The Processes of Reform in Victoria's Alcohol and Other Drug Sector, 2011-2014

Final Report

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The views expressed in this publication are those of the authors and not necessarily those of the Victorian Alcohol and Drug Association.

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Executive summary

Background

In mid-2014, the Victorian Alcohol and Drug Association (VAADA) approached the Drug Policy Modelling Program, at the National Drug and Alcohol Research Centre, University of New South Wales to undertake a project exploring and describing issues and concerns related to the 2014 alcohol and other drug (AOD) sector recommissioning process in Victoria. This project commenced in July 2014 and concluded in November 2014.

We reviewed policy documents and allied material, and consulted with 20 stakeholders from 18 AOD organisations. These stakeholders were CEOs/senior managers during the reform period.

Pre-commissioning

The work leading up to sector reform occurred over a number of years. Although our analysis is based principally from the release of the Auditor General's report on the management of AOD services (the VAGO report) in 2011, it is worth noting that other review and planning activities occurred in previous years. These processes all contributed to the interest in and foundation for sector change and renewal.

An intensive period of AOD system planning took place following the VAGO report, as evidenced by the release of major policies on AOD sector priorities and directions including a whole-of-government strategy document and a 'roadmap' noting priorities for change and directions regarding consultation. Meanwhile, broader community sector reform was under way and a human services review project report emphasised government priorities including holistic and integrated models of care that functioned across systems and targeted the most vulnerable and disadvantaged. The end of pre-commissioning for AOD services was marked by the release of an AOD framework, which outlined the implementation phase of the reform process.

While the human services review emphasised strategies for reform that involved collaborative relationships with providers and meaningful consultation, operating from a partnership approach (Shergold, 2013), AOD stakeholders that contributed to this project had substantial concerns about the extent to which consultations were meaningful. There had been consultations prior to and for the VAGO report. There were Departmental presentations and roadshows preceding and linked to policy releases. Advisory Groups had been carefully convened and designed to engage in consultation on major service types, with mechanisms to share meeting notes and summaries.

However, the significance of the Advisory Group (and other) consultations was not clear. According to the terms of reference, the Advisory Groups were meant to be about implementation. Stakeholders felt the purpose of the groups was not apparent and the information discussed during meetings was not reflected in subsequent reform documents and approaches. Further, there was a lost opportunity to problem-solve implementation challenges with the benefit of input from practice managers. Another complicating factor was the reduced capacity in the Department as the reform process unfolded, which meant a loss of critical expertise and leadership regarding reform discussions with the sector.

Our findings suggest it is difficult to know what is in focus at the time unless you are fully aware of the various steps in pre-commissioning and of the Department's view regarding the approach to

change (i.e., consultative or not). Added to this is the dynamic nature of the reform environment given broader policy priorities and allied reforms.

Looking back, it is apparent that government largely put the design of the new system forward. The Advisory Group process was intended to be about model implementation, however those involved were not clear on this intention and implementation issues were not always canvassed.

Recommissioning

Recommissioning involved major change, using an open tender process, and limited time between the call for submission, the finalisation of approved providers, and the planned date for the reformed system to commence. The emphasis on consortia arrangements in commissioning documents added to the complexity of recommissioning, especially given the multiple stages in the selection process. Variations between original proposals and what organisations were asked to consider for the Higher Level Delivery Plan and service agreement stages of recommissioning meant an ongoing atmosphere of uncertainty. Some organisations faced particular difficulties in reconfiguring proposals quickly, in preparation for latter stages of the selection process.

Stakeholders identified a need for greater detail in the Advertised Call for Submission regarding service specifications and their comments often focused on how to operationalise services. To some extent, this may reflect the confluence of concerns about the proposed changes to the system and the limited funding available. While service specifications in the Advertised Call for Submission suggested an ambitious program of work, the funding for particular service types (notable examples being standard counselling and care and recovery co-ordination) was limited. Linked to this was the lack of scope to discuss operational complexities with the Department during recommissioning, while good communication may have assisted the resolution of broader impacts of the reform conditions being put forward.

Stakeholder concerns about the funding available were also expressed in terms of the likely impacts on workforce capacity, organisational infrastructure, and ultimately service quality. They also spoke about the implications of separating intake and assessment from other areas of service delivery in terms of financial viability and practicalities of operation. The context for service delivery in rural areas needed consideration in designing the approach to recommissioning.

Transition

The period between service agreements being finalised and the start date for the reformed system was short and, although extended twice, it involved substantial change in organisational arrangements (from buildings to staffing to referral pathways, etc) placing increased pressure on management and staff. The changing start date for the reformed system meant ongoing disruption for organisations, for example around staff redundancies and contracts. The protracted competitive process damaged relationships between organisations and negatively impacted the sector's relationship with the Department. A number of service and system planning issues emerged during the transition period, highlighting the need for stewardship at systems-level (i.e., across organisations and catchments); which is a unique role for the Department to address.

As with all change processes, there is an opportunity to learn from experience. The perspectives put forward by stakeholders in this project have highlighted specific activities and elements that could be improved, along with the importance of allowing sufficient time for various stages of the process

– including, and especially, transition. Using a competitive tendering approach requires careful attention to planning and preparation, a streamlined, clear, and time limited selection process, and sufficient time and resources for implementation planning and transition. Prior to this, careful deliberation is needed to determine the optimal approach to recommissioning - whether a clean sweep involving an open tender is best or if a program of incremental change that engages with organisations using co-operative and collaborative approaches would better support a strong and sustainable sector and a shared focus on system configuration for improved client outcomes.

Analysis, reflections, directions

Key messages from our analysis of project findings include:

- Change is difficult, even more so when no new funding is available
- Meaningful consultation was a gap in the reform process
- The reform process included multiple phases, from planning to recommissioning and then implementation, and the articulation of these phases ahead of time would have assisted the sector to account for and possibly reduce the impact of reform demands
- Having multiple phases in the recommissioning process was onerous for organisations and ongoing changes to what was on offer at each phase in this process made things more difficult
- The translation of planning documents and service contracts to implementation and then system redevelopment takes time
- Promoting consortia through competitive tendering processes had negative consequences for organisations
- While the interest in having more than one contracted provider in a catchment may have been intended to increase client choice, this approach does not guarantee a diversity of service models
- The catchment based intake and assessment services have been a major systems change that will impact service providers, referrers, and clients. The integrity and impacts of the model, at client and system levels, should be examined

Considerations for future reform processes

- Given the resource requirements and risks of major change, ensure that identified solutions match the problems and consider the appropriate scale for reform (incremental / large scale)
- Where recommissioning is involved, establish the approach early in the process; whether consultative / collaborative or not, and maintain the approach throughout
- Collaborative approaches to major change are important (e.g., Ansell, 2011; O'Flynn, 2009; Shergold, 2008), to include practice expertise in problem-solving, support service 'buy-in' to major change and to support the identification and resolution of important and sometimes unforeseen implementation challenges. True collaboration has implications for the nature and timing of recommissioning arrangements and the timely resolution of issues arising
- Consider the information and infrastructure needs for reform (e.g., demand modelling, pricing structure, outcomes framework, client information management) and address these needs prior to changing funding arrangements
- Tailor the funding approach to sector conditions and reform goals

- When recommissioning, allow time for the selection phase and for transition
- In deciding on submissions, avoid pre-empting organisational arrangements. Emphasising consortia and seeking to have more than one contracted provider in each catchment does not guarantee diversity in the service models on offer
- Avoid a 'one size fits all' approach to reform across metropolitan and regional areas. The service context (number and range of services, networks, etc) and resources (funding, workforce) vary across metropolitan and rural areas and they need consideration when planning service modalities and networks
- The Department has a unique stewardship role regarding systems level issues and concerns

In closing

Areas for Departmental monitoring and evaluation that are particularly relevant at this early stage of implementation include:

- Centralised intake and assessment model – streamlined / complex treatment entry
- Funding approach – both the DTAU common price and weightings, to ensure appropriate pricing
- Funding approach - understandings about the scope for consecutive courses of treatment based on client need
- Care and recovery co-ordination requirements and funding amounts

As the changed system becomes established, it is important that the results of this major reform effort to improve service pathways and outcomes for clients are rigorously analysed. This should include an examination of:

- Consumer experiences in and perspectives about the reformed system
- Impacts on fragmentation / streamlining within AOD treatment pathways and in relation to other systems with which clients are engaged
- Management and practitioner perspectives on benefits, costs, and areas for improvement

This project has a number of limitations. It draws from the views of one set of stakeholders to specialist AOD services in Victoria. There are many other stakeholders; the Department, other government departments, consumers and carers and other funders. It would be useful to have these additional perspectives on the reform process and, particularly from consumers and carers, an understanding about impacts of the change period and if the new arrangements have resulted in improvement.

Our work occurred just prior to the reformed system commencing operations. While it has been invaluable to capture the perspectives of stakeholders at this critical point, it is equally important to learn how and whether these perspectives alter with the benefit of experience. This would require a second round of consultation some six months or more into operation, where we would learn more about the reform outcomes and the ways in which the issues and concerns that have been raised are ultimately resolved. This would assist in shaping future reform processes and approaches to sector design and change.

Upon submission of this final report to VAADA, the VAADA Board requested that they provide an Addendum, with some key points highlighted. This addendum is produced below, without input from the study authors.

Further Reflections from the VAADA Board – Addendum to DPMP AOD Sector Reform Analysis Project February 2015

VAADA would like to acknowledge the thorough and extensive work undertaken by the DPMP in the development of this report. We would also like to recognise the important contributions made by sector representatives to ensure that the project findings were reflective of the broad range of perspectives from providers across Victoria.

The VAADA Board has discussed the report and endorsed it for public release, however there are a number of points that it was felt needed to be further highlighted to more comprehensively reflect a range of issues being communicated to VAADA throughout the recommissioning period. These issues are discussed below, and although they are noted in the report, the points raised have been collated from the feedback received by VAADA throughout the recommissioning period.

- Department of Health capacity, expertise and experience

Throughout the extended recommissioning process VAADA received feedback from people within the AOD sector that the Department of Health did not appear to have the capacity to effectively undertake the change process envisaged by the reform agenda. Not surprisingly, an extensive departmental restructure and a large number of staff redundancies significantly impacted many departments across government, including the AOD Division. In the process sector knowledge, expertise, understanding and historical knowledge held by longer term personnel within the mental health and drugs arena was depleted at a very crucial point in time.

It was understood that people who had been with the department for many years and had sector knowledge, expertise and well established relationships across the sector had moved on and this, in conjunction with the remaining and seriously diminished number of staff dedicated to guiding the reform, had a negative impact on the change process.

- The confusing role, function and purpose regarding the advisory groups

The sector advisory groups were established as an early consultative mechanism by the Department to allow sector input on key elements of the system could have been an excellent forum to test the validity of the proposed reform ideas and strategically work through the challenges and opportunities from the perspective of existing providers. However, it was clear from the outset that these groups had a very limited scope to inform and influence the pervading mantra of 'co-build' and 'co-design' and much of the work being undertaken at another level by the Department.
The initial concern came with the directive that each of the proposed groups would be limited to

involvement of 5-6 sector representatives. VAADA knew that a selection of such a small group would have challenges to ensure that broader sector views were considered and this was evident through the recruitment phase of this activity.
The groups were being promoted as a collaborative initiative between DH and VAADA, however VAADA was quick to note that we did not have a role in setting the terms of reference or meeting agendas once membership of the various groups had been established. This failure to provide a truly collaborative endeavour was further realised once meetings commenced. Some of the groups met a maximum of four times and throughout the process it was difficult to determine how group discussions were being reflected in the meeting notes, let alone how group deliberations were utilised to shape the proposed treatment streams. Feedback from numerous participants to VAADA indicated that DH had envisaged a model for reform and that this model was not being modified or adapted based on the feedback provided by group members.

This perceived failure to incorporate or utilise the vast sector knowledge and experience at the conceptual phase of recommissioning has had a negative impact on work that transpired throughout the 'design' phase and subsequent phases. Whilst it is acknowledged that the groups came to a premature close due to probity timeline requirements, there is a strong sense and little doubt that the opportunities for co-design of the system were lost at this critical stage.

- Issues arising from differences between metropolitan and rural and regional areas that had not been adequately considered

The reform appears to have neglected the specific needs of regional and rural Victoria, despite the well-developed understanding that issues differ from metro environments. Despite the well understood facts that different responses are required regarding service access, and that there are a range of challenges in navigating communities with limited local services options, it was strongly felt that a 'one size fits all' approach across the state was taken.

Through the dogged adherence to a competitive tendering approach little regard was provided to the significant value and importance of the many well-established service linkages and client pathways throughout regional and rural Victoria. Many pre-existing providers felt such linkages and pathways and their value were ignored. It is understood that new providers in regions are now having to establish networks, relationships and partnerships in an area they have had no prior operational experience. Others pre-existing service systems have had to curtail, demolish or depart existing service delivery arrangements as well as having to make staff redundant and cease delivery in small towns which will no longer be directly serviced by a local AOD funded program. All this has occurred at great opportunity costs to the communities involved and may impact on service access for clients in the future.

Importantly though, there appears to have arising a significant amount of service system fragmentation. Whilst funding decisions were made under the guise of probity, it would appear that little attention was afforded to the level of integrated co-ordinated care which would remain or be impacted. Successful providers have subsequently been brought together to try and develop some modicum of an integrated and co-ordinated service system at the local level between competitors. This has proven to be problematic and appears to be a failure of process when looking at the service

system structure in numerous regional catchments.

- Problems arising from the restrictive timelines and the difficulties the limited transition implementation period has had

As recommissioning progressed it became clear that there was insufficient time available to ensure that such broad ranging changes would be able to be well considered prior to implementation. The November 2014 election appeared to be the impetus driving the timeline and although it was clear that significant work was still required, it was understood that delays beyond the election were not possible according to the then current government. The strict adherence to these timelines created a range of repercussions ranging from lack of preparedness, inability to pilot and evaluate and an overall rush to implement while in a state of unpreparedness across numerous functional aspects that would normally be required. This included limited consideration for data collection systems, guidelines, protocols, monitoring systems and funding models.

VAADA is of the view that the range of developmental projects should have been finalised prior to implementation of the new system. Areas such as performance management, demand modelling, data collections and monitoring and evaluation of implementation are key areas that should have been finalised and tested.

VAADA had been communicating concerns regarding the limited attention provided to the transition. It is acknowledged that implementation was delayed for short periods of time on two occasions, and VAADA agreed with those decisions based on the status of various reform activities. However neither of these were planned and they occurred at very late stages, each time requiring approved providers to alter their planning for the start date.

- Issues arising from model design and lack of rigorous testing

VAADA acknowledges that the AOD system model developed does draw from previous evaluation of the Victorian system, however there is a strong view across the sector that the model was conceptualised within DH and failed to adequately be tested with the sector. There have been queries from stakeholders throughout the previous two years on the potential benefits of piloting a new system, potentially in a metropolitan and rural setting.

For example, the changes for intake and assessment are considered some of the most significant in the recommissioned system and despite the limited evidence put forward for a centralised model (and VAADA articulated failures in other sectors), and despite it not being fully described, it was implemented without further consideration.

Obviously the arguments presented are not intended to negate the need for innovation or formulation of changes meant to improve equity of access and ensure those in need are able to access treatment when it is required. However, in the current experience there did not seem to be the political will to pilot the proposed approach and initiate changes where required prior to the full roll out across the state. There is also concern in the sector that the model is based on a medical case mix approach which is not appropriate for a holistic psychosocial response.

Subsequently services have had to reshape their delivery and adapt to issues that have been presented since implementation. Whilst some may refer to this as 'teething problems', it is clear that many of the problems could have been avoided with a well thought through and tested model. At this stage it seems inevitable that the system which arises from the current reform will not address the fragmentation which existed in the past. The lack of an outcomes framework means the model and services cannot be evaluated for their effectiveness and furthermore, from the service user experience we have been able to glean so far, it will also be more complex to access and manoeuvre than the previous system. The failure of these two elements will necessarily remain a key focus for the foreseeable future.

1. Introduction to the project

In mid-2014, the Victorian Alcohol and Drug Association (VAADA) approached the Drug Policy Modelling Program, at the National Drug and Alcohol Research Centre, University of New South Wales to undertake a project exploring and describing issues and concerns related to the 2014 alcohol and other drug (AOD) sector recommissioning process in Victoria. This project commenced in July 2014 and concluded in November 2014.

Objectives

The project had three major objectives, to:

1. Describe the key stages and activities leading up to recommissioning of the Victorian AOD service system
2. Identify issues and concerns arising from processes during this phase, leading up to the release of the AOD Treatment Framework
3. Identify key issues arising from the re-commissioning process

Approach

The project involved a documentary review and group interviews with key stakeholders from the AOD sector.

Documentary review

We reviewed documents to identify major stages in the reform process and elements and features of the reformed system. Key documents include:

- Victorian Auditor-General's Report. (March 2011). *Managing Alcohol and Drug Treatment Services.* www.audit.vic.gov.au/reports_publications
- Victorian Department of Health. (January 2012). *Reducing the alcohol and drug toll Victoria's plan 2013–17*. www.health.vic.gov.au/aod/sectorreform
- Victorian Department of Health. (June 2012). *New Directions for Alcohol and Drug Treatment Services: A roadmap*. www.health.vic.gov.au/aod/sectorreform
- Victorian Department of Health. (August 2013). *New Directions for Alcohol and Drug Treatment Services: A Framework for Reform.* www.health.vic.gov.au/aod/sectorreform
- Victorian Department of Health. (October 2013). *Advertised Call for Submission. Delivery of selected alcohol and drug services in Victoria. No. 2487.* www.health.vic.gov.au/aod/sectorreform

We also used a range of additional documents, for example, Ministerial communiqué, information posted on web pages, and fact sheets. This includes information provided on the Victorian Department of Health website for the reform (www.health.vic.gov.au/aod/sectorreform) and on the VAADA website (www.vaada.org.au).

We also referred to an earlier document relevant to the reform, namely the *New Blueprint for Drug and Alcohol Treatment Services 2009-2013 Client Centred, Service Focused* *http://docs.health.vic.gov.au/docs/doc/9228A36CB98A6417CA2578A10013A10E/$FILE/blueprint09-13.pdf*

Group interviews

In preparation for project consultations, VAADA developed a tentative list of potential candidates for the interviews, aiming for participation from those in management positions and with specific roles in relation to the reform. These roles included being on one or more Advisory Groups for the reform, formulating and revising submissions for recommissioning, and planning for service implementation post recommissioning. Individuals and organisations were selected to seek a cross-section of

experiences in relation to funding success in the recommissioning; and a cross-section of organisations from metropolitan, statewide, regional and rural locations. Invitations were sent via email, to the identified individuals and (where relevant) their CEOs / executive managers.

We held four group interviews, involving 20 people from 18 organisations[1]. Participants were CEOs or senior managers at alcohol and other drug services located throughout Victoria. Six participants were from rural/regional organisations.

Each interview included 4-6 participants and took from 1 to 1.5 hours. In addition, two representatives from VAADA contributed to discussions in one of the group interviews[2]. Two of the group interviews involved some participants using teleconference facilities.

We covered six areas in the group interviews: background; pre-commissioning; recommissioning; transition; benefits and negatives of the overall process; and final comments (the Appendix includes the list of questions). The interviews were digitally recorded and transcribed for thematic analysis.

In this report, where key stakeholder information is presented we have identified the management level of the speaker. However information on their role, position, organisation and location is not included, for confidentiality.

Collaborative research approach

We used a collaborative process throughout the project, where VAADA identified key documents, suggested key stakeholders, and organised and hosted the group interviews. We designed the project, facilitated the interviews, analysed the data, and prepared the report. VAADA provided a timeline of key events (policy updates, meetings, etc), which we updated using project information, and they provided comments on the draft report regarding any inaccuracies or major omissions.

Prior to data collection, ethics approval was obtained from the UNSW ethics committee (application number 9_14_032).

Report structure

This report has six sections:

1. Introduction and method
2. Pre-commissioning
3. Recommissioning
4. Transition
5. Analysis, reflections, directions
6. References

[1] This is 19 of the 28 people/organisations originally invited to take part and an additional participant in a management role relevant to the project. Note that two organisations provided two participants each.

[2] To support the independence of project findings, their comments have not been included.

2. Pre-commissioning: key stages and activities

In this section we have described the impetus for reform, the consultation and policy development activities that occurred during pre-commissioning, and features of the policy reforms that were put forward. We have outlined major policy developments related to the reform up until the commencement of the tendering process in August 2013.

A long-standing interest in sector improvement

Since major reform in the early 1990s, the Victorian AOD sector has experienced substantial growth. By the mid-2000s there were 27 service categories (Ritter, et al. 2003). A number of major reviews were commissioned during the 2000s that provided direction for service and sector improvements (e.g., Ritter, et al. 2003; Berends, et al. 2004a; Berends, et al. 2004b) and, in 2008, the Victorian Department of Human Services developed *A New Blueprint for Drug and Alcohol Treatment Services 2009-2013 Client Centred, Service Focused* (the 'Blueprint'), which was explained as establishing the reform agenda. Blueprint authors noted that,

> Reviews undertaken in 2003 and 2004 found that the existing alcohol and other drug treatment system is fragmented with variable connections to the other welfare, health and employment systems required to support clients with complex needs. Rapid growth in the service system in the late 1990s and the early part of this decade may have exacerbated this fragmentation with agencies struggling to deliver a wide range of programs and initiatives. (Department of Human Services, 2008, p. 5)

The Blueprint set out a new plan for the sector, placing,

> Improved outcomes for clients, their families and their communities at the centre of that plan. Quality, evidence-based treatments and interventions are our tools for helping people to tackle their harmful substance use. Strong collaborations and partnerships help connect our clients to the wider range of health and welfare services they might need to successfully reintegrate into society" (p. 9)

Six priority areas were identified: prevention; improving access; excellence and quality; clients; children and families; and young people. Each area was accompanied by detailed plans showing actions, timeframes for completion, and key partners[3].

New impetus for reform

The Victorian election in late 2010 resulted in a new government and a continued interest in sector reform, consistent with a general interest in community sector change.

In March 2011, the Victorian Auditor-General's Department published a review of the state's alcohol and other drug sector that was entitled *Managing drug and alcohol prevention and treatment services* (Victorian Auditor-General's Office (VAGO), March 2011). Review authors noted there had been substantial policy inaction in the sector for some time, despite clear indications of substantial concern. While regular review and refinement were described as important for ongoing improvement, the report authors felt that, "the Department has no assurance that the service

[3] See http://docs.health.vic.gov.au/docs/doc/9228A36CB98A6417CA2578A10013A10E/$FILE/blueprint09-13.pdf for details. Accessed 22 September 2014

system objectives of effective case management and continuity of care for clients and consistent, high quality services, are being achieved" (VAGO, March 2011, p. vii). Particular issues pertained to the episode of care funding mechanism that, it was said, was not a good reflection of cost and did not allow for increasing client complexity. Instead, the mechanism encouraged a fragmented and episodic approach to care and there was a built-in incentive for data manipulation to meet funding targets in the context of under-costed units of care.

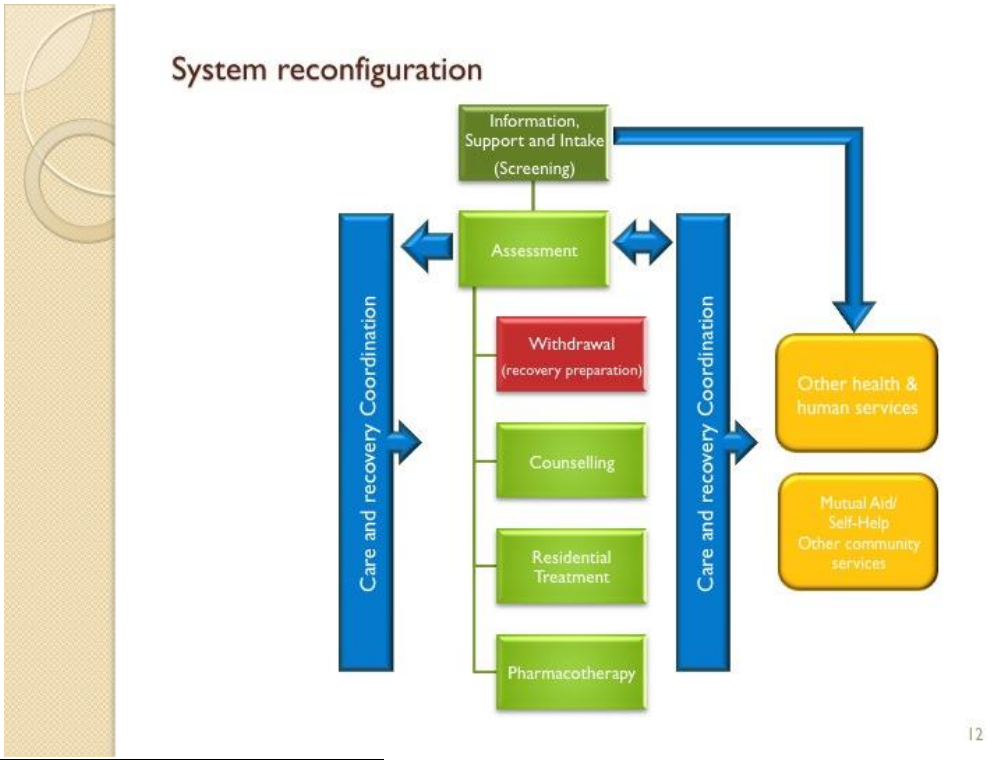
The VAGO review provided a major impetus for reform that built on the long-standing interest in change. The Victorian Government announced they had, "identified a need for greater cohesion and coordination in relation to alcohol and other drug policy and services, and as a result, has committed to develop a whole of government Victorian Alcohol and Drug Strategy as a high priority" (Department of Health, 2011)[4].

Preparing for reform

A number of activities were implemented in preparation for reform. A whole-of-government AOD strategy-planning group operated for twelve months. Soon afterward, AOD practice oriented Advisory Groups commenced. Key policy documents on the new system were released. In the meantime, a presentation from Victorian Department of Health personnel at the VAADA CEO's forum in August 2011 provided an early indication of how a reconfigured system may look (see Figure 1).

Figure 1. Department of Health presentation to CEO forum, 19 August 2011 (extract)

Source: Victorian Department of Health presentation: Revised treatment types. Treatment reform.



[4] This information is from the *Expert Advisory Group Whole of Government Victorian Alcohol and Drug Strategy Terms of Reference*. Available at: http://docs.health.vic.gov.au/docs/doc/B73250C8E552D575CA2578E200781781/$FILE/final%20EAG%20terms%20of%20reference%20for%20web%204%20august.pdf. Accessed 22 September 2014

This presentation flagged many of the changes that were to eventuate. As shown in Figure 1, there was a reduced number of treatment types and the addition of a discrete central intake and assessment function. Care and recovery coordination was highlighted as a major feature of the treatment pathway. Information shown later in the presentation detailed 'first steps' toward a new system, that include:

- Streamlined treatment types
- Common screening and assessment tools
- Recovery focused treatment planning and referral
- Coordinated and centralised intake, screening and assessment in each region
- Better use of technology with online self-assessment tools, brief interventions and referral pathways
- Access to screening and brief interventions through telephone helpline

Whole-of-government approach to AOD problems

Expert Advisory Group

A whole-of-government Expert Advisory Group (EAG) operated from July 2011 to June 2012, to support the development of a whole-of-government alcohol and other drug (AOD) strategy. Members (15) were largely from AOD services (4) or related service areas (e.g., pharmacy, medical health, justice), with a minority from business or local council positions[5]. The EAG, together with an Inter-Departmental Committee on Alcohol and Other Drugs, was tasked to:

> Identify current programs, collaborations and partnerships; utilise the plethora of existing reports as an evidence base for recommended strategies and future actions; identify issues across portfolios, including the portfolios relevant to supply reduction, demand reduction and harm reduction; identify areas for reform, gaps, and improvements to services for individuals, families and communities, and; conduct stakeholder consultation including public forums[6].

A series of community meetings and consultation fora were held and a submissions process took place, late in 2011[7].

VAADA undertook further community consultations to inform strategy development, from late January to late February 2012. The consultations included group discussions, an online survey, and vox pops. The report authors[8] highlighted participant concerns about AOD related problems. For example, in response to the question "with regard to tackling alcohol and other drugs issues, is the government getting it right" around two thirds of survey and vox pop participants answered 'no'. Almost all consultation participants felt that, "there are urgent changes needed to the way Victoria

[5] This information is from the *Expert Advisory Group Whole of Government Victorian Alcohol and Drug Strategy Membership List*. Available at: http://docs.health.vic.gov.au/docs/doc/EAG-membership-list Accessed 28 November 2014

[6] This information is from the *Expert Advisory Group Whole of Government Victorian Alcohol and Drug Strategy Terms of Reference*. Available at: http://docs.health.vic.gov.au/docs/doc/B73250C8E552D575CA2578E200781781/$FILE/final%20EAG%20terms%20of%20reference%20for%20web%204%20august.pdf. Accessed 22 September 2014

[7] This information is from the Victorian Department of Health website. The consultation documents and report on the consultations are no longer available. See http://www.health.vic.gov.au/aod/strategy/. Accessed 22 September 2014

[8] See Victorian Department of Health (February 2012). *Whole of Victorian Government Alcohol & Drug Strategy Community Engagement: Key Themes Report - February 2012*. Available at, http://docs.health.vic.gov.au/docs/doc/B1DD24D5BCE87EF0CA2579C30010B278/$FILE/VAADA%20engagement%20report%20-%20Feb%202012.pdf Accessed 22 September 2014

tackles issues around alcohol and other drugs" (Victorian Department of Health, February 2012, p. 28).

Whole-of-government AOD strategy

A whole-of-government strategy, entitled *Reducing the alcohol and drug toll Victoria's plan 2013–17,* (the 'Strategy') was released in January 2012. The Strategy,

> Sets out how the Victorian Government will work with the community to bring down the alcohol and drug toll and deliver better health outcomes to thousands of Victorians who want to recover from the harm associated with alcohol misuse and drug use. The plan identifies actions for building resilience among Victorians, particularly young people by fostering a healthy culture of individual responsibility. (Department of Health, January 2012)

The Strategy was essentially a 15 point plan which had action oriented items that were organised into five areas: leadership; pharmaceuticals; illegal drugs; care, treatment and recovery; and alcohol. With regard to 'care, treatment and recovery', the actions were as follows:

- Set new directions in alcohol and drug treatment services so they are more cost-effective, person-centred and supportive of recovery by individuals and families
- Provide more person-centred care, especially for vulnerable families by progressively delivering more connected care across social services to reduce the impact of substance misuse on families and communities
- Support community-based action to address social factors driving substance misuse to deliver targeted, culturally appropriate services to communities
- Promote recovery and reduce stigma in the community to support people as they recover from addictions. This work will be modelled on the success of beyondblue's work with depression. (Department of Health, January 2012)

AOD sector policy: Roadmap

In June 2012, another major policy was released, entitled the *New directions for alcohol and drug treatment services. A roadmap (*the 'Roadmap'). In the Foreword to the Roadmap, Minister Wooldridge explained that, the document "sets out our framework for the reform of Victoria's alcohol and drug treatment system…focusing on the things that will make an immediate and significant difference" (Department of Health, June 2012, foreword). The Roadmap made the case for sector reform and outlined directions for system change, while outlining the consultative approach planned for working with others to enable that change.

The Roadmap included a description of an expressed need for AOD sector reform and matched key issues that were identified in the VAGO report with proposed responses to be realised through AOD system redevelopment (Department of Health, June 2012, p. 17). Table 1 shows the key issues synthesised from the VAGO report and a summary of responses (focusing particularly on stage one of recommissioning).

Table 1. Key issues for AOD sector reform identified in the VAGO report and planned responses

Source: Roadmap document (Department of Health, June 2012)

Issue (VAGO report)	Response	Notes
The system is not integrated or responsive to individual needs	Person-centred and family-inclusive treatment Holistic treatment planning New care and recovery coordinators (C&RC)	Treatment planning that accounts for family members AOD treatment part of the DHS's "new holistic response" C&RC providing care coordination or intensive case management as part of this integrated response
The system is fragmented and complex	Six core treatment types Clearer, simpler treatment pathways Recommissioning services for joined up pathways	Reduction from more than 20 service types Regional intake systems and local treatment networks Recommissioning framework for purchasing integrated treatment services against core service types to achieve a joined-up pathway for clients
The system is difficult to access and navigate	Central telephone intake Regional/area intakes Self-help online screening and support	Statewide service Regional intake systems On-line tools
Quality of service provision is inconsistent	Recommission for quality Standardised screening and assessment	Consolidate service types Standard tool
The service mix is not aligned to community needs	Future planning based on needs More flexible funding streams to allow local response and innovation	Regional plans, linked to health and hospital plans and to human services planning Accounting for local population needs
A workforce strategy is required	New strategy Focus on family-inclusive practice	Workforce framework
Service pricing and performance measures need review	Core services repriced Performance measures to be adapted over time	New funding model that demonstrates what is being bought and to what benefit

According to the Roadmap, the reformed system would deliver AOD treatment that is,

- Centred on the person, family and culturally inclusive, and oriented toward recovery
- Accessible, easy to navigate
- Of a high-quality and based on evidence
- Integrated with the other health and human services that people need
- Designed to intervene when problems are first detected
- Sustainable and responsive to community needs
- Connected to services and programs that can help build bridges to treatment
- Delivered by a skilled and competent workforce (Department of Health, June 2012, p. 2)

A two-year program of reform was described that included a number of key actions, "to achieve a better alcohol and drug treatment system for Victoria" (Department of Health, June 2012, p. 5). These actions involved:

1. Changing the treatment system's models of practice so that it becomes more centred on the person, more family and culturally inclusive, and oriented towards recovery
2. Ensuring children of people in treatment become core business for our services
3. Establishing a central telephone intake and triage service to refer people to the most appropriate service and developing options for regional or area-based intake to support improved treatment pathways
4. Introducing common screening and assessment tools in specialist alcohol and drug treatment services and in the other settings where people with alcohol and drug problems are likely to present
5. Putting in place a central bed vacancy register to better utilise bed-based services and ensure joined-up care pathways for clients
6. Rolling out new counselling programs in Barwon-South Western and Eastern Metropolitan Regions
7. Redeveloping pharmacotherapy services
8. Instituting new hospital and community diversion programs to intervene earlier with people identified as at risk
9. Strengthening web-based information, self-help and referral services
10. Working with the Departments of Human Services, Education and Early Childhood Development and Justice, as well as with the Commonwealth, to fully exploit the opportunities for better integrated and joined-up services
11. Purchasing integrated treatment services at an area/regional level that are connected to statewide and highly specialised services
12. Developing new service specifications for core treatment types
13. Redeveloping the youth alcohol and drug treatment system to achieve earlier intervention and better integration with the other services that young people need
14. Drawing together a quality framework for treatment that builds on existing quality standards
15. Releasing a new workforce development framework and implementation plan

In the Roadmap, the Department of Health outlined a consultative approach to shaping change. It was noted that the next steps would involve working in partnership with VAADA, APSU and other peak agencies, while engaging consumer, families, delivery agencies and key partners to, "explore how we can successfully implement these reform directions and achieve transformational change in the delivery of alcohol and drug treatment services in accordance with the guiding principles" (Department of Health, June 2012, p. 31).

It is also worth noting that the Roadmap (Department of Health, June 2012) provided a brief description of the system as at 2010-11. Key points include:

- Over $112 million invested in AOD treatment services in 2010-11, increasing to more than $116 million in 2011-12 (and $146.4 million in 2012-13; Ministerial media release, 8 June 2012)
- More than 28,000 clients in treatment, 43.5% of whom were new to treatment
- More than 13,000 clients in pharmacotherapy treatment
- Around 49,000 courses of treatment delivered

- AOD services provided by more than 100 agencies, involving 39% NGO, 29% community health services, 20% health and hospital services, and 10% Aboriginal community-controlled organisations

In a press release from November 2013, the Premier of Victoria reflected that the Roadmap was a landmark document regarding,

> How the Victorian Government and community sector service providers can work together to improve the lives of vulnerable Victorians…[providing] a thoughtful analysis and resulting recommendations on how through better collaboration, Government and service providers can develop a more effective, efficient and innovative service system[9].

Sector Advisory Groups

In July 2012 a number of Advisory Groups were convened. While there were originally eight Advisory Groups, two were suspended early on as they were about service types that were not in stage one of recommissioning. While the original intention was for the groups to meet three times over a 12 month period (Victorian Department of Health, not dated) the counselling and withdrawal groups each met five times while the intake and assessment and care and recovery groups each met four times. The meetings were held between July 2012 and March 2013 (see Table 2).

The Department of Health prepared notes from the initial two meetings of these groups (that occurred between August and October 2012), which were available on the VAADA website. The Department also prepared summary papers based on all meetings of the groups and these summary papers were available on the VAADA website.

Table 2. Advisory Group meetings for core service types in stage one of recommissioning

Service type[a]	Number of meetings[b]	Meeting dates	Number of meetings with notes[c]
Counselling	5	Jul 2012 - Feb 2013	2
Intake and assessment	4	Jul 2012 - Feb 2013	2
Withdrawal	5	Jul 2012 - Mar 2013	2
Care and recovery	4	Jul 2012 - Feb 2013	2
TOTAL	*18*		*8*

Notes. [a]Only treatment groups in stage one of recommissioning have been included in the table. [b]The summary papers noted the number of meetings that were held. [b]Notes from the first two meetings of each group show the dates of these meetings (see VAADA website www.vaada.org.au Accessed 22 September 2014).

The service sector reform project

During this period of AOD planning and policy development, broader reforms were underway. In late 2012, Minister Wooldridge commissioned senior academic and former public servant, Professor

[9] *Roadmap to improving lives of vulnerable Victorians. Media release*. Premier Dennis Napthine, 1 November 2013, http://www.premier.vic.gov.au/media-centre/media-releases/8308-roadmap-to-improving-lives-of-vulnerable-victorians.html. Accessed 22 September 2014

Peter Shergold, to lead the 'Service Sector Reform project'. This project was part of a reform agenda set out in the policy entitled *Human services: The case for change* (December 2011, Department of Human Services[10]), which detailed an argument for systems-level change (i.e., involving multiple government and community sector health and human service systems) that involved targeting the disadvantaged and operating from an integrated model. The 'Case for Change' policy described several major concerns about the existing approach to service delivery in human services, including: system fragmentation and poor coordination; a program orientation rather than people focus; workforce constraints; holistic service delivery not being consistent with existing program-centred silos; a focus on immediate presenting problems rather than underlying issues and longer term outcomes; the potential for service delivery arrangements to encourage dependency; and inequity of effort by level of need.

The project led by Professor Shergold focussed across services and systems and sought to optimise responses to high need individuals. The project goal was, "to explore how government and non-government service providers can work together to improve outcomes for Victorians", involving "a process engaging all stakeholders in a discussion about community and human services and in particular, to examine how support for Victoria's most vulnerable people could be delivered in a more integrated way" (Shergold, 2013, p. 4). Methods included the development of a preliminary paper, which was used to guide consultations, and a request for written submissions. Ultimately, around 700 people took part in consultations and 100 submissions were received (Shergold, 2013).

The Service Sector Reform project report was released in July 2013. There were two overarching messages. First, it was important to maintain the momentum for reform – the opportunity for major change and the multiple reforms already underway. Second, cultural change was required, to develop a genuinely collaborative approach (involving "greater collaboration between public service agencies and CSOs" (p. 15), with a shared understanding that client need comes first, and improving working relationships between public servants and community sector employees. Shergold noted that many consultation participants argued that, "high-level statements of collaborative intent were sometimes not matched by the conduct of the public servants actually involved in the contracting and oversight of social services" (p. 16) while public servants expressed concerns about a lack of sector understanding regarding the constraints and pressures they face. Shergold (2013, p. 16) concluded by saying that, "the behaviours underlying partnership need to be clearly stated and extended to all aspects of collaboration, from the joint development of public policy through to program design, implementation arrangements, evaluation and accountability processes".

The report included a statement of ten partnership principles and a set of 25 recommendations. Briefly, the principles involved:

1. Achieving the best outcomes for clients
2. A holistic (joined-up and wrapped-around) approach
3. Partnership (a collaborative relationship between public service agencies and NGOs)
4. Shared governance (where all providers of publically funded services should be regarded as 'co-producers' of services)

[10] Department of Human Services (December 2011). Human services: The case for change. http://www.dhs.vic.gov.au/__data/assets/pdf_file/0007/679813/1_iwas_human_services_case_for_change_0412.pdf. Accessed 6 October 2014.

5. Provider choice (including a range of providers)
6. Program flexibility (responsive to local need)
7. Citizen control (encouraging clients to take greater control of services they require)
8. Public accountability (focusing on agreed outcomes)
9. Early intervention
10. Facilitation (public service in stewardship role) (see Shergold, 2013, p. 17)

The recommendations were about:

1. The statement of principles (see above)
2. Collaborating on service design
3. Embedding partnership
4. Monitoring the reform process
5. Strategic and facilitative government approach to commissioning
6. Delivering services through NGOs
7. Simplifying regulation and processes
8. Standardising contracts
9. Providing support to collaborative service delivery
10. Focusing on results and funding for outcomes
11. Pricing service delivery
12. Enhancing productivity
13. Supporting CSOs
14. Capacity building
15. Transforming public service leadership
16. Making better use of information and communications technology
17. Enhancing online community participation
18. Designing excellence
19. Encouraging new forms of social finance
20. Supporting flexible service delivery
21. Focusing on the most troubled families
22. Empowering service users
23. Improving local area governance
24. Valuing cultural competence
25. Acknowledging community voice (see Shergold, 2013, pp. 47-51)

Funding model development

Finally, it is worth noting the planning work on funding for AOD services. As part of the preparations for reform, the Department contracted an external consultant (Aspex Consulting and Health Policy Solutions) to work on a new funding model for Victoria's AOD services. A reference group was convened in relation to the consultant's new funding model work; "made up of representatives from a range of AOD agencies, reflecting the key service types under discussion" (Department of Health, May 2013, p. 3). The group met in April 2013.

Policy direction

In combination, this series of policy documents spoke to the context for change; the drive for integrated services across community health and human services and the need to make best use of limited resources to deliver positive and enduring outcomes. As noted in the Roadmap (Department of Human Services, June 2012, p. 11),

> Achieving better outcomes for our clients requires that the reforms we undertake in the alcohol and drug treatment system link with and complement other reform work being

undertaken by the Victorian Government, particularly the groundbreaking reform in the human services system, reforms outlined in the *Victorian Health Priorities Framework 2012-22,* mental health reform and key strategies in justice.

Translating policy: The Framework

In August 2013, fourteen months after the Roadmap and one month following the Shergold report, the *New directions for alcohol and drug treatment services. A framework for reform (*the 'Framework') was released. In the foreword to the Framework, Minister Wooldridge noted that "change in the alcohol and drug treatment sector is taking place in step with the broader government reform agenda for Victoria's health and human services" and that planned reforms were consistent with directions in the Shergold report (Department of Health, August 2013, foreword). In other words, there was a consistency in policies developed across the health and human services and those specific to the AOD sector.

The Framework document heralded the move toward recommissioning and included a description of key elements. It provided, "a plan for reform of the adult community-based treatment system" (Department of Health, August 2013, p. 1); an explanation of the first stage of recommissioning and the sequence of activities involved. The Framework included a description of:

- The consolidation of existing service types to core treatment types
- The catchment-based intake and assessment service
- The need for an integrated response (e.g., with areas such as primary health, child protection, employment, and housing)
- Workforce development strategies
- Quality tools and mechanisms in place or in development
- The shift from outputs to outcomes
- Expectations regarding information management and sharing

A number of developmental projects were also identified in the Framework, to: address screening and assessment; undertake analysis and modelling to inform planning; design an activity-based funding model; and enhance information collection, management and reporting (Department of Health, August 2013, p. 5). The Framework authors noted that the service specification for the recommissioning process would specify funds by catchment, the price offer for each program or function, and criteria for evaluation, as well as minimum requirements (p. 25).

Summary timeline of key activities and events leading up to the Framework

As reflected in the information above, the period before the release of the Framework involved many activities and events; it was a busy time both for the public service and for sector stakeholders. A summary of these activities and events is shown in Figure 2.

Figure 2. Summary timeline of key activities and events pre-commissioning

DATE	POLICY DEVELOPMENTS	FORMAL (GROUP) CONSULTATIONS	INFORMATION SHARING / INFORMAL CONSULTATIONS / OTHER ACTIVITIES
2008	• Blueprint released		This policy, produced by the previous government, is symbolic of the intention to effect change
Jan-Jun 2011	• VAGO report published (Mar 2011)		
Jul-Dec 2011		• Whole-of-government Expert Advisory Group commences (Jul 2011)	• VAADA CEO forum with Departmental presentation on reform (Aug 2011) • Initial, one off meetings between the Department and key people from the sector focusing on service types (Oct-Nov 2011) • Community meetings and consultation fora to inform the whole-of-government strategy (from Jul 2011)
Jan-Jun 2012	• Strategy released (Jan 2012) • Roadmap released (June 2012)	Whole-of-government Expert Advisory Group concludes (Jun 2012)	• VAADA holds community discussions, on-line survey, vox pops to inform the whole-of-government strategy (Jan-Feb 2012) • Department provides presentations on Roadmap (Jun 2012 onward)
Jul-Dec 2012	• CSO service sector reform project commences (Shergold, Dec 2012)	• AOD Advisory Groups commence (Jul 2012)	• Extensive consultations undertaken to inform the service sector reform project (Dec 2012-Feb 2013) • VAADA facilitates on-line consultation regarding the key questions being proposed in Advisory Group meetings • AOD treatment principles consultation paper released (Sep 2012)
Jan-Jun 2013	• Draft AOD principles released (Feb 2013)	• AOD Advisory Groups conclude (Mar 2013) • Specially convened Advisory Group meets with external consultant regarding funding model (Apr 2013)	
Jul-Aug 2013	• Service sector reform project report published (Shergold, Jul 2013) • Framework released (Aug 2013)		

The sequence and pace of policy development is apparent, with the period from January 2012 to August 2013 involving four major policy releases (Strategy, Roadmap, Shergold report, Framework).

Analysis and stakeholder views

Key stakeholders spoke about the sector's readiness for change. They voiced a number of concerns about the pre-commissioning stage of the reform process. There was considerable discussion on the decision-making approaches guiding the reform; about the amount of attention given to problem and solution definition and the approach to consultation as the process unfolded. On a related issue, there was extensive discussion on the role and usefulness of the sector Advisory Groups. Some stakeholders commented on staffing changes in the Department and the timetable for reform, as well as the gap between seeking change and arriving at an agreed / appropriate model for the sector. These areas are described below.

Seeking change

In the group interviews for this project, stakeholders commented on the long-standing interest in change. They noted the significance of the VAGO report as a marker for action. One senior manager explained that, "the sector had been involved in being fairly critical about a number of areas of the drug treatment sector. And the VAGO report really captured a lot of our views and feedback from over a number of years and really pulled that all together". Many stakeholders felt there was a shared enthusiasm for change, across the sector and in the Department. For example, a manager commented that, "the sector was really on board [saying] 'we want change, this is great, we're with you and we're ready for this'".

Insufficient process to define problems and arrive at solutions for the service system

The stakeholders generally felt there was a lack of consultation prior to recommissioning to fully understand factors underpinning problems in the sector and to arrive at appropriate solutions.

This perspective was reflected in comments about the way the new system model was developed. A senior manager explained that, "the model was developed so quickly in response to the VAGO report, it was a knee jerk reaction and therefore very quick development and then to consultation which is simply, they have an idea of what they want to do and they consult with us….a lot of the model was unclear".

This perceived process gap, to fully comprehend the problem and enable the consideration of possible solutions, was explained by a CEO as follows,

> I think we missed the fact that they went from, 'here's the problem' to 'we're going to fix it this way'. And there was no conversation around, 'what is the cause of these problems' and, 'what is the potential range of solutions that are available'. So it was very old school in terms of the government saying well, 'given input, here's the problems' (you know, access, fragmentation, etc and most of us agreed with that) but it very quickly went from that to 'we are going to recommission', a spill and fill tendering process and, 'we're going to get you to help us specify and design that system'. And people seemed to go, 'ok, we're ready for change, we want it, let's do that'. And in hindsight, it made much more sense for us to say 'yep, here are all the problems. What's causing them?'

One senior manager explained that, while "there was a range of documents and reviews that had been undertaken", there was insufficient shared dialogue to identify appropriate solutions. This senior manager felt that,

> There was very little action in terms of working with the Department and providers. A gulf of difference in how this is going to translate. What is the exploration around plugging those gaps? Very little joint work to come up with solutions and then silence because of reform. Consultation and a range of options were not put forward prior to the reform being announced.

Consistent with these views, a number of stakeholders raised information and resource gaps that they would like to have seen addressed early in the reform process. It was noted that some demand modelling work was underway, however findings were not available throughout the commissioning process (and there was a commonly held view that the data were flawed). Similarly, a performance management framework was in development and some stakeholders felt that this would have been useful early in the process, to guide the establishment of outcome measures and facilitate the demonstration of sector improvements post reform.

Conversely, one CEO felt that there was too much consultation and that it was ineffective. She/he commented that, "it would have been easier if the Department had said, 'this is what we want to buy, this is what it's going to look like, here it is in black and white'. I see it in other programs; an exposure draft. [The Department says] 'this is what we're thinking and you have four weeks to give us feedback. We'll consider that and then we'll put out the final version'. That, to me, is consultation". Building on this perspective, another CEO felt the usefulness of some meetings and consultations was not clear. They said,

> There was a lot of meetings. And a lot of uncertainty. Lots of consultation but you weren't really sure if the consultation was meaningful or whether there was a fixed agenda or how it would manage up. Throughout that system the rigidity of the intake and assessment service model was not clear. The process was rushed at the end. Some meetings were not helpful. You can over consult as well, there were a lot of meetings where it was like, 'we've already talked about this'.

Inconsistency in the nature of the approach to reform was expressed by a number of stakeholders. For example, one CEO explained that the Department moved between an autocratic and collaborative approach and that this didn't work well for anyone. This stakeholder said that,

> There is confusion around what is the actual mechanism for recommissioning that they've used. It's largely an old school model but they're trying to slot in elements of a modern approach to it, which contradict or overlap or don't make sense. Either you say, "here's the specs and you create the model and deliver", as long as you deliver the outcomes it's up to you what you deliver in the model. Or, you have a partnership approach where you say "here's the money, let's sit down and figure out the best way to use it". There's some mixture of the two and it just doesn't work when you mix them up because one minute you're coming to a solution and then they're coming in with a "no, it's like this" autocratic expectation. So you keep going back between partnering and then, "*bang*, just do what you're asked"'.

The Advisory Groups

Many stakeholders had been members of one or more of the Advisory Groups. There were few positive comments about this aspect of the reform process and considerable concern. Much of this concern reflected uncertainty about the role of the groups.

There was a generic set of Terms of Reference, for the groups, which described their role as follows,

> Provide advice on how the alcohol and drug treatment reform program can be successfully implemented. They will identify any issues, opportunities, obstacles or factors to be considered in the implementation of key reform proposals and assist the department in problem solving issues that arise (Department, not dated).

This role description suggests the groups' focus was on implementation rather than model development and this was reflected in some of the comments from stakeholders. For example, one senior manager explained that, "people were only asked to comment on something already put up. It wasn't like you would start at the beginning and say, well 'let's design something'". Similarly, a CEO commented that the Advisory Group process was "perfunctory in the end". A senior manager noted that, while the groups were consulted about some things, they "did not contribute to the development of things particularly".

These comments reflect a level of confusion regarding the purpose of the Advisory Groups. Comments from one CEO provide a useful illustration,

> It was definite, that feeling. That people couldn't see. In the Department's defence, they were very clear that these were not decision-making mechanisms. They were really clear, 'Thank you for your input, but we will now take that away and make decisions around it'. There were conversations around that period on, 'what sort of impact are the conversations having?' Cos they weren't reflected in the minutes, for example, or they weren't being reflected in what was being fed back. So there was genuine concern.

This perspective links with other comments on the purpose and intention of the Advisory Groups. For example, a CEO said that, "we don't know where that feedback loop went" and another CEO noted that "it seemed like they chose bits and pieces of the feedback, cos it was never presented back". Some stakeholders noted that the meeting notes did not reflect the discussions at the meetings or the details in the service specifications used in recommissioning, with one senior manager stating that, "I was on several of those working groups and I cannot see at all that the view of those working groups has been held in the final model". Similarly, one stakeholder commented that while consumers and carers were represented on the Advisory Groups, they struggled to see how the meeting notes and summaries reflected their input.

> One comment we got from a lot of consumers and carers generally, and a lot of other staff…they talked about wondering how the decisions reflected in the specs [had been informed by their input]…not defined to them how much impact them being on an Advisory Group would have and there was quite a bit of disappointment in some of the stuff they'd raised…there wasn't a real connect between the activity in the Advisory Group and in the specs in the view of several people I spoke to.

Confusion about the Advisory Group role and process was also reflected in comments about the groups ceasing unexpectedly, or at least suddenly. One senior manager felt the group they were in,

"was not completed" and, although another meeting was planned, the onset of probity meant, "there was no talking. It hadn't finished".

Some stakeholders expressed frustration with the groups, in that their efforts to obtain information or resolve an implementation issue were unsuccessful. One manager felt that they, "obtained pieces of information [at the meetings]. We felt we had to ask the right questions to get the next piece of information to have a stab at how it was going to work". Similarly, a CEO said that, "when they would propose something we would ask, 'well how does that work on the ground given X,Y,Z? How do you operationalise that?' And we'd usually give some real life examples. And I think they got to the stage where they couldn't answer any of it and so they [the groups] petered out very quickly. There was no dialogue".

This expansive set of views regarding the Advisory Groups, along with their timing after the release of the Strategy and Roadmap, suggest that while stakeholders felt their input to the reformed system design was needed the groups were not intended to inform system design. Instead, their focus was meant to be on implementation and how services would look 'on the ground'. This information could inform the Framework document and ultimately the service specifications for recommissioning.

Loss of capacity in the Department and a set timetable for change

Many key stakeholders commented on the loss of Departmental staff part way through the reform process and the associated loss of critical expertise and leadership regarding reform discussions with the sector. Retrenchment packages in the public service meant a substantial reduction in the resources (people) available, with one CEO suggesting the Department's reform team was reduced "from something like 16 down to 3 or 4". Similarly, a senior manager explained that as they observed the Departmental changes their confidence in the process reduced. They said, "it was really a very experiential experience of, 'wow, this is starting to be a bit of a challenge in terms of how we are going to get this over the line'". Added to this pressure was the Department's apparent commitment to achieve change within set timelines. One CEO summed up these concerns as follows, "so you've got half the bureaucrats, people who know nothing, but an absolute commitment to stick to those timelines and make it happen on time", while another said, "I think they lost such a lot of corporate knowledge and reform knowledge with the decimation of the team that they crashed through".

Conclusions

The work leading up to sector reform occurred over a number of years. Although our analysis is based principally from the release of the VAGO report in 2011, it is worth noting that other processes of review and planning occurred in the previous decade and contributed to the interest in and foundation for change and renewal.

An intensive period of AOD system planning took place following the VAGO report and this resulted in major policies on AOD sector priorities and directions, principally the Strategy and the Roadmap. Meanwhile, broader community sector reform was under way and a human services review project (Shergold, 2013) emphasised government priorities including holistic and integrated models of care that functioned across systems and targeted the most vulnerable and disadvantaged. The end of

pre-commissioning for AOD services was marked by the Framework document, which outlined the implementation phase of the reform process.

While the human services review emphasised strategies for reform that involved collaborative relationships with providers and meaningful consultation, operating from a partnership approach (Shergold, 2013), AOD stakeholders had substantial concerns about the extent to which consultations were meaningful. There had been consultations prior to and for the VAGO report. There were Departmental presentations and roadshows preceding and linked to policy releases. Advisory Groups had been carefully convened and designed to engage in consultation on major service types, with mechanisms to share meeting notes and summaries.

However, the significance of the Advisory Group (and other AOD) consultations was not clear. According to the terms of reference, the Advisory Groups were meant to be about implementation. From stakeholder comments, there were concerns about the purpose of the groups and that the information discussed during meetings was not reflected in subsequent reform documents and approaches. Further, discussions about some implementation challenges - that would benefit from practice manager input - may not have occurred.

Our findings suggest it is difficult to know what is in focus at the time unless you are fully aware of the various steps in pre-commissioning and of the Department's view regarding the approach to change (i.e., consultative or not). Added to this is the dynamic nature of the reform environment given broader policy priorities and allied reforms.

In conclusion, it is apparent that government largely put the design of the new system forward. The Advisory Group process was intended to be about model implementation, however those involved were not clear on this intention and implementation issues were not always canvassed.

3. Recommissioning

This section is about the conditions in the call for submission and phases in the selection of providers. It covers the period from the Advertised Call for Submission in October 2013 to completion of the commissioning process in June 2014.

The Advertised Call for Submission

Recommissioning commenced in October 2013, with the release of the *Advertised Call for Submission. Delivery of selected alcohol and drug services in Victoria. No. 2487* (ACS) (Department of Health, October 2013). The ACS covered adult non-residential service types, these being counselling; care and recovery coordination; and non-residential withdrawal; and two whole of catchment functions, catchment based intake and assessment, and a catchment based planning function[11].

The recommissioned system included substantial changes to the definition, organisation, and funding arrangements for adult non-residential alcohol and drug services. According to the ACS, features of a reformed service system would address six priority areas, namely to:

1. Simplify and streamline the system

2. Integrate alcohol and drug treatment into the broader health and human services system

3. Strengthen the alcohol and drug treatment workforce

4. Underpin practice with quality tools and mechanisms

5. Shift accountability for service provision from outputs to outcomes

6. Manage information and data effectively (Department of Health, October 2013, p. 8)

Key elements of the reformed system are shown in Table 3.

[11] Residential withdrawal, residential rehabilitation and youth-specific alcohol and drug treatment services would be considered in stage 2 of recommissioning. A list of 15 programs and treatment types that were entirely out of scope from recommissioning was shown on pages 12-13 of the ACS. (Department of Health, October 2013, p. 12-13).

Table 3. Key elements of the alcohol and other drug system, as identified in the call for submission

Source: Department of Health (October 2013)

In the ACS, key elements of the reformed sector would include:

- A reduction of treatment types to categories supported by the evidence and aligned with clear therapeutic / support functions
- A move toward local planning, by allocating funds (and thus services) according to 16 geographical catchments (9 in metropolitan Melbourne, and 7 in non-metropolitan areas)
- The introduction of centralised intake and assessment services at statewide and catchment levels, to provide a visible 'front end' to treatment and divert clients to the most appropriate services and systems according to need. Intake and assessment to include telephone and on-line modalities
- A mandatory *Adult Alcohol and Drug (AOD) Screening and Assessment Tool,* which includes a two-step process and provides a foundation for mid-treatment and post-treatment review
- A single price common counting tool, the Drug Treatment Activity Unit (DTAU; $644 in 2013-14)
- The price of all services has been expressed as a multiple of this unit price and weightings have been used to arrive at the final price for completed activities (e.g., the weighting for 'counselling – standard (course of counselling)' is 0.91, meaning that the activity price is $644 x 0.91 = $586). There are price modifications according to client complexity, Indigenous background, and forensic status
- Two classifications of clients ('standard' and 'complex') that are determined at intake and assessment and have implications for the intensity of counselling (and associated price) and eligibility for care and recovery coordination
- Some flexibility in the allocation of DTAU, as only 80% of an organisation's DTAU would be tied to specified activities. The remaining 20% would 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 DTAU, (Victorian Department of Health, October 2013, p. 20)
- A catchment-based planning function that would be funded via a block grant

The Annex to the ACS included a statement of treatment principles, a description of the target client group and a statement of outcomes, as well as a description of 'in scope functions' (service types). It outlined the way each treatment stream would fit together in the new system. For each service, there was an overview, set of general objectives, key features, function, and an outline of the funding model and accountability. An example is shown in Table 4.

Table 4. Description of counselling

Source: Annex 1: Department of Health. Advertised call for submission no. 2487 (October 2013, pp. 15-17)

Overview

The Victorian Government is seeking to appoint Service Providers to deliver catchment-based alcohol and drug counselling services. Counselling services will be located in each of the 16 catchments.

Where the catchment based intake and assessment unit assesses a person as needing counselling, they will be referred for this service. The counselling stream incorporates face-to-face, online and telephone counselling for individuals and families, as well as group counselling and day programs.

Counselling is classified as standard or complex and duration can range from a brief intervention/single session to extended periods of one-to-one engagement or group work.

The new counselling stream comprises the existing counselling functions that currently sit within Generalist, Forensic, and Therapeutic Counselling, Consultancy and Continuing Care types and Family Counselling.

Clinical assessment and review is an ongoing process throughout the service period and this information will be shared with other services, where appropriate.

At completion of counselling treatment, clients will leave with an exit plan or will continue to work with the care and recovery coordination function for further supported referral.

Objectives

The counselling stream aims to support positive behavioural change in the AOD client through:

The delivery of evidence-based therapeutic counselling interventions to clients and their families

Working collaboratively with clients and their families.

Key features

The key features of the counselling stream include:

- The delivery of robust, evidence-based, therapeutic individual, group and family counselling interventions
- A focus on recovery-oriented care
- Priority access for 'complex' clients and those transitioning to and from bed-based services
- The use of new technologies as an adjunct to counselling

Functions

The Counselling stream will, at a minimum:

- Operate Monday to Friday during standard business hours and demonstrate capacity for after- hours service
- Deliver therapeutic counselling interventions of varying duration and intensity to individuals, families and groups
- Liaise with care and recovery coordination regarding care planning, referrals and progress and to prevent duplication of service as required
- In collaboration with the client and their family, build on the client's initial treatment plan to:
  - Determine details of the type of counselling interventions required to address the therapeutic needs of the person, building on the plan provided at intake and assessment
  - Deliver evidence-based psychosocial interventions including but not limited to brief interventions, cognitive behavioural therapies, community reinforcement therapy, contingency management, motivational enhancement therapy, social behavioural therapy and group work
  - Undertake exit planning
- Work flexibly to meet people's varying needs, including on an outreach basis as appropriate
- Provide secondary consultation where required
  - Make follow up contact with standard clients at 3 and 12 months post treatment exit to:
  - Track progress of recovery post-treatment
  - Support re-engagement with alcohol and drug treatment services or other supports, where appropriate

The treatment streams in the recommissioned system were described as comprising one or more products, each of which has a counting unit (e.g., completed referral, course of counselling). These products were subject to funding using a "defined multiple of Drug Treatment Activity Units" (Department of Health, October 2013, p. 19). According to the ACS, the prices were intended to cover direct, fixed costs and overheads. The DTAU for 2013-14 was $644. The weighting and price for DTAUs in 2013-14 is shown in Table 5.

Table 5. Drug Treatment Activity Unit Prices, 2013-14

Source: Department of Health, October 2013, p. 19

Product	**Price 2013-14 AUD**
Intake and referral	
- phone	59
- face	59
- internet	46
Comprehensive assessment and initial treatment plan	503
Care and recovery coordination	1,431
Counselling	
- standard	586
- complex	2,198
Withdrawal	
- standard	547
- complex	1,368

Returning to the counselling service type outlined above, details on funding that were shown in the Annex document are included in Table 6, below.

Table 6. Funding arrangements for counselling

Source: *Annex 1: Department of Health. Advertised call for submission no. 2487 (October 2013, p. 17)*

This function will be funded through an activity-based model based on courses of counselling.
Payment will be made on the basis of a standard fixed price. A price will be set for a course of counselling. Where counselling is delivered through day or group programs, the number of courses accounted for should be on the basis of the number of participants divided by the number of EFT required to run the group.
There are two prices for counselling, based on whether the comprehensive assessment conducted as part of the intake and assessment function by either the catchment based intake and assessment service or by the ACSO [intake service for forensic clients] identifies the client as being complex.
Standard counselling price: $ 586.00 per course of treatment
Complex counselling price: $ 2198.60 per course of treatment
These represent average prices. It is expected that providing the care necessary to meet the identified needs of some clients may cost more in some instances and less in others. However the overall cost will average out and service providers will be expected to adjust the duration and intensity of the treatment response to meet the complexity of the client's presentation. The model has been designed to give providers the flexibility to respond to a spectrum of client needs. There will be scope for reclassifying between standard and complex should a client's clinical requirements change significantly during the treatment episode, or to source additional treatment activity in some instances.

The selection process

An open process of recommissioning was involved. Prospective service providers were described as including non-government (not-for-profit) organisations, and pubic and private (for-profit) providers, operating in Victoria and interstate (Department of Health October 2013).

A three-phase process was put forward in the ACS. Phase 1 involved the assessment of submissions, short-listing, and interviews to determine preferred providers for each catchment area. Phase 2 involved the request for and evaluation of high level delivery plans and further information, along with negotiations to determine final approved service providers and allocations. Phase 3 involved negotiation and execution of service agreements with approved service providers (Department of Health, October 2013, p. 5). While those interested in delivery services in more than one catchment were only required to submit one submission in phase 1, if they were shortlisted then catchment specific delivery plans would be required.

Submissions were originally due in November 2013, however the closing date was extended to early December 2013. Other key dates in the ACS include the identification of preferred providers in February – March 2014 (signifying the end of phase 1), the negotiation of funding agreements with approved service providers in April - June 2014 (signifying the end of phases 2 and 3), and the commencement of new service delivery arrangements from 1 July 2014 (Department of Health, October 2013, p. 6). (The start date for recommissioned services was extended to 1 August and then 1 September 2014). A summary timeline of key activities and events during recommissioning is shown in Table 7.

Table 7. Summary timeline of key events and activities during recommissioning

Source: Department of Health, October 2013 / as shown

DATE	COMMISSIONING EVENTS AND ACTIVITIES
Oct 2013	● Advertised Call for Submission released 9 October
Phase One	*Assessment of submissions, shortlisting and interviews to determine Preferred Providers for each catchment area*
Nov 2013	● Submissions due 29 November 2013
Dec 2013	● Due date for submissions extended to 4 December 2013
Dec-Jan 2014	● Submissions evaluated against eight evaluation criteria (stipulated in Part B, section 6.1 of the ACS) to determine an initial short list of Preferred Service Providers for interview
Jan-early Feb 2014	● Interviews scheduled with Preferred Service Providers (whose selection "is for the purpose of negotiation only and does not constitute an offer by the Department to enter into a Service Agreement", Department of Health, October 2013, p. 28)
Phase Two	*Delivery plans and further information requested and evaluated, and negotiations held to determine final Approved Service Providers and allocations*
Mar 2014	● High Level Delivery Plans requested from the initial short list of Preferred Service Providers ● Final short list of Preferred Service Providers determined ("to be approved by the Minister…for the purposes of negotiation only and does not constitute an offer by the Department to enter into a Service Agreement", Department of Health, October 2013, p. 28) ● Target commencement date for new funding and delivery arrangements to be in place extended from 1 July to 1 August 2014 (Department of Health, March 2014)
Phase Three	*Negotiation and execution of service agreements with Approved Service Providers*
Apr-Jun 2014	● Negotiation of Service Agreements with Approved Service Providers. ("Please note that it is the Department's expectation that Service Agreements will be executed substantially in the form provided with this ACS and that only minor matters of negotiation will be considered", Department of Health, October 2013, p. 28) ● Recommissioning completed and Approved Service Providers announced 6 June 2014. This involved, "more than $41 million of redeveloped services across the state" and included, "27 organisations or consortia, comprising 83 agencies in all, which will deliver adult non-residential services across 16 catchment areas". Details by catchment, LGA, and AOD functions (service types), along with consortia members and lead agencies were also included (Department of Health, June 2014, p. 1) ● Target commencement date for new funding and delivery arrangements extended to 1 September 2014 (Department of Health, June 2014, p. 2) ● Up to $2.3 million announced by the Victorian Government, that would go "towards a transition support package that will directly support clients, service providers and workers until 1 September and beyond" (Department of Health, June 2014, p. 2)

As summarised above, recommissioning commenced in October 2013 and it involved multiple steps of pre-selection and negotiation before being completed in June 2014.

Consortia

The emphasis on consortia during sector reform was often raised in consultations and some background information is included here. The ACS (Department of Health, October 2013) included an appendix of terms and definitions. In the appendix to the ACS, a consortium was defined as "a legal entity consisting of a combination of agencies" (Appendix 1, p. 2). The ACS included the following statements about consortia:

- It is expected that "core service provision in each catchment will be delivered, in most cases, by up to three contracted providers (being either single entities or consortia)" p. 12
- Consortia must "demonstrate that their proposed governance structures and processes are efficient and explain the role and function of each consortia member" p. 14
- Consortia may be incorporated as a single body, a non-incorporated consortia, or involve "subcontracting by a Prospective Service Provider (Lead agency) to other members" p. 29
- Consortia submissions must indicate which members are providing which services and how the entities involved would relate with each other p. 29

Having considered the ACS, timeline and key stages for re-commissioning, along with conditions regarding consortia, we move now to analysis and stakeholder perspectives on this stage of the reform process. Findings are arranged under five headings: service specifications; the drive for consortia; the multiple steps in selection; contracting for service diversity, and; change and funding.

The service specifications

Lack of detail and clarity

Many stakeholders in the consultations expressed frustration about the lack of detail and clarity in the service specifications in the ACS, particularly around operationalising the requirements. They said, "the level of detail that I would have expected from a tender process was not there", there was a "lack of information around reportables", "there wasn't that level of detail", and, "I am waiting for some service specifications to be delivered, to clarify what it is that you are expected to do".

Some explained this lack of detail and clarity in relation to difficulties in deciding on workforce requirements and the hours of work that constituted a DTAU. This was a particular concern expressed in relation to two of the 'new' service types; counselling and care and recovery co-ordination. For example, stakeholders said, "what is 'standard counselling', what is 'complex counselling'?", "what's meant to happen on the floor really?...a basic counselling session may be 3 hours of direct care time or whatever", and care and recovery coordination (e.g., "the only thing that got said was complex case work would be 15 hours and then they retracted that"). One senior manager said,

> In building a workforce you need to know how many people you need on the ground to deliver X number of widgets or whatever you're doing. And we've had to rely on dividing the dollars in order to figure out how many positions there may be and that may well change….we've gone to a recruitment process premised on the kind of thing we wouldn't ordinarily want to use, which is the dollars available rather than the work to be done.

Sector input through submissions

Some felt that the lack of detail came from a Departmental perspective that the sector had the expertise regarding therapeutic and operational elements of service delivery and that implementation details of the service model should come from the sector. One senior manager noted that, "they just put the tender out and waited for the field to put into submissions: a model". Some held a view that the Department didn't have the necessary expertise to articulate this model. One CEO commented that,

> They didn't know what the answers were. They didn't know how to run the system. So, what they were asking through the ACS process was for people to put forward a proposal that they seemed to pick bits and pieces out of it and then go, "ok this is the way we are going to operate".

These perspectives are summed in comments from another senior manager, who felt that the Department had lost "knowledge of operationals" due to staff retrenchments. They "were almost moving into the sector blindly" and seeking insight through the recommissioning process. At the same time, according to this senior manager, Departmental staff were, "not really listening because they had their own idea of what they felt that they needed to deliver".

Extent to which collaborative planning occurred within the recommissioning process

Some stakeholders spoke about the uncertainty regarding sector input to reform; whether some form of collaborative planning had been intended. Some comments were about the development of service specifications (for the ACS) and others referred to the period following the release of the ACS. One senior manager said that,

> There was no energy or willingness from the Department at a key stage, around developing an AOD system and sharing people's ideas. Around developing specifications and "what are the key bits of a treatment system?"

Another senior manager expressed frustration about the purpose of consultations before recommissioning - as they felt the system model was still being configured *after* the ACS had been released. This person explained that,

> It appeared with the ACS that they were still making it up. Still trying to see, what were people's ideas about a system going forward? And then it's like "well why did we go through this process of consultation and these Advisory Groups?" That should have been informing – but then the gap was, when the specs came out, what was the in-between? There was nothing in-between.

Some felt there was a tension between different approaches to planning for reform that continued throughout the process. As reflected in his/her comments regarding pre-commissioning, a CEO explained that the Department was, "torn between an old school way of doing things and trying to be a bit 'modern' around co-design. They look like they deliberately had some gaps in terms of not filling in all the details in the service specs. To allow providers to come up with their own things. Which, if they're clear about that I don't have an issue with that." This CEO expressed frustration that, following the completion of commissioning, the Department was more directive, which meant

the solutions that had been created could not be pursued. He/she explained that, "you have to back track [because the Department is now saying] 'no, do this' and, 'do this'".

Another CEO explained that problems regarding the lack of detailed specifications and the selection process itself were a result of pre-defined ideas, resourcing issues, and timeline pressures. This person commented that,

> They had a clear direction and very tight timelines. In some ways it's not surprising that you end up with all these good intentioned processes that were underdone. They were trying to achieve it but they didn't do that last step where you fed back what you had collected and gave people a sense of "this is what it will look like".

The drive for consortia

Stakeholders were clear that the Department favoured consortium arrangements for the reformed system and that this was apparent before the ACS was released. There was anecdotal evidence of organisations forming partnerships in readiness for recommissioning and, in some cases, promoting their new image in preparation. One senior manager commented that, the "underlying message was to form consortia….the message was if you don't form a consortia you will be at risk", while another said that "the agencies that chose not to partner, they missed out. People that couldn't make it work, they may have started a conversation but couldn't work it out, or agencies that didn't get that they couldn't stand alone, they missed out".

Some agencies were at risk in this environment, as one CEO explained,

> A lot of people didn't understand consortia and didn't know to pair up. I would go to meetings and see that they were not engaged. They are just flat chat doing the business. By the time the consortia were sorted out it was too late, consortia had too many members. So you go on your own. It was interesting going to meetings and seeing people trying to work out what they were going to do and, really, people were there who had already done it - had already formed their consortium.

Another CEO reflected a similar sentiment, speaking in relation to smaller organisations,

> There was a lot of consultation but many of the consultations were not very clear about the proposed model. The smaller organisations are possibly providing fantastic clinical services and are expert in their area, or their catchment, but they were a) not privy to the consultations or b) if they were, the model was very unclear about how it was going to work. That coupled with inexperience with tender processes, straight away that put people who weren't good in tender writing or who weren't part of a large consortium, they weren't able to put themselves in a very good position.

Choosing between consortia was a common area of discussion. Some stakeholders felt they had to make a call about who to work with, while other stakeholders 'kept the door open' throughout the shortlisting and approval process and made adjustments throughout. As explained by one senior manager, "people have now joined different consortia because some didn't get up". Conversely, some organisations have found themselves in multiple consortia, which has its own complexities. As noted by one senior manager,

> To hold your business you have had to join three consortia, with different governance arrangements and different ways of operating. Spread yourself across three different groups. [You are] beholden to whims of different groups.

Some stakeholders expressed uncertainty about the consortia that have resulted from recommissioning. One CEO explained that, "it's a bunch of organisations that have come together for the sake of winning business. We have this 'bowl of spaghetti' but they haven't actually worked out how they're going to deliver. Also, most of them haven't got what they thought they were going to get out of it".

Multiple steps in selection

Some stakeholders spoke about the workload involved in the various stages of the selection process. They also commented on the lack of opportunity for negotiation at key points.

In simple terms, the proposal was submitted and initial short-listing led to interviews, then short-listed organisations/consortia were asked to submit a Higher Level Delivery Plan (HLDP), then Preferred Service Providers learned whether they had been successful and in what proportion / across what service types. This occurred between December 2013 and June 2014.

Interviews

There was a level of frustration with the interview process that followed the initial short-listing, which involved set questions and included a bell to signify question time was up. Questions were not available until shortly before the interviews and members of multiple consortia attended interviews for each submission.

Some stakeholders felt the interviews could have been an opportunity for discussion and clarification regarding their submissions, but this could not occur within the rigid structure that was used. Stakeholders commented that the process was, "totally not interactive", "it wasn't an inquiry", "it's like a job interview where you have those set questions", "we were not allowed to introduce any new material".

Negotiations

The HLDP stage of the process involved substantial modification of the size and range of services available for bids (for some organisations) and this meant substantial reconfiguration of what had been originally proposed. Some stakeholders felt the process almost involved having to write two tenders (initial and HLDP). Following this, while some stakeholders expected minimal change between funding amounts put forward for the HLDP and in the final service agreement they were offered, further changes were sometimes made.

For example, one senior manager referred to the challenges arising from the multiple steps in the selection process and ongoing changes. He/she described developing the initial proposal with the understanding that there was considerable potential for systems level planning; developing a cross-organisation, multi-service model. However, expectations about system configuration regarding intake and assessment and having multiple providers meant the viability of the original proposal was put into question when the HLDP was requested and again when the final service agreement was put forward. This manager explained that,

> A lot of people did form quite strong partnership arrangements and wanted to address the system in a catchment. So people put forward a submission based on a system. It was usually the collective of streams of activity that the Department wanted and looking at that notion of place-based [service delivery] and how a system could work. So people were genuinely wanting to improve. The process was you put in a submission and they start talking about "you're still in for 100% of this, but only 40-60% of that", some people were only given 20%. Ranges of 30-70% and 20-60%. And you had to then put in another, stage two submission. It appeared then, that the goalposts had already moved at that stage.

Similarly, another senior manager explained that, "I think that what people put in their tenders initially was, 'this is what we'd do if we got all these services'. By the HLDP you're starting to think, well they're asking questions about 'what would you do if you only got this and this'". In another case, a senior manager stated that, "the second time around they were saying 'ok, now pretend you haven't got intake and assessment. Who would you work with for intake and assessment? Or pretend you haven't got this or pretend you haven't got that". So it was like, "ok, let's play 'dreamy statements'".

The timeframe between different phases of recommissioning was a particular issue, involving limited time between getting the HLDP and having to provide a response (around 2-3 weeks, according to stakeholder comments). This was also a concern when offers of work were put forward. In some cases, organisations received contracts for service delivery that had different configurations / proportions of services to be delivered from that put forward in the original submission or the HLDP. They were put in a position of either accepting the contract for service delivery or losing business, despite the changes that had occurred. There was little time or opportunity for negotiation at this point, although this may have helped with system design and service viability. As explained by one CEO,

> There was basically a few days to do the negotiations because the timelines were so short. There was really no negotiation. It was like, "accept, or don't, at your peril". So I think that the third phase was completely taken out of the equation, which was where some of these issues could actually have been put on the table. Say, "look, this really doesn't make sense, you're further fragmenting", get people to digest the outcomes. That'd disappeared. The first [phase] was too big which meant the second was a waste of time. So, they could have gone from one to three without the bit in the middle almost.

Similarly, a senior manager noted that,

> The only discussion we've had with the Department was in the three days after you got the thing [offer of work] was, "sign up to this and send it back to us". There's been no discussion around the different levels of the service agreement. We have no idea, still, what the service agreement is. And the services start in two weeks. And *no discussion* [speaker's emphasis].

Contracting for service diversity

One element that was raised as impacting recommissioning outcomes was the Department's commitment to 'client choice', by having more than one contracted provider at catchment level. As noted previously, in the ACS the Department stated that, "funding for core service provision will be allocated to up to three contracted service providers within each catchment" (Department of Health,

October 2013, p. 4) and, “core service provision in each catchment will be delivered, in most cases, by up to three contracted providers (being either single entities or consortia)…as far as practicable, treatment providers should cover whole catchment/s” (p. 12).

There was some misunderstanding about whether this meant multiple providers that represented independent organisations were required or if a single consortium could include multiple providers[12]. One CEO explained there were substantial negative impacts from this confusion,

> If you were a major service provider in one region, you might have had 60% of the business. And, there was another provider that effectively did the other 40%. People thought, well let’s come together. We’ll partner up and we’ll go for 100% together and we think we can do that really well. And the way the specifications were framed gave you the idea that there may be two providers. Ok, you thought you’d be meeting that criterion. Then you thought, hang on, they’re actually talking about two providers of contracts. And so you’ve just pulled the two key providers together and you end up with 50% of the business and an unknown comes in and does the other 50%. You’ve done yourself a disservice by partnering.

Rural areas

The rural context for service delivery, where there is a limited number of providers and amount of funding, meant there were particular challenges related to the requirement about having more than one provider in each catchment. One senior manager noted that, “you now have two different employers that can provide AOD services, for two or even 0.5 days a week in some of those areas. By the time you look at the corporate costs and then separating the services in such small towns you are really going to struggle to maintain that”. Another senior manager noted that,

> The notion of having to split, of competitiveness and of having more than one provider…all very well in larger regional cities and or metropolitan but when you’ve got a 0.5 only or 1 FTE in a service and now there’s an expectation that there’ll be two providers in that town. They have not even considered that place based notion about the things that are critical around workforce and service delivery. It’s just been this standard approach across the whole state, which is a nonsense. It doesn’t work and the fall out of that is yet to be seen.

Similarly, a CEO noted that,

> One of the key outcomes that this process was trying to achieve was a lack of fragmentation and it may be that the outcome is increased fragmentation, in those regional areas in particular where intake and assessment by one provider and another provider’s effectively been split. New ones have come in, so it’s actually more fragmented.

Change and funding

Stakeholders expressed general concerns about a perceived reduction in funding, although, as noted by one CEO, the Department has, “been crystal clear that there’s no money that’s been pulled from the system. The money’s the same, but it’s redistributed slightly”.

[12] Consortia featured in the recommissioning outcomes. Ministerial Communiqué Number 6 (Department of Health, June 2013) listed successful service providers, totalling 24 consortia and three stand-alone agencies. The consortia have an average (median) of six agencies, while the largest has 17 agencies and the smallest has two.

Many stakeholders spoke about system changes in this context. There was a particular focus on centralised intake and assessment and the implications regarding funds availability for remaining services. Some stakeholders described negative impacts on the workforce. Inadequate costings for particular service types were also a concern.

Intake and assessment

Given the establishment of centralised intake and assessment services and the no-growth budget, there was less money for remaining services. One CEO said, "well the language is that you're having to do a whole lot more with a whole lot less. Particularly when you have a central statewide intake and assessment and catchment based intake and assessment". A senior manager explained this in terms of the intention to divert people from the AOD system,

> They have invested very heavily in intake and assessment and part of that is around being able to pick this group of people that don't need to come into treatment and divert them out. I still think if you look at the amount of intake and assessment being done even after that after the other three tiers[13], there's a lot coming in and we don't seem to have the services to match.

This issue was particularly important in regional Victoria, where the entry of a new provider for intake and assessment in all but one area meant that existing AOD organisations felt they had less funding for treatment. One senior manager said,

> We were given 100% of our services but not intake. Which had already been fragmented right from the beginning. That's the theme in [another regional area] as well, where we are expected to provide the same services. They are saying it's basically the same amount of FTE, but we've got 20-25% less funding to deliver.

Another senior manager explained that,

> The way the regional catchments designed their system in the ACS process was intake and assessment wasn't just a stand-alone, 'you come in or phone a number'. You had workers doing intake and assessment and the model only worked because you had intake and assessment with all the other treatment products.

There was a recognised need to build relationships in regional areas that would enable client pathways and figure out how the reformed system would look. The challenges involved were described in these comments from a CEO,

> There is a big risk that the intake and assessment model won't work like the government is hoping. They have developed a model and an extra layer, where they are bringing in what is

[13] Post re-commissioning, the Department released a five-tiered classification for client severity that has been designed to direct clients to appropriate levels of care, including non-AOD options. A fact sheet on demand modelling led to the conclusion that 20% of clients could be redirected away from AOD treatment as specialist treatment was not warranted (Victorian Department of Health, July 2014). The Department explained that, "Turning Point Alcohol and Drug Centre are developing a model that segments treatment seekers into tiers of severity/complexity. The five tiers of severity/complexity reflect the range of clients accessing Victorian alcohol and drug services, from non-dependent populations to the most at-risk client populations who require intensive treatment and coordinated support" (see Department of Health. (July 2014). *AOD Reform QandA Transition 110714*. Accessed 6 October 2014).

> perceived as a new provider. Nobody knows if the model is going to work. With opposition from other services it doesn't help. In regional areas things are always easier because everyone knows everyone and works together.

Workforce

There was a view that the workforce was being deskilled as a function of the money available. One CEO noted that, "we filled all our lower positions, it's the higher ones we can't get people for" and another responded by saying, "because the salaries aren't enough". One example provided by a senior manager involved the need to change from employing registered division one nurses for withdrawal services to medication endorsed nurses, "who certainly don't carry the same amount of skill and expertise as a division one withdrawal nurse. That's creating more pressure on the sector and on the managers because it requires a lot more supervision at that level". In another example, a senior manager explained that their organisation had made the decision to cut management numbers rather than front line workers.

A senior manager extended this discussion to reflect on the funding split across multiple contracts as limiting the scope to have a service team, "based on a whole lot of levels of skill". A CEO expressed this concern in terms of the lost potential from a catchment wide service where, "you could have had a couple of positions at entry level with a diploma and the bulk of your staff in the middle and at least one senior worker to oversee it. [That would mean] you've got enough capacity to have a system with depth rather than splitting it".

Finally, the short term nature of contracts (to end June 2015, with the likelihood of extension for a further three years) has added to funding insecurity and planning challenges.

Funding

A further point was raised regarding the amount of funding available for services. One senior manager felt the amount of funding was generally inadequate,

> So care and recovery coordination is really underdone; it's worrying how underdone it is. And counselling, given it was the mainstay previously, is underdone. Looking at the funding it looks like we can do about six sessions for standard clients and maybe 12-15 for complex clients. And the clients that meet the criteria are very complex. And I'm just not sure about non-residential withdrawal because – again it comes back to those consultation groups. They've gone to the model that they always described in writing; that non-residential withdrawal is working with clients who are really simple (no problems, stable housing, linked with GP) but my experience with residential withdrawal over about 15 years is that that service picks up a percentage of really complex clients. They are actually so complex they can't go into residential withdrawal, they can't manage. They're not in the system anywhere.

Another senior manager felt that the funding for the care and recovery service type "was absolutely woeful" and did not reflect the stated intention to support people to fully 'recover' from their chronic relapsing AOD problem. Another stakeholder, who had been part of the Advisory Group for care and recovery, noted that, "what was in the specifications to actually resource that was so far removed from what the whole group had achieved. That was a classic example of that process really feeling like it was totally ignored in what came out".

Transparency and consistency

Some stakeholders reported on seeming favouritism in the approach leading up and involving recommissioning. Their concerns about favouritism centred on the Department's engagement with a limited pool of providers (for advice) in the period leading up to recommissioning and the allocation of some funding outside of competitive tender processes. One CEO commented that the advisory role of some organisations that appeared close to the Department, "did create some tension". Further, he/she felt that taking "that alternative sort of approach with a bucket of money during a competitive process" was problematic[14]. Another senior manager felt that those in "specialist (Advisory) Groups" had been 'cherry picked', while another said that, "the loudest voices had to be accommodated" by government. Another CEO explained that, "it's perception. You've got to be really careful in competitive times and to me it was really careless".

Conclusions

Sector reform involved major change and limited time between the call for submission, the finalisation of approved providers, and the planned date for implementation. The emphasis on consortia arrangements added to the complexity of recommissioning, especially given the multiple stages in the selection process. Variations between original proposals and the services proposed at each stage (HLDP, agreement) meant an atmosphere of uncertainty and, for some, difficulties in reconfiguring proposals in a short space of time.

The stakeholders' call for detail regarding service specifications may reflect the confluence of multiple concerns about the changes involved and the limited funding available. While service specifications in the Advertised Call for Submission suggested an ambitious program of work the funding for particular service types (standard counselling, care and recovery co-ordination) was limited. Linked to this was the lack of scope to discuss operational complexities during the move to implementation.

Stakeholders expressed concern about the limited funding available and the possible impacts on workforce capacity, organisational infrastructure, and ultimately service quality. Some stakeholders were concerned about separating intake and assessment from other areas of service delivery in terms of the viability of organisations operating without intake and assessment. The context for service delivery in rural areas needs consideration in designing the approach to recommissioning.

[14] For example, the announcement on 28 April 2014 regarding the $4M investment in a residential facility for new mothers with AOD problems and their babies, which would be "co-located with the UnitingCare ReGen adult alcohol and drug withdrawal service facility in Heidelberg" (see http://www.premier.vic.gov.au/media-centre/media-releases/9726-4-million-for-new-unit-to-help-mums-beat-addiction.html Accessed 6 October 2014).

4. Transition

Consultations for this project occurred two weeks before the new system was due to commence. While transition was not a major focus of the project, the research team had a unique opportunity to document stakeholder perspectives about sector reform on the cusp of system change. Three major themes emerged from stakeholder comments: the limited time for transition, the limited scope for discussions to inform transition, and impacts of the reform process. There was also some discussion about perceived benefits from reform. These areas are described below.

It is also worth noting the ongoing activities that are occurring post transition, although full description is beyond the scope of this project. This includes fact sheets and other materials posted on the Department's website and a CEO forum on reform.

Time

Three inter-related topics emerged from discussions about the need for more time to transition to the reformed system:

- A general view that major change takes time
- Concerns about the limited period for implementation following the establishment of service agreements
- The need for sufficient time to fully develop and establish new intake and assessment service models and referral pathways in the new system

One CEO raised concerns about, "the whole fragmented ICT referral platforms (systems for client information management) and uncertainty around deliverables…they needed to put more time into sorting through these elements and getting some consistency". A senior manager reflected that, "I think the Department is starting to get that this transition is going to take a minimum of 12 months. Big changes take five years to bed down". The limited time for transition to new arrangements has placed considerable pressure on services. Some commented that while the original intention was to have a six-month period for transition, the actual period was less than three months.

Challenges arising from the start date for the new system that refer to intake and assessment services included having enough staff employed, ICT systems in place, and establishing working relationships across organisations. One CEO said that, "within 10 weeks you are supposed to set up all these systems and get all these things running. Employing staff has been hard enough and we know it takes an 8-week process. Then you start talking to IT firms and you have to start in new locations and tech companies are saying '12 weeks to do this, 12 weeks to do that'".

Another CEO explained that,

> I'm involved in multiple catchments and I'm not confident that we've got communication to our service users and referrers right at all. I think there's a huge information gap and intake and assessment providers in the catchments have been unclear, uncertain about even contact numbers for example, and how the process of both receiving and sending on referrals to funded providers is going to work.

Similarly, a senior manager commented that,

> To be two weeks out and not to have anything documented, like an MOU around what they think it should be looking like, or even to have [this] as the basis of discussion indicates that the intake and assessment providers are scratching their heads and just saying, "wow".

Finally, a CEO noted the importance of time to move to intake and assessment services, stating that,

> If the Department wants this to work there needs to be time to change models based on what we got and haven't got and then operationalise them. So we have a good foundation to make the changes that they want to work rather than possibly cutting corners.

A systems-wide perspective

Stakeholders identified a number of implementation planning issues arising from the reform or from the process itself, where a systems-wide perspective was warranted. They expected the Department would have a role in guiding discussions and providing direction to resolve uncertainties. Examples include,

a) Supported accommodation. One CEO explained that,

> We suggested we needed the Department to take a lead in supporting the transition in supported accommodation arrangements to this new arrangement…Four weeks ago there was this assertion that it was up to organisations that previously had nomination rights to negotiate with the now successful service providers of care and recovery co-ordination in the region to make arrangements for transition. I would have thought, with respect, that the Department should take a lead role in these sort of conversations.

b) Lack of consumer and service provider awareness regarding contingency planning during transition. Another CEO commented that,

> Even from the end of June – all the new providers are getting phone calls from all these clients who say, "I've rung my whats-is-name and they've said they're not providing services after the end of September or we can't see you so you'd be better off contacting one of these new providers". And of course, as one of the new providers we don't have funding until 1 September to provide those services.

c) Departmental advisors during transition. Another CEO explained that,

> The central office has passed on so much to the regional area. And the regional area doesn't have a clue.

d) Major change in the constellation of service providers in regional areas. A CEO said,

> People have been hit the hardest in rural areas. All of a sudden someone else is telling them how things are going to be. There is a sense of injury among some organisations that have lost services. Some will never recover. How to move forward?

e) Negative effects on sector relationships in some areas, particularly where organisations lost funding.

> One CEO felt that, “we now see suspicion and broken relationships”, while another felt that, “there’s a lot of hurt out there”

f) Defunded services and referral gaps. A senior manager said,

> How do successful organisations ensure that the gaps created by organisations that are defunded are addressed? In our case, being successful, how do we make sure the community gets the services they need when other services are no longer there?

g) Sector wide leadership to move forward. A CEO stated that,

> [We] need time to get to a place where we figure out how to make this work. But how does the sector heal itself, and heal those fractured relationships? [We] need organisations to make it work and take the initiative. It is about embracing change. [The] critical question is, who is going to lead change?

Reform impacts

Some stakeholder comments reflected a level of disappointment and, at times, distrust of the Department as a product of the reform process. Examples include,

a) A perceived lack of purposeful consultation, with one CEO noting that, “months of probity and the inability to have a conversation and finish those other (Advisory) Groups with clarity meant that a lot of people are feeling really unhappy that, they feel like they’ve been tricked or were somehow unaware”

b) Insufficient communication, with a senior manager stating “that lack of communication really damages relationships”

c) The view that a respectful approach to de-funding and recommissioning was not undertaken. A CEO said that, “each individual organisation wasn’t even told, sat down and worked through which parts of their contract are in reform and which aren’t. That’s a simple courtesy process and now there’s all these unintended consequences”

Some managers commented on the ongoing nature of reform process impacts, suggesting that, “it has been so divisive”, “new information is coming everyday…it’s hard to bed down any model”, and “the Department missed an opportunity to build this the way they wanted it to look”. A senior manager felt that the lack of consistency in information had impacted sector stability at a number of levels. They said,

> In trying to build partnerships they’ve also destroyed partnerships. In trying to bring stability into the sector they’ve completely de-stabilised it. The fact that they’re giving us no consistent information and if you’re passing that onto your staff and then you’re having to turn around a week later and say well what I told you a week ago wasn’t right and this is what is happening now. And so it’s affected the whole system down to the people on the ground.

Finally, it is worth noting that concerns were raised about the ongoing loss of staff in the central office of the Department. As one CEO said, “it’s felt to me like there’s nobody that I can actually know who’s championing our sector anymore in the Department”.

Benefits

This project, commissioned by VAADA, aimed to document the process of sector reform in Victoria and the issues and concerns from service provider perspectives. There was some discussion about

benefits; both in terms of the reform process and elements of system design. One stakeholder praised the inclusion of a systematic approach to involving consumers and carers in the Advisory Groups (not withstanding the lack of translation from discussions to recommissioning documents). A senior manager identified the increased collaboration between partner agencies that has occurred as a result of the consortia that have been developed.

Identified benefits related to sector design were, of necessity, coming from a theoretical rather than practical perspective (as reformed services had not commenced operation at the time of writing). From this orientation, one CEO commented on the potential for transparency in accessing treatment, given the centralised and systematic approach to intake and assessment. Some stakeholders spoke favourably about the consolidation of treatment types and their alignment with the evidence-base. The emphasis on treatment matching and access to a greater range of social and community capital for those in need was well regarded (albeit with reservations about the amount of funding for care and recovery co-ordination). One CEO commented on the shift toward performance management and outcomes with accountability at catchment level, which he/she felt was a reasonable attribute of the sector that may have benefits from services and funders alike. The inclusion of follow-up calls and better catchment co-ordination were also raised.

In summary, and from a theoretical perspective, the following benefits may be identified:

- A consistent approach to intake and assessment, involving a mandated tool that includes standardised measures
- The consolidation of treatment types
- Efforts to reduce demand and target services to those most in need by diverting low risk individuals away from the specialist system
- The continuation of a capable and committed non-government sector that provides specialist outpatient services for those with AOD concerns

Once the reformed system is in place there will be an opportunity for a rigorous assessment of these changes and the impacts that have eventuated.

Conclusions

The transition period was short and involved substantial change, placing increased pressure on services. There has been damage to relationships and attention is needed to rebuild these relationships. A number of service and system planning issues have emerged during the transition period, highlighting the need for a stewardship role at systems-level (across organisations and catchments); something for the Department to address.

As with all change processes, there is an opportunity to learn from experience. The perspectives put forward by participants in this project have highlighted specific activities and elements that could be improved, along with the importance of allowing sufficient time for various stages of the process – including transition. In the next section, key messages regarding the current reform and approaches to future reforms have been discussed.

5. Analysis, reflections, directions

In this section we have drawn together the findings and developed a number of concluding statements. This is followed by general reflections about approaches to reform. We concluded this section by identifying areas for attention sooner rather than later to support ongoing support for and improvement in Victoria's AOD sector. Project limitations have also been described.

The process

Change is difficult, even more so when no new funding is available.
As shown throughout this report, tremendous energy has been expended in driving, shaping, and engaging with the reform process. Major changes have occurred. All of this takes resources and when there is a no-growth budget environment and the redistribution of funds by service type then change is more difficult. Some frustration, disappointment, and anxiety about the future is almost inevitable and this has been apparent in the perspectives put forward by stakeholders.

Meaningful consultation was a gap in the reform process.
Although the language of consultation and co-design was used in documentation regarding the reform process, there were substantial criticisms that the consultations that did occur did not have a clear purpose and did not impact the end result. This was despite the establishment of structures (principally the Advisory Groups) to obtain sector input on implementation and the considerable number of meetings and information sessions that were held, along with the stated policy intention for a partnership approach to sector reform (cf., Shergold, 2013). Three messages have been derived from stakeholder comments:

- A clear and well articulated approach to reform - whether 'old school or co-design'- was needed so that the sector had a sound understanding of what to expect throughout the process and they could respond accordingly
- According to the terms of reference, the purpose of the Advisory Groups was to inform implementation, however this didn't eventuate. Group members were not clear about the purpose of the groups, suggesting that the original purpose of the groups wasn't fully explained / put into practice. Further, implementation challenges continued to emerge throughout the reform process – although the groups ceased well before recommissioning and the open tender process precluded a collaborative approach in that period
- Collaboratively oriented discussions between Departmental and sector representatives appear necessary, to allow the identification and resolution of implementation challenges, with the benefit of practice and operational management experience along with knowledge of local conditions

Reform included multiple phases, from planning to recommissioning and then implementation, and the articulation of these phases ahead of time may have assisted the sector to account for and reduce the impact of reform demands
As we have shown, the reform process had a number of phases that varied in their focus (service development, tendering, transition) and expectations. The timing of recommissioning phases could not be anticipated by service providers and this, in combination with the competitive tendering approach and changing conditions across phases in recommissioning, meant competition between

organisations, insecurity regarding the future, and concerns about sector sustainability were just some of the concerns that arose. This situation was compounded by the limited funds available for services that occurred in the context of a portion of funds going to catchment based intake and assessment.

The translation of planning documents and service contracts to implementation and system change takes time.
Time pressures are inevitable when major reform is being undertaken and, in this case, when related reforms are happening across community health and human service systems. However, the truncation of recommissioning elements of sector reform to an eight-month period added to the challenges and pressures involved. In particular, more time was needed for the exploration of issues arising from proposal changes during the steps in the selection process and implementation challenges, as well as emerging problems. As noted above, examples range from addressing arrangements for supported accommodation and establishing centralised intake and assessment services (and networks), to setting up new sites and ensuring ICT capacity, as well as building working relationships across organisational boundaries. Developing compatible client management systems across organisations and monitoring and evaluation strategies to determine if the changes in system meet the stated reform objectives would have been useful. A longer period for transition was needed.

Having multiple phases in recommissioning and ongoing changes to what was on offer made things more difficult.
The multi-stage competitive tendering process was overly complex. The need to provide HLDP, within a short timeframe and (for some) with considerable changes to funding amounts and service configurations increased the workload during recommissioning (e.g., like 'writing two tenders').

The changes that occurred between the HLDP and the final offer of work meant that services were in an environment of uncertainty for a prolonged period and that the models originally developed and put forward for funding needed reconfiguration within a short period (and no negotiation) at two steps in recommissioning (e.g., 'the goalposts had shifted'). In some instances, this change in conditions meant reduced funding and service types; making it difficult to maintain a cohesive and viable model.

Promoting consortia through competitive tendering processes resulted in unintended consequences and this approach does not necessarily address client choice.
The interest in having more than one contracted provider for services per catchment, alongside the drive for consortia, meant that organisations that combined to form consortia effectively denied themselves a business opportunity (in that they could not be successful for the entire quantum of services in a catchment). Further, where services operated in a regional environment the consequence of splitting available funding across more than one contracted service provider caused challenges regarding FTE and service viability in some locations. Having more than one contracted provider, while not guaranteeing diversity in the models of service delivery (thus addressing client choice), has meant a duplication of supervisory and other arrangements.

The catchment based intake and assessment services are a major systems change that will impact service providers, referrers, and clients. The integrity and impacts of the model, at client and system levels, should be examined.

Centralising intake and assessment is a bold experiment for the sector and one that has fundamentally changed the point at which services engage with clients, who decides what treatment is needed, how referral pathways operate, and the approach to managing client information. The model carries considerable potential, in terms of diverting low risk individuals away from AOD services and supporting the specialist nature of the interventions on offer, as well as the coordination of care pathways. But how centralised intake and assessment operates in practice will be a function of the organisations involved and the other services they offer. For example, where an organisation does not offer intake and assessment there is a dependent relationship with the catchment-based service and, at the very least, a more complex process than that if an organisation has intake and assessment along with other services. In regional Victoria, service and systems capacities, as well as the distances involved mean that an understanding of local context is critical.

From a broader perspective it is important to know what happens to those diverted away from treatment. Do they find another sector that can provide for their needs? Do they show up again in the AOD sector once their needs have escalated?

It is important to monitor and identify improvements to the reformed system by learning from experience. The ways that services adjust to the centralised arrangements and what this means in practical terms (time, cost, ease of implementation, through to client access and treatment outcomes) should be reviewed.

Considerations for future reform processes

As with any major reform, substantial insights are possible when looking back on the process. Given that a second stage of reform has been put forward (for residential and youth services) it is particularly timely to consider strategies for improvement. We have identified a number of considerations for future reform processes.

- Given the resource requirements and risks of major change, ensure that identified solutions match the problems and consider the appropriate scale for reform (incremental / large scale).
- Where recommissioning is involved, establish the approach early in the process; whether consultative / collaborative or not, and maintain the approach throughout
- Collaborative approaches to major change are important (e.g., Ansell, 2011; O'Flynn, 2009; Shergold, 2008), to include practice expertise in problem-solving, support service 'buy-in' to major change and to support the identification and resolution of important and sometimes unforeseen implementation challenges. True collaboration has implications for the nature and timing of recommissioning arrangements and the timely resolution of issues arising
- Consider the information and infrastructure needs for reform (e.g., demand modelling, pricing structure, outcomes framework, client information management) and address these needs prior to changing funding arrangements
- Tailor the funding approach to sector conditions and reform goals
- When recommissioning, allow time for the selection phase and for transition

- In deciding on submissions, avoid pre-empting organisational arrangements. Emphasising consortia and seeking to have more than one contracted provider in each catchment does not guarantee diversity in the service models on offer
- Avoid a 'one size fits all' approach to reform across metropolitan and regional areas. The service context (number and range of services, networks, etc) and resources (funding, workforce) vary across metropolitan and rural areas and they need consideration when planning service modalities and networks
- The Department has a unique stewardship role regarding systems level issues and concerns

In closing

The reform includes a number of innovations that carry both potential and risk, and Victoria's AOD sector has a strong history of leadership and innovation in system design and service delivery. The latest round of change needs careful monitoring to ensure that clients benefit. Where adjustments are needed, they should be made. Particular areas for attention at this early stage of implementation include:

- Centralised intake and assessment model – streamlined / complex treatment entry
- Funding approach – both the DTAU common price and weightings, to ensure appropriate pricing
- Funding approach - understandings about the scope for consecutive courses of treatment based on client need
- Care and recovery co-ordination requirements and funding amounts

As the system becomes established, it is important that the results of this major reform effort to improve service pathways and outcomes for clients are rigorously analysed. This should include an examination of:

- Consumer experiences in and perspectives about the reformed system
- Impacts on fragmentation / streamlining within AOD treatment pathways and in relation to other systems with which clients are engaged
- Management and practitioner perspectives on benefits, costs, and areas for improvement

This project has a number of limitations. It draws from the views of one set of stakeholders to specialist AOD services in Victoria. There are many other stakeholders; the Department, other government departments, consumers and carers and other funders. It would be useful to have these additional perspectives on the reform process and, for consumers and carers, whether improvements have been realised. A second limitation is the approach to sample selection, which involved VAADA identifying potential candidates and contacting them. While this is a standard approach in purposive sampling, there may be others whose views could improve the accuracy and comprehensiveness of project findings.

Finally, our work has occurred just prior to the reformed system commencing operations. While it has been invaluable to capture the perspectives of stakeholders at this critical point, it is equally important to learn how and whether these perspectives alter with the benefit of experience. This would require a second round of consultation some six months or more into operation, where we would learn more about the reform outcomes and the ways in which the issues and concerns that

have been raised are ultimately resolved. This would assist in shaping future reform processes and approaches to sector design and change.

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Appendix: Group interview questions

What is your role in the organisation and in relation to the recommissioning process? (Brief round table)

As you would know, the Department released a 'directions document', a framework for alcohol and drug treatment services reform in August 2013. This document is the basis for the recommissioning of services that commenced with the release of the Advertised Call for Submissions for adult non-residential services, in October 2013.

One task for the project is to describe the key stages and activities leading up to recommissioning. What would you identify as the key stages and activities leading up to the release of the framework document in August 2013?

Consultation activities (workshops, discussion papers, calls for submissions etc)

Advisory groups and summary papers

Other

What issues and concerns would you identify that arose from processes during this phase?

Now I'd like to focus on the recommissioning process itself, which commenced with the Advertised Call for Submissions in October 2013. In your view, what are the key issues arising from this process?

In relation to the approach to competitive tendering

In relation to funding availability

In relation to contract management and accountability

In relation to transitional arrangements

Other (prompt re consortia if not covered previously)

Thinking about the recommissioning process overall…

What are the strengths and benefits of the recommissioning process?

What could be done better or differently?

What is the one thing you would change?

Do you have any final comments regarding the Victorian alcohol and other drug sector reform process?