recovery Service	Y
Bourke Aboriginal Health Service (BAHS)	N
Bulgarr Ngaru Medical Aboriginal Corporation	N
Calvary Health Care Riverina Limited	Y
CatholicCare as the Trustees for the Roman Catholic Church for the Archdiocese of Canberra and Goulburn	Y
Coonamble Aboriginal Health Service (CAHS)	N
Drug and Alcohol Multicultural Education Centre (DAMEC)	Y
Glebe House	Y
Griffith Aboriginal Medical Service Incorporated	N
Guthrie House Cooperative Limited	Y
Haymarket	Y
Hunter New England Local Health District	N
Illawarra Aboriginal Medical Service (IAMS) Aboriginal Corporation	Y
Karralika Programs Inc	Y
Katungul Aboriginal Corporation Community & Medical Services	N
Kedesh Rehabilitation Services Ltd	Y
Maari Ma Health Aboriginal Corporation	N
Manly Drug Education & Counselling Centre (MDECC)	Y
Marrin Weejali Aboriginal Corporation	N
Mission Australia	Y
Namatjira Haven Ltd	Y
Network of Alcohol & other Drug Agencies (NADA)	NA
New England Medicare Local	N
Ngaimpe Aboriginal Corporation (The Glen)	Y
Nimbin Neighbourhood and Information Centre	N
North Coast (NSW) Medicare Local	N

	Member of a peak body (Y/N)
Odyssey House McGrath Foundation	Y
One80TC	Y
On Track Community Programs	N
Orana Haven Aboriginal Corporation	Y
Pius X Aboriginal Corporation	N
Rekindling The Spirit	Y
Riverina Medical and Dental Aboriginal Corporation	N
South Coast Medical Service Aboriginal Corporation	N
South Coast Women's Health and Welfare Aboriginal Corporation (Waminda)	N
St Vincent's Hospital Sydney Limited	Y
The Buttery Ltd	Y
The Lyndon Community	Y
The Oolong Aboriginal Corporation	Y
The Salvation Army	Y
The Ted Noffs Foundation	Y
The Trustees of the Society of St Vincent De Paul	Y
Toora Women Inc	Y
Uniting Care NSW, ACT (The Uniting Church in Australia Property Trust, NSW)	Y
Walgett Aboriginal Medical Services (WAMS) Co-operative Limited	N
Walhallow Aboriginal Corporation	N
Watershed Drug and Alcohol Recovery and Education Centre	Y
We Help Ourselves (WHOS)	Y
Weave Youth Family Community Inc	Y
Weigelli Centre Aboriginal Corporation	Y
Wellington Aboriginal Corporation Health Service	N
Western NSW Local Health District	N
Women's Alcohol and Drug Advisory Centre (WADAC) Inc.	Y
Winnunga Nimmityjah Aboriginal Health Clinic/ Health Service (ACT) Incorporated	N
Yerin Aboriginal Health Service	N
Youth Off The Streets	Y
Northern Territory	

	Member of a peak body (Y/N)
Amity Community Services Inc	Y
Anyinginyi Health Aboriginal Corporation	Y
Balunu Foundation	N
Barkly Region Alcohol & Drug Abuse Advisory Group Incorporated	Y
Bushmob Incorporated	Y
Central Australian Aboriginal Alcohol Programmes Unit	Y
Central Australian Aboriginal Congress Incorporated	Y
Council for Aboriginal Alcohol Program Services Incorporated	Y
Danila Dilba Health Service	N
Drug and Alcohol Services Association Alice Springs Incorporated	Y
Forster Foundation for drug rehabilitation (Banyan House)	Y
Foundation of Rehabilitation with Aboriginal Alcohol Related Difficulties Corporation	Y
Kalano Community Association Incorporated	Y
Katherine West Health Board Aboriginal Corporation	Pending – requested membership, awaiting return of application
Miwatj Health Aboriginal Corporation	N
Northern Territory Department of Health	NA
Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council Aboriginal Corporation (NPYWC)	N
Northern Territory Council of Social Service (NTCOSS)	NA
Sunrise Health Service Aboriginal Corporation	Pending – requested membership, awaiting return of application
The Salvation Army (NT) Property Trust	Y
Warlpiri Youth Development Aboriginal Corporation	N
Wurli-Wurlinjang Aboriginal Corporation	Y
Queensland	
Alcohol and Drug Foundation Queensland (ADFQ)	Y
Brisbane Youth Service (BYS)	Y
Central Queensland Indigenous Development Limited	N
DRUG ARM Australasia	Y
Eagle EDGE Solutions Inc	N
Ferdy's Haven Alcohol Rehabilitation Aboriginal Corporation	N

	Member of a peak body (Y/N)
Gindaja Treatment & Healing Indigenous Corporation	Y
GoldBridge Rehabilitation Services	Y
Gold Coast Drug Council (GCDC) Inc	Y
Institute for Urban Indigenous Health Limited	NA
Krurungal Aboriginal and Torres Strait Islander Corporation for Welfare, Resource and Housing	N
North and West Queensland Primary Health Care Association Inc	N
Pormpur Paanth Aboriginal Corporation	Y
Queensland Aboriginal and Islander Health Council	NA
Queensland Injectors Health Network (QuIHN)	Y
Queensland Network of Alcohol and Other Drugs Agencies (QNADA) Ltd	NA
Royal Flying Doctor Service of Australia (Queensland Section)	Y
The Salvation Army	Y
The Gumbi-Gumbi Aboriginal and Torres Strait Islanders Corp	Y
The Uniting Church	Y
Youth Empowered Towards Independence (YETI) Inc	Y
South Australia	
Aboriginal Drug & Alcohol Council of SA Incorporated	NA
Aboriginal Sobriety Group Incorporated	Y
Baptist Care	Y
Catholic Church Endowment Society	Y
Department of Health South Australia	NA
Finding Workable Solutions	Y
Mission Australia	Y
Offenders Aid & Rehabilitation Service (OARS)	Y
South Australian Network of Drug and Alcohol Services (SANDAS)	NA
The Corporation of the City of Port Augusta	NA
The Salvation Army (SA) Property Trust	Y
Umoona Tjutagku Health Service Aboriginal Corporation	Y
UnitingCare Wesley Adelaide Inc	Y
Vietnamese Community in Australia/SA Chapter Incorporated (VCASA)	Y
Tasmania	

	Member of a peak body (Y/N)
Alcohol, Tobacco and Other Drugs Council (ATDC) Tas Inc	NA
Anglicare Tasmania Inc.	Y
Circular Head Aboriginal Corporation	Y
Community Connections Incorporated	Y
Cornerstone Youth Services	Y
Department of Health and Human Services	Y
Holyoake Tasmania Inc	Y
Tasmanian Aboriginal Centre Incorporated	Y
The Salvation Army (Tasmania Property Trust)	Y
Youth and Family Focus Inc	Y
Victoria	
Albury Wodonga Aboriginal Health Service Incorporated	N
Anglicare Victoria	Y
Banyule Community Health	Y
BAYSA Ltd (trading as Barwon Youth)	N
Bendigo Community Health Services Limited	Y
CatholicCare Archdiocese of Melbourne (CatholicCare)	Y
Cummeragunja Housing and Development Aboriginal Corporation	N
Dhauwurd-Wurrung Elderly & Community Health Service Inc	N
Eastern Health (Turning Point)	Y
Gateway Community Health	Y
Grampians Community Health	N
Inner South Community Health Service	Y
ISIS Primary Care Service	Y
Jesuit Social Services	N
Knox Community Health Service	N
Mildura Aboriginal Corporation Inc	Y
MonashLink Community Health Service Limited	N
Ngwala Willumbong Co-operative Limited	N
Njernda Aboriginal Corporation	N
Northern District Community Health Service	N
Odyssey House	Y
Peninsula Health	Y

	Member of a peak body (Y/N)
Ramahyuck and District Aboriginal Corporation	N
Self Help Addiction Resource Centre Inc (SHARC)	Y
Southern Health (South East Alcohol and Drug Service - SEADS)	Y
Sunbury Community Health Centre	Y
Taskforce Community Agency	Y
The Australian Community Support Organisation (ACSO) Inc	Y
Uniting Care Ballarat Parish Mission	Y
Victorian AIDS Council/Gay Men's Health Centre (VAC/GMHC)	Y
Victorian Alcohol and Drug Association (VAADA)	NA
Western Regional Alcohol and Drug Centre	Y
Windana Drug and Alcohol Recovery	Y
Youth Projects Ltd	Y
Youth Support and Advocacy Service (YSAS)	Y
Western Australia	
Aboriginal Alcohol & Drug Service (AADS) Incorporated	Y
Bega Garnbirringu Health Services Incorporated	Y
Bloodwood Tree Association	N
Centrecare Incorporated	N
DRUG ARM WA	Y
Holyoake	Y
Milliya Rumurra Aboriginal Corporation	Y
Mission Australia	Y
Ngangganawili Aboriginal Community Controlled Health and Medical Services Aboriginal Corporation	N
Ngnowar-Aerwah Aboriginal Corporation	Y
Palmerston Association Inc	Y
Swan City Youth Service Inc.	Y
Western Australia Alcohol and Drug Authority	NA
Western Australia Council on Addictions Inc	Y
Western Australia Country Health Service	Y
Western Australia Network of Alcohol and other Drug Agencies (WANADA)	NA
Women's Health Care Association	Y

Case example: Healthcare planning approaches undertaken by Medicare Locals

The focus of this case study is on the processes of healthcare planning and needs assessment which have been undertaken by Medicare Locals since their establishment. Through the Rapid Assessment, it became evident that the various tools and approaches which have been used by Medicare Locals for conducting planning and needs assessment may be usefully examined in the context of planning for alcohol and other drug treatment, particularly for thinking about ways of assessing and responding to local community health care needs.

According to public information available (http://www.medicarelocals.gov.au) in 2011, the Australian Government established new organisations, Medicare Locals, to plan and fund extra health services in communities across Australia. In total, 61 Medicare Locals were put in place across Australia "[t]o ensure decisions about health services could be made by local communities in line with local needs". It was also noted that Medicare Locals would have "flexibility to be innovative in how they respond to the needs of their communities." Medicare Locals were rolled-out progressively and as such, have not been uniform in their operations. The more established Medicare Locals have tended to offer more health services and employ more health workers than those more recently established.

Prior to the launch of the Medicare Locals, a discussion paper on governance and functions was released which described the aims and purpose of the new Medicare Locals structure (http://www.ascmo.org.au/ind/Medicare-Locals.pdf). It was said that "[t]he reforms aim to encourage a model of care that allows providers the opportunity to organise and coordinate care around the needs of the patient. This is in contrast to the uncoordinated and poorly integrated episodic care that arises when health care delivery is dictated by funding models and not patient's health care needs" (p.3). A key role for Medicare Locals was therefore said to be "undertaking local health planning, identifying gaps in services at the local level, examining opportunities for better targeting of services and establishing formal and informal linkages with the acute and aged care sectors" (p.4). It is these planning functions which are of particular interest to the Review. Planning processes were described in the first of the five nominated objectives for Medicare Locals - Identification of the health needs of local areas and development of locally focused and responsive services:

> "Over time, detailed local population health and service plans will be developed to inform the planning and coordination activities undertaken by Medicare Locals. Decisions and processes based on evidence and strong population health data will enable a stronger focus on prevention and early intervention, result in more appropriate service utilisation, improved patient access and greater clinical and administrative efficiency. The development of Healthy Communities Reports (giving health consumers and providers access to greater levels of information regarding health services and performance in their region) will further inform planning, prioritisation and resource allocation, resulting in the right care being provided in the right place, at the right time" (p.5).

Guidelines for planning and needs assessment were also provided under the Medicare Locals Accreditation Standards. The objective of 'Standard 6: Analysis and Planning' was "A planned approach to service delivery informed by adequate and appropriate research, analysis and consultation" (http://www.medicarelocals.gov.au/internet/medicarelocals/publishing.nsf/Content/ML-accreditation-standards~standard6#.Uncqtb9rZvU).

Planning Tool

The Australian Medicare Local Alliance has hosted information on their website about the Medicare Local Planning Tool (http://www.amlalliance.com.au/policy-and-advocacy/medicare-local-health-planning-tool). The tool has been described as "a simple, online map-based tool that has been designed to help Medicare Locals with their service planning and the maintenance of local health service information. It provides access to a range of validated national population health data sets as well as health services information from the National Health Services Directory (NHSD). It is a tool that will evolve and expand as more data sets are added and underlying health service information is improved and integrated." This tool has been available to Medicare Locals as a service without charge[146]. The tool has been said to assist with planning in the following ways:

- It is a practical, visual tool that will help you to identify and visualise the health and social characteristics of your region - and Australia more broadly, assisting you in your needs assessments and subsequent service planning
- It will act as an easy platform with which you can update and maintain health service information as part of the National Health Services Directory
- It provides a framework to support health program development and analysis
- It draws on national information and data sets including:
    - Education, household, community and economic data
    - Population distributions and projections
    - Indigenous health
    - Mortality
    - Maternal, children, family, countries of birth
    - Prevention, chronic disease, MBS, aged care

Such a tool (depending upon whether appropriate data input is available) may also be relevant for assisting with the planning and provision of AOD treatment.

Based on the policy and advocacy documents and position papers available on the Australian Medicare Local Alliance website (http://www.amlalliance.com.au/policy-and-advocacy), it does not appear that AOD treatment has been a priority area to date.

Needs Assessment

Although the Commonwealth has required all Medicare Locals to undertake needs assessment, various Medicare Locals have presented different opinions about the level of specification and guidance which has been provided to successfully undertake these assessments. In Queensland it was suggested that "the Commonwealth policy documents provide little guidance or contextualisation on how those plans should be developed, or the extent of planning needed to drive effective and equitable health promotion and prevention work of Medicare Locals" (http://www.mnbml.com.au/content/Document/population_planning_report_1213.pdf, p.1). This opinion was not shared by Hume Medicare Local, for example, who said that "[c]lear direction is provided by the Australian Government Department of Health and Ageing in relation to conducting a health needs assessment and planning" (http://www.humeml.org.au/Portals/0/documents/Population%20Health/Summary%20HML%20Population%20Health%20Report%202013.pdf, p.7).

It would appear that each individual Medicare Local has approached planning and needs assessment processes slightly differently. However, two key aspects seem to have broadly applied to many,

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[146] The planning tool is only accessible with a Medicare Local password, however this presentation provides slides of screen shots which demonstrate the visual aspects of the tool, and how various services can be displayed using interactive maps (Drug and Alcohol is one of the categories listed): http://www.amlalliance.com.au/__data/assets/pdf_file/0020/45236/20120905_prs_Gabe-Gossage_-National-Health-Services-Directory.pdf

these being (i) partnerships and community consultation and (ii) data input into planning. For example Far North Queensland Medicare Local describes their population health planning processes thus (http://www.fnqmedicarelocal.com.au/programs/population-health-planning.html):

> "To address health outcomes at a population level FNQ Medicare Local must work in *partnership* with a wide range of health and community organisations to improve population health outcomes and reduce the inequalities which exist in the Far North Queensland population. Our planning and *data-gathering* helps us to understand the health needs of the population and to then use this information to inform strategic planning, priority setting (via the annual plan), service delivery, and resource allocation across the primary health care continuum." (emphasis added).

The Hume Medicare Local (HML) Population Health Report 2013 (http://www.humeml.org.au/Portals/0/documents/Population%20Health/Summary%20HML%20Population%20Health%20Report%202013.pdf) describes the processes used in the development of the HML needs assessment and population health plan. HML is also of interest as it geographically covers two States (NSW and Victoria). Community consultation and data input were emphasised in this approach to planning:

> "The HML population health plan will be guided by planning principles such as the *meaningful engagement with community and health providers* irrespective of discipline, sector or funding body, taking into account the environment, economic, political, social, cultural and behavioural factors. HML population health planning is grounded in the social model of health and uses an equity based approach to planning and is culturally appropriate. Population health needs include the broad environment of health and incorporates issues of deprivation and inequality related to the social determinants of health. The HML will address issues of inequity by paying particular attention to sub population groups within the catchment.
>
> There are important differences between need, demand and supply which have implications for health needs assessment. The HML will undertake a building block approach to compile a picture of the health of the combined and individual 13 areas it services. *Combining data from demographic and health profiles, community and stakeholder engagement, service mapping* against best practice benchmarks will provide information that will be assimilated to identify service gaps that may exist locally. The HML will identify and adopt a prioritisation process that is clear and transparent as a means to address areas where healthcare needs are greatest.
>
> The methodology in this population health plan is based on using best practice and *a systematic approach to data collection* that informs the need for and use of health services and *community and key stakeholder perceptions and knowledge of health issues at a local level.* Local identification and ownership of issues provides a strength base for the reform of primary healthcare services required to ensure the most cost effective and person centred efficient delivery of health interventions at both a primary and secondary level" (p.8, emphasis added).

Importantly, the needs assessment processes, in some cases, revealed rapidly changing population demographics and pockets of disadvantage at a local government level which may not have seemed obvious. For example, the first Sydney North Shore and Beaches Medicare Local (SNSBML) Regional Needs Assessment Report noted that "[o]n the surface the region appears to enjoy relatively good health yet this report identifies population cohorts, geographic hot spots and specific health issues based on the in-depth look at local regional health data. Concerns exist over certain social determinants, such as access to transport, stress and addiction which can impact health outcomes"

(p.9). Again, the needs assessment was developed using extensive stakeholder consultation and data analysis through a collaboration between the SNSBML team and consultants.

Another example of planning processes can be seen in the ACT Medicare Local. The ACT Medicare Local has launched a Population Health Commissioning Atlas (http://www.actml.com.au/Uploads/Documents/ACTMLPopulationHealthCommissioningAtlas_web.pdf). On the ACT Medicare Local's 'Health Needs Assessment and Planning' website, it is said that "The Atlas' findings about health status and variation in the ACT will drive how we focus our activities and programs over the next year as we continue to improve the health of Canberrans and keep them well and out of hospital" (http://www.actml.com.au/about-us/health-needs-assessment-and-planning). The 'Needs Assessment Overview' describes the processes and approach to needs assessment, and the key inputs into the 2013 Needs Assessment Report (http://www.actml.com.au/Uploads/Documents/ACTMLOverviewPopulationHealthCommissioningAtlas.pdf). Major inputs into the 2013 Needs Assessment Report included (p.2):

- A Population Health Commissioning Atlas containing information about the ACT population including demographic and socio economic status from sources such as the ABS; health service use from Medicare and hospitals; estimates of prevalence of illnesses and disease; and comparative results in areas such as immunisation and screening
- A Local Supplement which examines the determinants of health across Canberra's suburbs such as public transport utilisation and the extent to which residents can easily work to civic services such as health care, shops and schools
- A Consultation Report containing key findings from interviews with over 70 organisations representing community agencies, peak bodies, government services, private sector and primary care professionals in the ACT. They were asked if they thought there any gaps in services, unmet need in the community and where improvements could be made to primary health care.

The emphasis which has been placed on partnerships and community consultation as well as data input into needs assessment and planning is worthy of consideration in the context of planning for AOD treatment provision, especially for responding to local community needs. Furthermore, the examples provided here may provide some guidance for further thinking about how AOD treatment ITAs could specify needs assessment processes.

Case example: Working in partnership: an interdependent approach to AOD service planning and delivery in Western Australia

Introduction

Central to the Review is a deep understanding of the interdependence between key actors that shape the AOD sector. Specifically, the ways that government and services operate in processes of sector planning and procurement.

In our consultations with key informants for the Review, there was much discussion about the importance of meaningful consultation and communication and about having constructive working relationships between key stakeholder groups; in this case involving the purchasers and providers of services. This issue arises in relation to planning for treatment services; the approach to market; change management (reform); the delivery of services; monitoring outcomes; and the management of contracts. There are two aspects with particular relevance for the Review:
1. The way the Commonwealth does its business; and,
2. Processes that support sector reform processes[147].

We became aware of one approach to sector reform, in WA, which has been well received. This partnership approach aims to support sector planning and implement substantial change, with the ultimate goal of better outcomes for clients – and thus society. Given the significance of the partnership approach in relation to the Review, we sought to document this as a case example. Our focus is on the policy that underpins the approach and the main actors involved.

We commence the case example by outlining the origin and aims of the *Delivering Community Services in Partnership Policy* (hereafter referred to as the *Partnership Policy*) before moving on to the partnership approach involved. Policy actors, and their respective contributions, are described. Next, procedural instructions that address practical elements of policy implementation are explored. The final section provides results from the Review, canvassing key informant perspectives on the partnership approach in the context of sector development and reform.

Delivering Community Services in Partnership Policy (the *Partnership Policy*)

Origin

In WA, there is a substantial policy history that recognises the importance of working with sector agencies. In 2002, the *Funding and Purchasing Community Services (FPCS) Policy* was "introduced to provide government agencies with more flexible and less formal processes for engaging not-for-profit organisations in government service delivery…[and drew from values including] the need to develop a mutually respectful relationship, the importance of reducing bureaucracy and the requirement to maintain transparency and accountability". While the underlying values of the FPCS Policy remain critical, government has recognised the need to continue reforming the way it engages with the community sector (Government of Western Australia, 2011a).

The *Delivering Community Services in Partnership Policy (the Partnership Policy)*, introduced in May 2011, builds on and replaces the FPCS. It,

> "Goes one step further by putting the interests of citizens at the centre of the relationship between the public and community sectors, and challenges both sectors to redefine the way

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[147] That is, given that the review provides opportunity for reform, the question becomes what kind of processes may best support that reform.

they engage in the planning, design and delivery of human services" (Government of Western Australia, 2011b, p. 2).

The *Partnership Policy* 'has teeth'; its application is mandatory for all Public Authorities and its implementation is to be phased-in, with new arrangements put in place as existing arrangements expire.

Further, there is "a clear policy owner", which is "the joint government-community sector Partnership Forum" (explained below), that "comprises senior public servants and community sector representatives". The Partnership Forum's purpose is to "address issues of mutual concern with a view to achieving beneficial outcomes for both sectors and for the community" (Government of Western Australia, 2011a).

Aims

The *Partnership Policy* aims "to improve outcomes for all Western Australians through a genuine partnership between Public Authorities[148] [government departments] and the not-for-profit community sector in the funding and contracting of sustainable Community Services in Western Australia". It, "applies to all Public Authorities that provide funding for, or purchase Community Services from, not-for-profit organisations" (Government of Western Australia, 2011b, p. 1). This includes Commonwealth and industry funded services, "to the extent that the requirements of this *Policy* are not inconsistent with the requirements of that service or service sponsor" (Government of Western Australia, 2011a, p. 2).

Put simply, the *Partnership Policy* aims for:
- A partnership approach involving government and community sectors, focusing on funding and contracting of sustainable community services; and
- A reflective and action-oriented approach to enhance the planning, design and delivery of these services [with the ultimate goal of];
- Improved outcomes for West Australians

The achievement of these aims will be facilitated by:
- Promoting flexibility, innovation and community responsiveness in the funding or contracting of services by Public Authorities, to better meet community needs;
- Encouraging a more productive working relationship between Public Authorities and the not-for-profit community sector based on trust, collaboration, accountability and effective and sustainable[149] service delivery;
- Clarifying when services are to be put out to open tender and when a more targeted non-market based approach is more appropriate;
- Reducing "red tape", complexities and inconsistencies, and standardising terminology to clarify the dialogue between the parties; and
- Requiring that Public Authorities remain aware of Government's core desire to contract with the not-for-profit community sector in a manner that supports sustainable service delivery and recognises the importance of ongoing organisational viability (Government of Western Australia, 2011a, p. 2).

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[148] A Public Authority is "a department of the Public Service of the State established or deemed to have been established under the *Public Sector Management Act 1994,* or an agency authority or instrumentality of the Crown in right of the State" (Government of Western Australia, 2011a, p. 16).
[149] "Sustainable service delivery refers to the ability of an Organisation to continue to provide services over a long-term period and depends on the ability of that Organisation to secure funds to meet the full cost of service delivery, attract and retain human capital, and manage operational risk" (Government of Western Australia, 2011a, p. 2).

Guide to procurement

As reflected in the comments above, the *Partnership Policy* aims to guide procurement processes with the not-for-profit[150] community sector (Government of Western Australia, 2011b). A range of funding and contracting options are included in the *Partnership Policy*, including a definition of the term 'funding arrangement' and guidance on its application. It is explained that, "a funding arrangement is an arrangement where a Public Authority provides financial assistance to an Organisation to assist its established purpose. There is only one funding arrangement to which the [*Partnership] Policy* relates – a grant" (Government of Western Australia, 2011a, p. 7). A grant is defined as, "a financial assistance arrangement made for a specific purpose…and may contain conditions relating to the Organisation's conduct or activities" (Government of Western Australia, 2011a, p. 7).

The Public Authority determines whether grants will be provided to organisations and, while they are for "a discrete purpose and period", there is sufficient flexibility to allow for unique elements of the grant (i.e., that may impact timeframes). Funds distribution and reporting are designed to minimise the administrative burden on services, involving "less oversight, reporting and documentation than for service agreements" and payment as a lump sum, or through instalments" (Government of Western Australia, 2011a, p. 7). Standardised contract templates and conditions potentially add to the transparency of funding arrangements. Figure 1, from the *Partnership Policy* (p. 4) shows the three pillars of the policy; the nature of the relationship between identifying needs and developing and implementing a strategic response, the funding and contracting options; and strategies to reduce the administrative burden.

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[150] The terms not-for-profit and non-government organisations (NGO) are used interchangeably in this case study.

DELIVERING COMMUNITY SERVICES IN PARTNERSHIP
POLICY FLOW-CHART
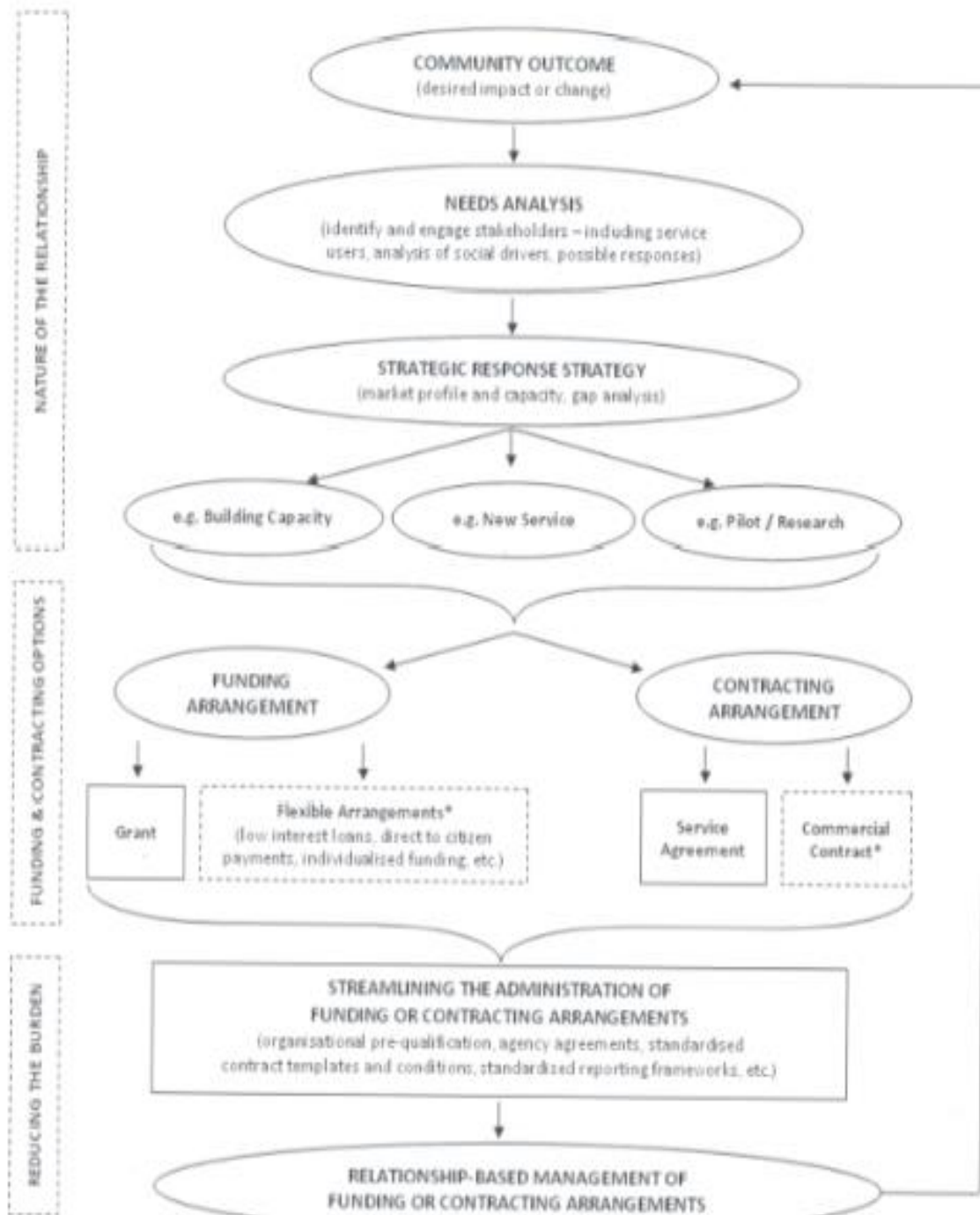
Having provided an introduction to the purpose and scope of the *Partnership Policy,* we now turn to the ways in which the partnership approach has been articulated and the key parties to the policy.

Partnership as the core

The *Partnership Policy* is based on six partnership principles and six behaviours, which are reproduced in Table 17.9. In brief, the principles involve a commitment to shared outcomes, a collaborative approach to decision-making and working together, a partnership based on mutual trust and respect, with openness and transparency, recognising the value and contribution of both sectors, an enduring commitment to sector sustainability, and a commitment to empowering service users in planning, design and delivery. The behaviours comprise a focus on demonstrable improvements in outcomes, consultation on all significant issues, transparency in decision-making, an interdependent approach to service planning and delivery, working together for sustainability, and engaging citizens in planning, design, and delivery processes (Government of Western Australia, 2011a).

Table 17.9: The 'Nature of the Relationship' between the public and not-for-profit community sectors Source: (Government of Western Australia, July 2011, p. 5).

Principles

1. A commitment to improve social, cultural and economic outcomes for the Western Australian community.

2. A collaborative approach to decision-making and working together recognising the interdependence in the delivery of Community Services.

3. A partnership based on mutual trust and respect, with openness and transparency in all activities.

4. A recognition of the value and contribution of both sectors in the design and delivery of Community Services and the important roles each play in the wellbeing of the community.

5. An enduring commitment to the sustainability of Community Services.

6. A commitment to empowerment of service users in the planning, design and delivery of Community Services.

Behaviours

1. An enduring focus and drive to deliver demonstrable improvements in outcomes for all Western Australians.

2. Consultation on all significant issues, including the development of policy, planning and service design.

3. Transparency in decision-making, including through the sharing of data and information, basis for funding decisions and contracting requirements.

4. An interdependent approach to the planning and delivery of Community Services.

5. Public Authorities and Organisations work together to ensure that funding levels are sufficient for sustainable Community Services.

6. Engagement of citizens in the ongoing planning, design and delivery of Community Services through direct and indirect methods of consultation and representation in the development of service delivery.

Policy actors

We have identified a number of policy actors that are integral to the realisation of the *Partnership Policy.* Some of these groups reside within government and work both across government departments as well as focusing on sector change and development. Others represent the AOD sector, including services and consumers. These policy actors are introduced here, with a very brief outline of their role and then a description is provided below.

The policy actors and a précis of their roles in relation to the *Partnership Policy*:
- The Department of Finance; advice, support, administration
- The Partnership Forum; high level joint government-community sector group, supported by the Departments of Premier and Cabinet and Finance
- The Drug and Alcohol Authority (DAO); leadership, planning, relationships, change process
- The Drug and Alcohol Interagency Strategic Senior Officers' Group (DASSOG); working collaboratively, showing leadership in their own portfolios
- The West Australian Network of Alcohol and Drug Agencies (WANADA); representing the AOD sector, supporting two way channels of communication, supporting the change process through practical means
- The West Australian Substance Users' Association (WASUA); representing illicit substance users

Department of Finance

Administration of the *Partnership Policy* resides with the WA Department of Finance, Government Procurement, which is tasked to provide advice and be accountable for policy implementation. The *Policy* states that the Department "will provide ongoing support and oversight for the *Policy* and report to the Partnership Forum (the *Policy* owner) on the *Policy's* implementation and effectiveness (Government of Western Australia, 2011a, p. 2). The Department is responsible for the financial arrangements associated with policy implementation, while other policy actors shape the decisions made and the approach to procurement (the latter involving the Drug and Alcohol Office).

The Partnership Forum

Members of the Partnership Forum include Director Generals, NGO representation, and an independent chair. The role of the forum is to provide governance and oversight of the implementation of the *Delivering Community Services in Partnership Policy*. The Departments of Premier and Cabinet and Finance support the forum. In 2012, these departments worked on behalf of the Partnership Forum to deliver a 'Nature of the Relationship' series of events (3 in total), which are described as follows:

> This series sought to bring together service users, providers and state government agencies to explore practical ways of employing the principles and behaviours of the *Delivering Community Services in Partnership* (DCSP) *Policy*. Each event was designed to address the critical success factors in achieving maximum benefit for the community through the planning, design and delivery of community services.

> Participants were encouraged to explore some of the cultural barriers to adopting the DCSP Policy, whilst gaining important insights into how these challenges could be overcome to maximise contracting outcomes for the community. Anyone from the public and not-for-profit community sector was welcome to attend (Western Australian Department of Premier and Cabinet, 2013).

Structural and practical developments in support of the *Partnership Policy* include the following:

- The creation of a Funding and Contracting Services unit in the Department of Finance to support both the public and not-for-profit community sectors;
- Establishing a suite of standardised contract templates to reduce the administrative burden;
- Coordination of a range of education and training initiatives (targeted at both sectors) to raise the awareness of the DCSP Policy and associated contracting reforms; and
- Monitoring implementation of the DCSP Policy with updates provided to the Partnership Forum on the progress of implementation and emerging issues (Government of Western Australia, 2012).

The Drug and Alcohol Office

The Public Authority for AOD services in the state is the Drug and Alcohol Office (DAO), a statutory authority accountable to the Minister for Mental Health, which was established by an Act of Parliament in 1974. DAO both provides and contracts services, including prevention, treatment, training, and research (Government of Western Australia, 2014).

Public Authorities are required to have "regard to the desired impact or change they are seeking to achieve within the community…adopt transparent and consultative needs analysis processes…[and] "develop a strategic response strategy". Having undertaken these planning processes, Public Authorities must consider "the optimal funding / contracting arrangement that is best suited to the service response strategy and the desired nature of the relationship with the service provider…[adhering] to the principle that an innovative, responsive approach…is paramount and best served by funding and contracting arrangements that incorporate flexibility" (Government of Western Australia, 2011a, p. 6). Put simply, the approach involves considering desired outcomes, existing needs, and funding arrangements that will support sector responsiveness.

The Drug and Alcohol Strategic Senior Officers' Group

DAO's strategic direction is aligned with the *Drug and Alcohol Interagency Strategic Framework for Western Australia 2011-2015*, which was developed by a key leadership and strategy development group, the 'Drug and Alcohol Strategic Senior Officers' Group' (DASSOG), "in targeted consultation with key stakeholders and the community", (Government of Western Australia, nd, p. 14). The DASSOG illustrates the partnership approach taken *across* government, with representatives from the Departments of Attorney General, Child Protection, Communities, Corrective Services, Education, Health, Housing, Indigenous Affairs, Local Government, Racing, Gaming and Liquor, as well as the Mental Health Commission, Office of Road Safety, and WA Police (Government of Western Australia, nd, p. 14). During our consultations for the review DAO suggested that, "there is good buy into the DASSOG, as evidenced by attendance and contribution at the meetings". Stakeholders from the AOD peak for WA, WANADA, suggested that, "the state government has been very good at inter-sectoral planning and processes". These meetings are action-oriented and include a regular cycle of review and forward planning.

The DASSOG is led by DAO and it meets quarterly, where updates are provided and current / emerging AOD issues are discussed. DASSOG representatives develop, implement and report on an annual action plan that specifically outlines their key activities to support the *Drug and Alcohol Interagency Strategic Framework for Western Australia 2011-2015.* Annual Agency Plans are listed on the DAO site. By way of example, the plans listed for 2013/14 are from the:
- Department of the Attorney General
- Department for Child Protection and Family Support
- Department of Corrective Services
- Department of Education

- Department for Local Government and Communities
- Department of Racing, Gaming and Liquor
- Drug and Alcohol Office
- Office of Multicultural Interests
- Office of Road Safety
- Western Australia Police

The Western Australian Network of Alcohol and other Drug Agencies

The state's AOD peak body, the Western Australian Network of Alcohol and other Drug Agencies (WANADA), was established in 1984 and it is an independent, membership driven, not-for-profit organisation. WANADA's vision is "to be an effective voice on policy, quality and sustainability for the alcohol and other drug sectors in Western Australia" and its purpose is "to lead and support development of the alcohol and other drug sector to deliver best possible outcomes for the community of Western Australia" (Western Australian Network of Alcohol & other Drug Agencies, 2013, p. 2).

In 2012-13 there were nine staff at WANADA. During this period there were 36 full member organisations, many of which represent multiple AOD agencies, and 26 associate member organisations, along with 3 individual members.

Our focus in this case study is on WANADA'S role in relation to the *Partnership Policy.* One source of information, the annual report, suggests that WANADA has had significant involvement. This includes:
- Taking a lead role in supporting the sector to implement reforms arising from the policy and working with DAO to secure fostering partnership funds to delivery sector specific support;
- Working with DAO and the Department of Finance to inform their implementation of the *Partnership Policy;*
- Delivering workshops and one on one consultation for WANADA members and other DAO funded services, to support the development of tender responses.

During consultations for the Review, it was clear that WANADA is an integral part of planning and communication processes and that they have provided sector capacity building exercises to enable reform strategies and support sector sustainability. Key informant perspectives on the partnership approach, which are detailed below, provide further details on this point.

The Western Australian Substance Users' Association

The Western Australian Substance Users' Association (WASUA) was incorporated in 1996 and its core aim is, "to improve the health and social circumstances of people who use illicit substances in WA" (Western Australian Substance Users Association, 2012). There is a strong focus on illicit substance use and associated strategies for harm reduction. WASUA provides a number of services, for example, a health clinic and training. Our perception, from conducting the rapid assessment in WA is that WASUA's involvement in sector planning processes is in development and recent advances have been made. DAO has commented that they "are undertaking work to explore effective ways of obtaining consumer input – recognising that more needs to be done and there is a need for direction regarding how".

Implementing reform

From policy to procedures

In April 2013, 'Procedural Instructions' were released to accompany the *Partnership Policy*. The procedural instructions include guidelines regarding grants and service agreements along with standardised contract planning, development, and management templates (Government of Western Australia, 2013). Our focus in this case example is on aspects of the process that specifically reflect a partnership approach.

The role and responsibilities of the contract manager include the area of relationship development and management, where "the need for cooperative and non-adversarial relationships with Service Providers is paramount and DAO [Drug and Alcohol Office] will endeavour at all times to maintain open communication and a joint and mutually beneficial approach to problem solving" (Government of Western Australia, 2013, p. 16).

"Continuous dialogue" between all stakeholders is advocated (Government of Western Australia, 2013, p. 16), which includes information sharing and a proactive approach to identifying and resolving areas of potential concern.

A number of other procedural elements are supportive of a partnership approach, for example "sensitive relationship management" (p. xx) with the service provider when a service agreement is due to expire, ensuring continuity when there are staff changes in contract management, and instituting reduced financial reporting obligations as new service agreements are implemented.

Partnership for positive change

Words and actions illustrating the application of policy principles and behaviours

Consistent with the *Partnership Policy,* and reflecting a willingness and capacity to configure and lead major change, DAO is managing an extensive reform process in the AOD sector. This process commenced in 2011 and (at April 2014) it is ongoing. During our consultations, the energy and drive for reform was apparent. There was strong engagement from the range of actors involved. While much has been achieved, the work continues – with a vision for long-term, needs based planning, for sustainable community AOD services, within an outcomes-oriented framework.

Principles and behaviours listed in the *Partnership Policy* are embedded in the parlance that has developed. Strong communication and the sense of working together have been integral, with DAO explaining that, "it is not just a purchasing relationship. There is weekly dialogue, sharing ideas, working together on problems, and operating in a mutually supportive and constructive relationship". There is a strong commitment toward resourcing and upskilling the sector, as "it is critically important to have sector capacity building to operate in this environment. You need supportive relationships between the various stakeholders involved. Decisions must be made with good content (and context) knowledge". Further, "having stability in the sector and in government departments has been important….you need trust to enable openness and collective planning".

Another illustration of the *Partnership Policy* in action is evident in a sample of activities that have taken place. In May 2012, a two-day AOD conference entitled 'Implementing State Government Procurement Reforms' included sessions on procurement, sustainability and future funding, outcomes, and proposals. In one example from the conference, a DAO presentation entitled *Drug and alcohol procurement – responding to reform* (Hunter, 2012) described the policy and budget

context for reform, outlined DAO's perspective on progress and opportunities (e.g., 'a framework now exists'; 'opportunity to address sustainability'; 'relationships are critical'), and identified remaining challenges (e.g., 'procuring services on an outcomes basis is hard – need to better define and measure outcomes'; 'anxiety about the consequence, intended and unintended, reform will have in the medium/long term'). A second conference, in August 2012, focused on improving services through collaboration.

Workshops have been held on pricing, which encourage providers to cost services appropriately (not under-cost). The state peak, WANADA, has received funding to host workshops on procurement, which are scheduled to complement DAO's procurement plan, and to facilitate service access to proposal development and costing expertise. Workshops have also been held by service type, to develop agreed treatment outcomes that may ultimately be included in procurement documents. Community consultations have occurred or they are under way, to gather information about regional needs and priorities.

The reform process is moving into a new phase. WANADA members explained that, "a 10-year plan is being developed, involving a sector framework. Development is happening collaboratively, the sector is working with DAO. There was a workshop for the sector on 23 October (2013) where the framework for the plan was introduced and discussed" and, from other WANADA members, "at their recent forum they had 87 attendees. DAO provides a state context that is broad enough for us to do our planning".

This 10 year *Alcohol and other Drug Services Framework, 2015-2025* is outlined in DAO policy documents, with development activities to date involving, "input from key expert reference groups and a range of stakeholders and consumers, carers and 'significant others' in the metropolitan area'" (Government of Western Australia, 2014). DAO explained that the plan is initially drawing on planning tools (primarily the Drug and Alcohol Service Planning Model for Australia [formerly known as DA-CCP]) and input from an expert committee that includes DAO and sector representatives. Every two years, the statistical modelling on need will be revisited. In time, "the science will improve", with the availability of better information on sector activities and outcomes. There is scope for minor and major reviews within the 10-year timeframe, to ensure a plan that retains currency over time.

Challenges and directions

The above shows both how the principles and behaviours in the *Partnership Policy* have directed AOD reform in WA and also that implementation has been consistent with the goals, principles and behaviours of the *Partnership Policy*. That said, there have been challenges.

Major change involves considerable foundational work. At DAO, preparing for reform "has been very resource intensive; every service agreement has been reviewed, we have had to learn new ways of doing things". Resources have also been committed to activities that will build sector capacity in skill domains relevant to a new approach to planning and procurement and to an ongoing program of communication and collaboration.

A sector that is heavily reliant on government funding that may operate in an environment of complacency due to funding inertia may see change as code for 'reduced funding'. In WA, it was noted that, "there was a good deal of scepticism up front", however, sustainability funding supported the potential for change. As noted by key informants, "sustainability funding was provided in good faith [and] the sector was engaged in the change process".

There is extensive policy and sector investment in the *Partnership Policy* and in the reform process. DAO said that,

> The partnership forum sits above the minutiae of reform activities. There is a common agenda across government and including the sector. The process recognises the expertise of providers. We [DAO] have been able to maintain sector enthusiasm for the change process.

And service providers commented that,

> The procurement process in WA is well regarded. It involves working in partnership and includes a learning process for all. There has been a strong investment in change management in government, involving lots of training, etc. The new arrangements give NGOs a voice and power in the procurement process. NGOs have equal say. Planning and procurement involves identifying the need, services designing the solution, and a process to determine service delivery.

Purchasing arrangements have allowed for continuity in service provision and the nature of the market. DAO explained that, "we may use open, preferred provider, or closed processes for procurement. The process supporting this is agreed outcomes. Services to be delivered will be identified in the proposal. There has been a lot of background work leading to this circumstance". There are longer-term contracts and scope for extension, providing improved certainty for services.

Final word

Our focus has been the *Partnership Policy* and its application in the WA AOD sector. This policy is about a genuine partnership that recognises:

- The expertise and commitment of each party, and that
- Working together and effectively is advanced by establishing a relationship built on trust and respect

Sustainability is a shared objective that is regarded as fundamental to reform and involves advancing sector skills and practical resources for planning and design.

Government and the sector regard the partnership approach positively. An extensive change process that includes capacity building, respect for and engagement of sector expertise, information sharing and transparency within a collaborative approach to decision-making has facilitated reform. The increased budget for services, which was preceded by additional funds to support sector sustainability, is an important contextual note. It is not clear whether the *Partnership Policy* would have been implemented as well if new funds had not also been available. Another important contextual element is the long-standing relationships that exist between major AOD stakeholders in WA, which have also facilitated policy implementation.

The reform process has engendered a very active and dynamic environment, involving constant dialogue and planning activities along with formal information sharing and skill development activities. In WA, the momentum has been built to enable change and a long-term view of sector functioning and development. The *Partnership Policy* is an approach to implementing major sector reform that capitalises on the actors involved and the shared goal of improved outcomes for consumers.

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