VICTORIAN ALCOHOL & DRUG ASSOCIATION

Submission

Submission to the Community Sector Reform Council Discussion Paper

August 2014

VAADA Vision

A Victorian community in which the harms associated with drug use are reduced and general health and wellbeing is promoted.

VAADA Objectives

To provide leadership, representation, advocacy and information to the alcohol and other drug and related sectors.

The Victorian Alcohol and Drug Association

The Victorian Alcohol and Drug Association (VAADA) is the peak body for alcohol and other drug (AOD) services in Victoria. We provide advocacy, leadership, information and representation on AOD issues both within and beyond the AOD sector.

As a state-wide peak organisation, VAADA has a broad constituency. Our membership and stakeholders include 'drug specific' organisations, consumer advocacy organisations, hospitals, community health centres, primary health organisations, disability services, religious services, general youth services, local government and others, as well as interested individuals.

VAADA's Board is elected from the membership and comprises a range of expertise in the provision and management of alcohol and other drug services and related services.

As a peak organisation, VAADA's purpose is to ensure that the issues for both people experiencing the harms associated with alcohol and other drug use, and the organisations that support them, are well represented in policy, program development, and public discussion.

Introduction

VAADA welcomes the opportunity to respond to the Community Sector Reform Council (CSRC) discussion paper. We would also like to inform the Council that independent of the CSRC, VAADA had earlier commissioned independent research by the National Drug and Alcohol Research Centre (NDARC), which has reviewed all relevant alcohol and drug recommissioning documentation and widely consulted with sector representatives. Unfortunately the findings from this analysis will not be complete until late October 2014. We will endeavour to forward the final report when it becomes available.

VAADA has also undertaken consultation with the Alcohol and other drug sector to inform the development of this submission. An online survey was created and responses were received from stakeholders across Victoria, with representatives from hospitals, community health services and stand-alone AOD agencies providing feedback. There were broad ranging opinions provided which have been thematically analysed and incorporated into the views communicated throughout this submission. Where it was perceived as useful, quotes from the survey respondents have also been included.

Please note that VAADA has also contributed to the joint submission developed in collaboration with VCOSS, VICSERV and CHP.

The experience of recommissioning across the community mental health support (CMHS) and AOD sectors in Victoria raises a number issues which we hope can inform future activity in the social and community services arena. The use of competitive tendering is one strategy that can be utilised to create change, however through these recent experiences it has become clear that there are more effective approaches to produce the proposed outcomes of more efficient and client centred service systems.

The framework for reform for the AOD sector included explicit statements to focus on six priority areas for adult non-residential treatment services. These were to:

- Simplify and streamline the system
- Integrate alcohol and drug treatment into the broader health and human services system
- Strengthen the alcohol and drug treatment workforce
- Underpin practice with quality tools and mechanisms
- Shift accountability for service provision from outputs to outcomes
- Manage information and data effectively

The need for change has been articulated by both the AOD and CMHS sectors over many years. In the case of the AOD sector calls for restructure was also reflected in the Victorian Auditor-General's report entitled "Managing Drug and Alcohol Prevention and Treatment Services" released in March 2011. In the eyes of some, the genesis of the current reform activity lies in the perceived failure to address a range of sector issues over the course of previous Government/s.

While somewhat hypothetical, it is important to consider that 'if the sector had been operating under suitable performance management systems, supported by robust and transparent data systems, whether such widespread reform as presently occurring might not have been necessary'.

The Dominant Discourse

Within the Australian context at both a National and jurisdictional level there is growing concern from governments about the impact of demographic change, economic pressure and burgeoning growth of the welfare sector. Efforts at the Federal and State levels have sought to engage the community to explore these issues in a variety of ways. While the influence of such concerns have not been explicitly articulated in the existing set of AOD or CMHS reforms, it remains an issue which may or may not have played a role in current reform activity.

The articulated need to reform the Victorian AOD and CMHS sectors appears to be in many regards similar to issues raised for past and pending reforms in other Australian and international jurisdictions. In general commonly raised issues include queries such as:

- What are the features of an effective and suitable delivery system?
- What is most appropriate to ensure good client outcomes?
- How does a system provide accessible and equitable services?
- How does a proposed system deliver efficient and cost effective services?
- What are the best processes to achieve certain outcomes at a particular price?
- What is required to ensure the service model reflects needs and demand for services?

It is acknowledged that these issues may be immutable, fair and reasonable concerns for governments to consider, however it is critical that the rhetoric associated with such considerations is mindful of the systems which are under consideration. In the current recommissioning this includes the need to clearly articulate how the economic and business drivers underpinning the planned approach are being balanced with the differing perspective that characterises the work undertaken in the health and community service system. A key example that has reinforced the inadequacies in both the AOD and CMHS reforms has been in relation to the approach to competitive tendering.

The competitive element of the tendering process closed off some lines of communication within the sector

It appears that such an approach, under the guise of efficient and quality service provision, has failed to take into account the inherent value of local service delivery systems, current partnerships and relationships, and their value in environments where resources are scarce. Some of the key things that this approach to tendering has neglected includes:

- The intangible benefits brought about by local staff who understand local dynamics and the circumstances of individuals in a particular environment or circumstance;
- The inability of a structured call for submissions to reflect the complexity of service systems built up over years of collective effort to address complex client needs; and
- Consideration as to how these reforms, the associated processes and immediate impacts relate to the key messages outlined in Peter Shergold's 'Service Sector Reform Report' statement of principles.

These factors raise numerous concerns for many services, committed staff and consumers regarding the dissonance between the articulated principles in such important documents as Shergold's report and the techniques and tools utilised to effect change. It is somewhat ironic that the broad principles contained in Shergold's work speak of many things including diversity, yet how this has played out across the two sectors has been quite different. The outcomes of tendering have left the CMHSS with a limited number of service providers, significantly diminishing diversity and consumer choice. Whilst there are far more AOD service providers moving forward in the AOD sector, as compared to the CMHS system, there are still numerous concerns related to the notion of diversity, particularly given the reduction in funding to be received by many key organisations.

Co-design and Consultations

It is essential to acknowledge that both the AOD and CMHS sectors had for many years recognised that change was required. VAADA, with support of the AOD sector, entered into discussions early to ensure that sector representations would be made throughout the process. However as the process unfolded there were increasing concerns as to how sector needs and views were being incorporated.

A key and overarching principle for the proposed reforms was that of co-design of the new service delivery system. It was understood by the AOD sector at the outset that this notion of partnership between government and the sector would be difficult to achieve in the limited timeframe that was allocated. Although there was a range of consultative mechanisms available, it appeared that initial key system features had been determined prior to sector engagement. Feedback received by VAADA indicated that participants in some of the activities felt their voices were not being heard and could not determine how their input was influencing decisions being made by departmental staff.

This was made even more challenging within the scope of probity. Department of Health (DH) personnel provided a clear description of the fact the probity requirements would be implemented at an appropriate time and this was understood and respected by the sector. However it appeared that the application of probity significantly inhibited communication on key issues that should have been addressed prior to this period of the process. Examples of these barriers included a cessation of reform

advisory groups, the inadequate timeliness of responses to formal questions that were raised through the tendering period and the failure of preferred providers to be able to communicate with each other as the development of high level delivery plans occurred.

> *"The department needed to show leadership. They were silent when we really needed them to manage the process"*

Recommendation

1. Collaboration and co-design of the reform process with relevant stakeholders including the effected sector and service users must be robustly and transparently undertaken. Collaboration and co-design requires appropriate planning, resourcing, and time for consultation. It is a process that occurs before, during and after the implementation of the change process.

The role of the public service to manage substantive system changes

System design, development, tendering and decision making are all factors throughout this process that required a varied and comprehensive set of skills to deliver effectively. These activities require a solid understanding of change management planning and implementation; access to baseline data to inform proposals being made; technical expertise of funding, system design, contract management arrangements; and awareness of organisational and clinical governance procedures.

The departure of DH staff through the reduction of Victorian public servants appeared to have a significant impact on the capacity for much of this work to be undertaken comprehensively. This was directly experienced by the apparent difficulties to meet communicated timelines, as well as the perceived limited sector and content knowledge held by some personnel involved in the process. This is by no means intended as a critique of individual DH staff, rather it was seen as a symptom of poor planning from within government.

> *"DH was too slow to make decisions. Then inadequate time was provided to allow the sector to understand the requirements"*

Recommendation

2. Departments overseeing and administering the reform process must retain a high level of expertise within the workforce both on the service systems being reformed and the technical elements in the reform process

Change Management and Transition Planning

Effective change management is characterised as a structured and strategic approach to initiating and managing a change process, however there were many examples whereby the recommissioning process did not adhere to some basic principles. Examples include poor consultation, limited communication and decision-making without an apparent adequate rationale. All aspects of the process were impacted by the shifting and unrealistic timelines.

The concerns with available timelines were experienced throughout the entire process. Particularly through the tendering and submission writing period and subsequently post announcement of approved service providers. The determination by government to facilitate the transition process was announced far too late to provide adequate capacity of services and the AOD workforce to manage an effective transition of program delivery. This has had a deleterious effect on many clients who have not been able to be transitioned appropriately, particularly in settings where new providers will deliver services.

> *"Many clients are now not receiving service as their agencies close, or a placed on long waiting lists"*

> *"Just over a week to go before the new system starts, and we are uncertain what will happen with some of our clients"*

Further to this, many agencies have had to balance staff role changes, redundancies and recruitment, all whilst attempting to navigate the issues associated with a new funding model, client management systems, intersections with central intake and assessment procedures and the delivery of new treatment types. In fact, as the AOD sector embarks on the new system there are still many issues not yet resolved. Some will be finalised naturally as the sector moves forward, others will require more focussed attempts to ensure service users do not feel the impact of the ill prepared system.

> *"There is still a lack of clarity with how intake and assessment and treatment will work, particularly in rural and regional areas"*

Recommendations

3. A fair and reasonable amount of time should be provided to enable new providers to plan and prepare for new service arrangements and to enable a smooth transition, including adequate time to plan service user referrals.
4. An impact study should be undertaken to assess the immediate and long term impact of the recommissioning process on the affected workforce; appropriate safeguards should be built in to remedy adverse impacts
5. An impact study should be undertaken to assess the immediate and long term impact of the recommissioning process on the affected service users as well as vulnerable populations which may experience issues accessing the relevant service system; appropriate safeguards should be built in to remedy adverse impacts which should involve long term transitional planning accounting for the needs of service users migrating to new services

Outcomes of the reforms

Transitioning the new system to a functioning entity will take time and considerable effort, with both opportunities and challenges to be experienced at a local level before the success or otherwise of intended outcomes is known. In some locations services have received a significant reduction in funding and although there are new approved providers, there are numerous concerns as to whether this will enhance integrated models of client care. Not only does this impact at the agency and community level, but it also effects the system integrity and pathways established over long periods of time which cannot immediately be replaced by new players. It is expected that the impact of this will require considerable commitment by the respective sector personnel, Department/s and Government which will inevitably be called upon to financially assist in addressing identified, and in many cases avoidable, gaps as they arise. VAADA accepts that many aspects of the revised AOD systems are new. They will take shape over time and there is an expectation that some areas of activity will need to be enhanced as the system rebuilds.

> *Many clients are now not receiving service as their agencies close, or a placed on long waiting lists*

VAADA also understands that there have been a range of 'developmental projects' being undertaken, however feels strongly that these endeavours should have been completed in advance. Whilst the department and some sector representatives may have been aware of the status of this work and its implications, the broader sector has only recently been introduced to the key elements and their significance.

Recommendation

6. Projects and activities informing the reform process should be completed prior to the commencement, rather than in tandem with, or following the completion of the recommissioning process

The majority of current AOD service providers have been included in the range of successful consortia approved to deliver services in the recommissioned system, unlike the CMHS arena where there has been a significant reduction in the overall number of service providers. While there are positives for the AOD sector in comparison with our mental health colleagues as it allows for a greater diversity and spread of providers, many of the consortia members face significant funding decreases which may result in a more fragmented system. The changes in service delivery structures and costs involved with the departure of very experienced managers and clinicians, either through redundancies or resignations, has created a large financial burden for many organisations. This will have an impact as agencies attempt to reconcile the losses, whilst rebuilding their expertise within the new system parameters.

To a large extent the rationale for these reductions clearly lie in the way the new system has been configured. Some of these key elements include:

- The allocation of significant sector funding to the new catchment based intake and assessment units;
- The introduction of new agencies in many regions; and

- The attempts of equalisation of funding across all 16 catchments based on inadequate data measures.

In effect this has left a reduced funding pool available to deliver face to face treatment interventions, although it is understood that the demand modelling project has identified a model to prioritise service users most in need of the specialist AOD treatment. The five-tiered model that has been created seeks to assess severity of need and complexity, while initial modelling has identified that approximately 20% of existing clients may not require face to face treatment. Whilst this may be the case, as previously noted, VAADA is calling for transparent and independent system monitoring in order to determine where these people are referred to and how many of them seek to re-enter the AOD system in the future with a greater array of needs.

> *There is Lack of funding for tier one and two consumers; these clients will be ineligible for services in both AOD and PDRS which may result in greater harms and expense in the long run.*

It is proposed that an integrated, cross sectoral approach to service delivery will ensure these and other consumers that do not access AOD treatment have their needs met, however co-ordinated care is an issue which respective systems have struggled to embed. It is difficult to see how the siloed approach to reform, the commensurate impact on community health services and the fragmentation caused through a narrowly defined and competitive process, will address the challenge of engendering joined up and holistic service delivery and integration. In fact organisations previously providing localised collaborative responses may choose to withdraw completely from working with people with a mental illness or alcohol and drug issues as their ability to provide the appropriate service diminishes.

The UK Experience

There has been recent AOD and other sector reform activity in the UK over the past two years and VAADA believes it is useful to reflect on this for local considerations. Interestingly while our respective systems are in many ways different, many of the underlying issues and processes are common between jurisdictions. This includes issues such as concern with organisational size, models of partnerships and consortia, client pathways, and procurement as the means to set an appropriate price and achieve reform. It could be said that much of this discourse has also been reflected locally, as with the view that there have been significant financial impacts of recommissioning without investment from government to ensure that proposed reform objectives were realised. It is important to note, that while the experience in the local Victorian AOD sector has not played out fully, there is a general consensus among stakeholders that many of the issues and problems arising in the UK have potential of occurring locally.

Summary

The Victorian AOD sector has for a number of years supported the need for change. The failure of previous governments to address a series of underlying system concerns only added weight to the need for action. The many evaluations and reviews undertaken over a long period of time were not acted upon and these, in combination with the publication of the Victorian Auditor-General's Report as well as the election of a new Government, created the perfect storm for reform to address the range of issues that had been identified. The obvious synergies between the AOD and CMHS sectors may have been perceived to share a commonality in issues, and this may have been a precursor for the decision to embark on concurrent reforms.

VAADA had expressed concerns in early conversations with key people in Government and DH. These concerns related to the need to protect valuable human and organisational resources in any process of change. It was clearly articulated by VAADA that it would be most effective to gradually step up the sector to a mutually agreed vision of a new system than to dishevel it through an unsightly and damaging tendering process, which would have great risks attached to it as with the earlier competitive tendering experience in the late 1990's.

VAADA has made a call to establish independent monitoring of the impact of recommissioning across the AOD system, and we see this review as a key opportunity to promote the importance of such an initiative. VAADA is firmly of the belief that the outcomes will have a direct effect on consumers, as well as families, broader communities and other components of the health and community service system. It would be unfortunate, if not negligent, if this expansive recommissioning fails to deliver improved consumer outcomes and with no attempt made to monitor and assess the short, medium and long term results against stated objectives.

Recommendation

7. Independent monitoring of the reform outcomes should be appropriately planned, designed and implemented; this involves:
    - The development of robust, transparent and responsive data systems
    - The evaluation of these data by an independent monitoring body

VAADA applauds the Community Sector Reform Council for seeking submissions through the dissemination of the discussion paper and we welcome opportunities to work with the Council, the Department and the Minister in order to support the AOD sector to embed the changes in the most pragmatic way possible.

The Victorian Alcohol and Drug Association Inc. acknowledges the support of the Victorian Government.