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

EXECUTIVE SUMMARY

July, 2014

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

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

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

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

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

Aims of the Review

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

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

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

Current AOD treatment need and treatment funding

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

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

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

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

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

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

The Review focussed on two Commonwealth AOD treatment grant schemes, the Non Government Organisation Treatment Grants Program (NGOTGP) and the Substance Misuse Service Delivery Grants Fund (SMSDGF, Chapter 5). In total, these schemes distribute $130 million per annum (in three year grants), and represent 10% of the total Australian AOD treatment funding. The NGOTGP is an ongoing initiative that provides around $49.3 million per annum. Its core objective is to increase the number of treatment places available and strengthen the capacity of treatment providers to achieve improved service outcomes. In the 2012 grant round (for the period 2012/3 to 2014/5), 171 projects were funded, provided by 122 organisations (Chapter 5). The primary objective of the SMSDGF is to promote and support AOD treatment services to build capacity and effectively identify and treat coinciding mental illness and substance use. Our focus is on Priorities 1, 2, 3, and 5 of the Fund, which are directed towards treatment. From this orientation, the SMSDGF provides around $80 million per annum, with a priority focus on services for Aboriginal and Torres Strait Islander people. In the 2012 grant round (for the period 2012/3 to 2014/5), there were 303 individual projects, provided by 197 organisations (Chapter 5).

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

Current planning

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

"The absence of effective planning processes, assessment of need, unmet need, and gap analysis" (p. 193).

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

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

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

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

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

Current purchasing

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

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

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

Current monitoring and accountability

The multiple streams of AOD treatment funding (Chapter 3) extend to different strategies for monitoring and accountability, just one example of the complexities for organisations in managing multiple sets of funding, with different conditions, timeframes, and reporting requirements. The Commonwealth's contract management, performance and financial monitoring practices are under reform, with the intention to, amongst other things, increase consistency in their practices and reduce the contract management and monitoring burden on funded organisations. There has been variability in practices in relation to the payment tranches; the extent to which the performance measures are considered as deliverables; and the use of the Alcohol and Other Drug Treatment Services - National Minimum Data Set (Chapter 10). There are inherent difficulties in apportioning outcomes to particular sources of funding within a project, or even particular sources of funding within an organisation. Having the ability and mechanisms to measure and account for both individual project performance and the outcomes of the programs (NGOTGP and SMSDGF) as a whole is vital.

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

Role delineation: where does the Commonwealth fit in?

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

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

1. Advancing national priorities

The Commonwealth has a unique role and responsibility to advance areas seen as important *across* states and territories. There is no duplication with states/territories in this function. It is the only level of government with a "bird's eye" perspective on AOD treatment priorities across the nation. The provision of funding for treatment services, where those services have demonstrated cost-effectiveness and form part of a national priority, is an important Commonwealth role. Its role may also include setting national priorities for specific treatment types, and/or increasing the access of specific population groups to core AOD treatment. In addition, it may set national priorities for sector development through national capacity building initiatives.

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

2. Providing leadership in planning

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

3. Addressing service quality

Service quality is a key mechanism for ensuring good treatment outcomes are made possible. Key to service quality are treatment providers equipped with the practical resources to respond to priority groups and concerns, organisational structures within services that support good service delivery and the existence of sound intra- and inter-sectoral systems of care. States and territories share the responsibility for service quality and achieving health outcomes. However, the unique role for the Commonwealth is providing a nationally consistent approach to service quality by ensuring a national quality framework, nationally consistent quality standards and clinical guidelines, and national capacity building projects.

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

4. Supporting equity

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

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

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

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

Deciding what to purchase?

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

Instead of making an *a priori* decision, the Commonwealth could engage in the longer-term process of strategic and technical planning (Chapter 13). Planning processes enable purchasing decisions to be grounded in data on need and demand and focus the Commonwealth's effort in those areas that emerge as highest need. In the immediate 2015 grant round, a rapid consultation process could be undertaken (Chapter 16) with submissions from states/territories and input from an expert panel (inclusive of service providers and consumers) to establish the specific priority areas for Commonwealth funding (for treatment service types and for capacity building). These actions would both articulate with and commence the longer-term path to establish a strategic plan and engage with states/territories in technical planning into the future.

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

Duplication in what the Commonwealth and state/territories do?

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

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

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

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

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

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

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

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

Transfer funds to states/territories

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

> *"Better service planning could occur under a single purchaser model… [but]… could result in a loss of specified AOD treatment funds" (p. 283-4).*

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

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

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

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

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

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

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

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

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

Planning

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

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

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

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

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

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

Purchasing

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

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

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

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

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

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

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

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

Accountability

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

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

> *"Performance monitoring is important at both project and program level" (p. 303).*

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

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

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

Moving forward in 2014/2015

> *"The Commonwealth has a number of options to incrementally improve the planning and purchasing associated with the 2015 grant rounds, while laying the foundation for longer-term reform" (p. 308).*

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

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

Communication, collaboration and partnerships

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

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

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

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

Health outcomes

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

Disclaimer

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

Acknowledgements

This substantial research project would not have been possible without the extensive support of and collaboration from a number of key organisations and individuals. The state and territory health departments all gave freely of their time and provided us with data and shared their valuable experiences in relation to AOD treatment funding. The peak bodies in each jurisdiction (AADANT, ATDC, ATODA, NADA, QNADA, SANDAS, VAADA, WANADA) gave their time and expertise across the life of the review: facilitating access to data and treatment providers, participating in interviews and keeping the sector abreast of the project work. The School of Rural Health, Monash University completed the work on rural issues. The team at the National Drug Research Institute, Curtin University undertook the review of Aboriginal and Torres Strait Islander AOD services. We are very grateful for their specialist expertise in this area. Our 'critical friends' provided a very useful sounding board for the research. The Australian Institute of Health and Welfare, the Family Medicine Research Centre (University of Sydney), the Turning Point Pathways team, the National Drug and Alcohol Mapping Project team and the Financing and Analysis Branch, Department of Health provided valuable access to data. A number of stakeholders across the sector provided valuable feedback on the Working Papers. None of the organisations or people mentioned here have seen the final report nor have endorsed the findings, which remain the responsibility of the research team.

The Department of Health has funded the work, but also supported the research process through access to data, and willingness to be interviewed. While providing feedback and reflections throughout the course of the work, they have also allowed us to conduct the work rigorously and independently.

This work was commissioned and funded by the Australian Government Department of Health. Financial support was also provided by the Drug Policy Modelling Program core funds (Colonial Foundation Trust) and Professor Alison Ritter is a recipient of an NHMRC Senior Research Fellowship (APP1021988).