Psychiatric Disability Services
of Victoria (VICSERV)

Joint Submission to the Community Sector Reform Council Discussion Paper

September 2014

About this submission

This joint submission represents the consensus view of from VCOSS, VAADA, VICSERV and CHP regarding the recommissioning of alcohol and other drug services and community mental health services.

About VCOSS

The Victorian Council of Social Service (VCOSS) is the peak body of the social and community sectors in Victoria. VCOSS works to ensure that all Victorians have access to and a fair share of the community's resources and services, through advocating for the development of a sustainable, fair and equitable society. VCOSS members reflect a wide diversity, with members ranging from large charities, sector peak organisations, small community services, advocacy groups and individuals involved in social policy debates.

VCOSS raises awareness of the existence, causes and effects of poverty and inequality and advocates for the development of a sustainable, fair and equitable society. As well as promoting the wellbeing of those experiencing disadvantage and contributing to initiatives seeking to create a more just society, VCOSS provides a strong, non-political voice for the community sector.

About VAADA

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

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

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

About VICSERV

VICSERV - Psychiatric Disability Services Victoria is a membership based organisation and peak body for community managed mental health services in Victoria.

VICSERV envisages a society where mental health and social wellbeing are a national priority, pursues the development and reform of mental health services through a range of policy initiatives and events and delivers accredited training and professional development for the community managed mental health workforce working within a recovery framework.

About CHP

Council to Homeless Persons (CHP) is the peak body representing organisations and individuals with an interest in and commitment to ending homelessness in Victoria.

CHP works to end homelessness through leadership in policy, advocacy, capacity building and consumer participation. CHP is driven by principles that give focus to its belief that homelessness is unacceptable, avoidable and within our reach to resolve.

1. Executive Summary

VCOSS, VAADA, VICSERV and CHP welcome the opportunity to provide feedback to the Community Sector Reform Council on the recommissioning of the Community Mental Health (CMH) and Alcohol and Other Drug (AOD) sectors. Stakeholders have been consulted to inform this submission.

As indicated in the Council's discussion paper, the reform process has raised a number of important issues. The peaks believe it is essential that the Council provides advice to the Minister which reflects the impacts of the reform process in order to improve future decision making and change management.

The reform of CMH and AOD services was characterised by:

- lack of collaboration, consultation and poor communication;
- poor transition planning;
- a disconnect between the reform aims and the tender specifications; and
- significant costs to the community sector.

Given our experience in this process we recommend that any future recommissioning should be managed differently. Any future process needs:

- a greater focus on partnership and co-design of the system;
- specialist skills and expertise within government to manage change, and comprehensive understanding of the sectors involved;
- a stronger commitment to effective change management processes;
- a clearer understanding of service demand;
- more transparent communication and clarity of probity requirements;
- forward planning in terms of transition arrangements and support;
- an acknowledgement that such change requires financial investment; and
- more realistic timelines that encourage effective transition to new ways of delivering services.

The peaks have advocated for many years that changes to the service system were required to improve outcomes for clients. However, we believe that there are more effective ways than the competitive tendering approach that was undertaken. This submission first highlights the impact of the reform and tendering process, and informed by this experience, suggests alternatives for the future change processes.

2. The community mental health and alcohol and other drug services re-commissioning processes were poor

2.1 There was broad support for the reform goals and the need for change. However, this enthusiasm and trust has been severely affected by the:

- **lack of consultation, collaboration and communication throughout the reforms;**
- **changing and inappropriate timelines; and**
- **poor transition planning.**

The Alcohol and Other Drug (AOD) and Community Mental Health (CMH) sectors had for many years acknowledged that outcomes for clients could be improved by changing the service system. The sectors were ready to engage with Government and the Department of Health to implement reforms. The CMH sector had already made a case for change in the document "An agenda for change", which had a high degree of alignment with the Department's goals. The AOD sector entered into discussions with the Department about the need for reform, and was also supportive of the stated goals. Both sectors began to consider the opportunities that would arise throughout a change process and beyond.

Lack of authentic consultation, collaboration and communication

When the reform process commenced, indications and expectations were that service providers were to be involved in structuring and developing the system – through capacity building projects, consultation processes and advisory groups. However, service provider involvement never eventuated to the extent expected or desired.

The consultation processes on the framework models were tokenistic. VAADA received feedback that consultations appeared to be undertaken for administrative purposes only and that the notion of co-designing the recommissioned system was an inaccurate depiction of what was occurring. Rather than genuinely consulting with community mental health services, the Department was criticised for simply providing information. The consultation report (released six months after the event) highlighted some significant concerns which were never addressed.

A culture of secrecy and confidentiality permeated all aspects of service development, inhibiting opportunities for collaboration and discussion. For example:

- capacity building reference group participants were asked to keep information confidential and project reports were not released;
- the stakeholder advisory group was also asked to keep information confidential (preventing peak body representatives from consulting with their members); and
- framework and tender specifications were developed in house and without input from the sector.

The application of probity requirements stopped the sector from making contributions to service development (despite capacity building projects still continuing) or from entering into discussion about the future service system. The written question and answer process often failed to adequately answer the question posed or did not do so in a timely manner. In both sector reform processes there is evidence that there were different interpretations of what was required by the tender specifications.

Further increasing anxieties across the sector, VAADA received feedback and criticism that some sector members and certain sector representatives were privy to information that was not widely disseminated. This perception, whether accurate or not, significantly damaged the credibility of the approach to probity and therefore bought into question much of the decision-making that occurred throughout the tender period.

There was inadequate and infrequent communication from the Department to the sector throughout the process. With services unable to talk to each other or their clients about the tender process, the need for the Department to keep people informed of the process and impending changes was critical but never fulfilled.

Changing and inappropriate timelines

Initial timelines were not met. Delays in the release of the call for submissions, and then in announcements for phase 1 and phase 2 outcomes created confusion and had a range of administrative impacts on services, discussed below. The decrease in the timeframe for transition from six–nine months, to three months within the CMH sector has proved to be insufficient with new services not being ready by 1 August. This has had negative impacts on clients and services. Clients were not adequately prepared for change. New service providers have had to work to engage with transitioning clients.

The process of determining extensions in the AOD sector reforms was confusing and appeared *ad hoc* at best.

Where new arrangements such as consortia were created, there was insufficient time to create new legal entities before transition commenced.

Poor transition planning

With such a limited period between the announcement of successful tenders and commencement of the new service system, there was not enough time to meet the administrative or client requirements of transition.

Transition planning occurred too late in the process. The transition support package was hastily put together and did not respond to issues being raised by the sector and did not adequately address the scale of change or the risks.

In many cases successful services had to plan for and recruit a new workforce, sometimes simultaneously having to issue redundancies, before any handover or service planning could take place. In the case of AOD services, a number of consortia that were successful for only part of their bid were faced with renegotiating their consortia arrangements based on a funding allocation that was smaller than originally anticipated. These complex administrative arrangements were still being bedded down when new and relinquishing service providers met to discuss the new service system and client needs. There was no provision for 'warm referrals', providing an overlap between exiting and incoming service providers for those clients for whom such a change was likely to negatively impact their mental health. Even residential services were unable to provide an overlapping service. Instead resources were directed towards information provision.

The scale of change in CMH meant that many services were not fully operational by 1 August but relinquishing service providers were not funded to hold clients and facilitate their transition as places became available from the end of July 2014. This process was distressing for many clients and relinquishing services.

Many operational aspects of the new system are still to be determined or were being worked out post implementation, including performance management frameworks, service guidelines and data collection. There are a number of examples where the understanding of how aspects of the frameworks were to be delivered is either different or has changed – including issues associated with allocation of nomination rights, tenancy arrangements for residential services and how funding can be used.

Many of the concerns raised by services could have been avoided had Government effectively engaged the sector to work with Government to co-design and redevelop the service system. In the CMH sector these include the disruption caused to clients, carers, the workforce and existing partnerships. Collaborative effort ceased when contracts with well-established and quality service providers (who are continuing to provide services elsewhere) were replaced. There was a lack of practical support and time to enable an ordered, less financially costly and client centred transition. In the AOD sector these issues are similar, whilst acknowledging that the majority of service providers are also going to be involved in the new system, albeit for many with a lesser funding allocation.

2.2 The articulated goals of the reform were not adequately translated into the tender documents which has impacted on outcomes.

Despite similar reform goals and selection criteria, the tender process delivered vastly different outcomes in the AOD and CMH sectors in relation to the formation and ultimate success of consortia and in the funding of specialist providers. The AOD tender resulted in significant consortia and funding remaining with homelessness services in recognition of the important role they play in meeting the needs of people with AOD issues. The CMH tender resulted in no specialist homelessness providers (except for Sacred Heart Mission) and very few consortia. This is likely to be a result of a combination of different interpretations of and assessments against the selection criteria.

There were significant surprises at the outcome of the CMH process, particularly in relation to the scale and size of the change and the lack of choice and diversity in providers. This suggests either the Department was unaware of the potential of the impact of its process or it failed to adequately explain what it was hoping to achieve.

There was an ongoing lack of clarity in the AOD sector with regards to decisions about collapsing funding streams into the new proposed AOD treatment types and with regard to how assessment criteria within the advertised call for submissions was applied.

There was a loss of opportunity for joined up service delivery as a result of the reduction in services being provided through Community Health Services and, in the case of CMH, homelessness services. This appears to be contrary to the reform goals of improved integration.

In regional areas, clients are less likely to receive the level of treatment and support previously available. New providers do not have the infrastructure to deliver outside large regional centres so services are less available in some smaller towns. In some areas service providers had multiple sources of funding from mental health, gambling support, AOD and other programs. The loss of one funding stream has a flow on effect with a loss of capacity to deliver services and the loss of joined up service delivery.

Within the CMH service system there are questions about the value of intake and assessment services when there is only one service provider. In AOD there are questions about how the mechanism will integrate with existing, well established service providers who have strong links with the local community. Despite goals of integration and partnership, there were limited opportunities for providers to consider how to work together.

There has been a general understanding that the second phase of the tender process would enable consideration of an optimal service configuration in a catchment. However, providers had to contribute a high level delivery plan not knowing how much they might end up delivering or who else was in the area.

The AOD sector welcomed the last minute change withdrawing AOD funding within crisis accommodation from recommissioning, thus enabling these services to continue with their AOD work. However, it did highlight that it should have never been included in the first place and that there was inadequate consideration given to ensure the specialist capability in the homelessness sector was recognised within the recommissioning processes. The same could be said for funding targeted at Aboriginal clients and youth focussed programs that were also excluded from recommissioning at latter stages of the process.

This lack of clarity and shared understandings had a number of implications, including services making decisions about how and where to tender (perhaps to their detriment) and clients and carers not adequately understanding the directions and the impact it would have on their services.

2.3 The reforms have been very costly to implement. It is not possible, nor desirable, to undertake cost-neutral reform.

The financial and non-financial cost to the sector in implementing these reforms has been significant. The resource intensity and cost of this process does not appear to have been acknowledged or understood.

There were costs associated with preparing for the tender process and preparing tender documentation. Many services took staff off line and/or used their resources to employ tender writers.

The two phase process was particularly burdensome and costly. The number of "short listed" providers was too high in some catchments, as evidenced by the significant number of agencies who were ultimately not successful in the CMH sector. The preparation of the high level catchment delivery plans for these agencies was effectively a wasted (and costly) effort.

The cost of transition has been largely incurred by agencies, recognising that this funding has come from government and the community through fundraising and philanthropy. There was inadequate time (and limited knowledge or inadequate notification of the possibility) to consider less disruptive or expensive options such as interim subcontracting or transmission of business. Redundancy, legal and changing accommodation requirements have been significant for many services. Redundancies have cost hundreds of thousands of dollars.

Experienced staff are difficult to attract and the expected loss of workforce capacity is yet an unknown cost. The loss of capacity may have long term implications. There have also been personal costs to clients, carers and workers – particularly for those who needed to transition. VICSERV has estimated that at least 44 per cent of the workforce is moving either through redeployment, redundancy or ceasing of contracts.

While the Department did provide some funding for support, it was largely allocated for the provision of information to clients about the new system. It also included very small grants to assist with administration costs and supports for workers – in the form or change, personal or career management courses. There was minimal consultation with the sector as to how the resources could best be used. Advice from VICSERV that transition support should focus on providing capacity for temporary duplication in the system to enable the warm transfer of clients was not heeded.

2.4 There are concerns about some of the outcomes of the reforms.

The changes will require time to bed down, and the service system will be in transition phase for a significant period. It will take some time before the actual impact on clients, the workforce and the service system is known. However, there are a number of outcomes which are inconsistent with the stated goals of reform and others that may impact on the service system in the long term.

Some providers have moved out of areas where they were established, into new areas. It is questionable whether this will result in better outcomes for clients, however, it does carry significant short to medium term risk for clients having to move providers and has been costly to implement.

The CMH reforms did not deliver on either diversity of providers or real and genuine choice for clients in relation to their service provider. In particular:

- in rural areas there is often only one service provider, there are no longer any community health services providing CMH;
- there are no specialist homelessness service providers (with the exception of Sacred Heart Mission) or any providers targeting groups with particular needs or backgrounds; and
- there are no small providers.

The siloed approach to reform, the significant contraction of CMH providers and the reduction in the number of community health services appears to have impacted on joined up service delivery, particularly with drug and alcohol services and the homelessness service system. It is inconsistent with expectations of holistic service delivery and integration.

The significant reduction in the number of CMH providers and change in the AOD service mix may also have longer term implications. Organisations previously providing joined up services may choose to withdraw completely from working with people with a mental illness or alcohol and drug issues. This will reduce overall capacity of the generalist and specialist service system to provide appropriate responses and interventions to these groups of people. It may also impact on flexibility and local level responsiveness, particularly in regional areas where there is already evidence of small local service outlets no longer being available.

The relationship between the Department and the sector has been damaged as a result of the lack of consultation, collaboration and communication.

3 Future community sector change should be managed differently

3.1 Principles of collaboration, partnership and co-design should be applied to service system design and the mechanisms for achieving change

Partnerships between government and community sector organisations are an important part of effective service design, development and delivery. However in practice, true partnership is rarely achieved. Differing perspectives between the government and the community sector, and differing power relationships, are just some of the factors that hamper the genuine partnership. The processes involved in the recent tendering processes reflected these limitations.

The implementation of change should be characterised by collaboration and partnership between the government and the sector. Professor Peter Shergold, in his report on sector reform, recommended that the contracting of services to the community sector should involve consultation on all significant issues, including the development of policy, planning and service design. With their extensive history of working alongside other service providers and government to deliver the best possible outcomes for service users, community service providers are well placed to inform planning and service design.

Working with the sector to design and reach agreement on the reform directions and parameters of a new service system is central to a partnership approach. Similarly, allowing time for services to reorganise, change and implement these directions is an important part of co-design, and provides the opportunity for service organisations to be active participants in reshaping the service system for their clients.

Despite the decision to tender, there are significant opportunities for the sector and the government to work together to co-design and refine a new service system, but these were not taken up by the department.

Professor Shergold's report stated that:

> *"Genuine collaboration needs to be embedded in the structures and systems of public administration."*

Unfortunately, the evidence from the recommissioning process indicates that collaboration is not yet embedded in public administration in Victoria.

3.2 The public service requires specialist skills and expertise to manage substantial change

Recommissioning and competitive tendering both require specialist skills and expertise. Tendering of a new service type, or distribution of new funding, differ from tendering an existing service due to the significant impacts - financial and personal – these have in changing service delivery practices.

Recommissioning requires:

- an understanding of, and capacity to lead, implement and monitor change management;
- expertise and capacity to adequately identify and respond to risks, including expert knowledge of the service system and client and carer issues and needs;
- technical skills associated with such work, including understanding and analysing markets, and communication skills and balancing probity requirements with information needs; and
- resources to support the above.

It is critical in any future recommissioning processes that relevant departments have sufficient skilled staff who can manage the change process. The capacity of the Department of Health to deliver a robust recommissioned system was significantly diminished through the reduction in public servants across Victoria. The departure of personnel with strong content knowledge and organisational history greatly affected the management of these processes. The reduction in staff numbers appeared to have practical implications on the work produced within the Department, on the capacity to meet identified timelines and the understanding of how best the funded sector could have contributed to the design of the new service system.

During the recommissioning process it often appeared that timelines were not being adhered to due to the volume of work expected of the small departmental reform teams. This also emerged throughout the reform advisory groups, where a lack of historical sector knowledge was reflected in the proposal of models that did not take into account issues such as client engagement, the building of therapeutic alliances or an understanding of the pathways travelled by clients of mental health and /or alcohol and drug services. Ensuring that Departments have adequate resources and staff to manage and engage in complex recommissioning processes is critical.

3.3 Service sector evolution should have a strong evidence base and clearly articulated policy goals

Professor Shergold recommended that the Victorian Government take a "strategic…approach to commissioning services…". A strategic approach should commence with a rigorous policy development process that identifies need, articulates clear goals and selects the most appropriate policy instruments in partnership with the community sector. Throughout this process it is also important to continue to assess emerging needs and to maintain flexibility to address them.

A strong evidence base is a prerequisite for any policy change or development. A robust evidence base should be informed by service users, results (outcomes) of service provision and the knowledge of service providers.

The recommissioning of both CMH and AOD services involved a number of developmental projects to gather the evidence, and develop various aspects of the reform, including demand modelling and forecasting, performance management and client management systems. Many of the projects were not completed before the release of the tender specifications. Final reports or outcomes from the project were not publicly released. It is important that in any future processes these outputs are shared with the sector in order to inform organisational decision making.

In addition, the development of service guidelines, performance management and data collection frameworks did not become available until after the tendering process, or are still in development. In retrospect these should have been completed before tendering so that there was clarity about what was being purchased.

It is also important to continue to assess emerging needs and to maintain flexibility to ensure that objectives and instruments are regularly evaluated. Using these processes, an effective commissioning process can be developed that:

- identifies the services that are required to implement the policy;
- selects the best provider or providers of those services; and
- develops the most appropriate approaches to funding and evaluating the services.

A revised service system developed using this approach as part of rigorous policy development can deliver the outcomes that the community should expect from the government and the community sector.

3.4 There needs to be capacity within recommissioning processes that support place-based and locally responsive models.

Service systems often develop around local needs and local networks. These local networks can add significant value to the services being delivered and vice versa. For example, while drop-in and day centres may have been identified as less effective therapeutic interventions, they provide local sites to engage people with complex needs in a range of service offerings. Understanding local connection and the place-based impact of the commissioning (in this case tendering) of services is critical.

Given the complex needs of many people accessing community services, many organisations have built up combinations of funding over time, which allows them to meet the local needs of their client group. Recommissioning processes that do not take into account this delicate funding mix will have unintended consequences for vulnerable clients.

Similarly, such processes need to be able to respond to unique area needs and the benefits of existing partnerships, existing collaborations and existing capacity to provide locally responsive services.

The tender processes as executed appeared to not be able to take this into account. For example, existing and well established providers were removed from one area but required to set up in another, leading to upheaval in the local area and potentially the unnecessary loss of valuable local networks and expertise.

One strategy to mitigate some of these impacts would be to undertake an assessment of impact before and during the recommissioning process. An impact assessment before the process would have identified the vulnerability of smaller organisations, specialist services and local connections, either enabling a different approach in tendering or putting in place alternative strategies to plan for service closure and transfer of clients in a timely and respectful way.

3.5 Alternative models of service system change should be developed and evaluated through a rigorous analysis of change options and impacts.

Competitive tendering is an extremely blunt instrument to manage change. The experience of both the AOD and CMH sectors is that the tendering processes have been very disruptive, expensive and had many unintended or unexpected outcomes. It raises questions about whether the alternative approaches could have achieved better outcomes with less disruption. In particular:

- Could a regional approach have been more effective than a state-wide approach when the need for structural change was not the same in each region?
- Given program changes had strong support from services but needed funding reform in order to be implemented, was tendering necessary to change this aspect of service delivery?
- Was tendering useful for all of the service components?
- Was the attempt to attract new providers necessary given the impact on submitted tenders from existing agencies who felt the need to tender more widely rather than just in their natural communities?

After a period of collaboration and co-design between government and the community sector in order to develop an agreed service system framework, a rigorous analysis of mechanisms to achieve the reform goals should be undertaken. In sophisticated and complex service systems alternative methods to tendering should be the preferred methods of achieving change. While these may take longer than a tendering process it is argued that better results will be achieved.

There are a number of approaches that could be used to implement change in a collaborative manner:

- organisations can be given time to reorganise themselves where they do have capacity to develop the new approach;
- departments and peak organisations could facilitate cooperative ventures and consortia to implement the new service system framework; and
- governments and community sector organisations could undertake joint area-based planning to reorganise service provision in line with the new framework.

Only when collaborative approaches fail should competitive tendering be used to deliver reform. If competitive tendering is to be used, then the processes must be greatly improved.

The ultimate goal of reform for both government and the community sector is to deliver a service system able to better meet the needs of clients. Sharing the responsibility and using a collaborative approach to shaping a new service system can deliver this goal.

4. Conclusion

VCOSS, VAADA, VICSERV and CHP acknowledge that the collection of client data will be essential to determine whether the proposed outcomes of recommissioning have been achieved. It will be critical that government is flexible in its response to identified needs, and undertakes a transparent and collaborative approach to determining what aspects of the system are working well, and which need revising.

However, it is important to note that the recommissioning in both the AOD and CMH systems has created significant confusion for service providers and clients. This has been shown through the many discussions that peaks and funded organisations have been involved in as they have attempted to support the realisation of the proposed changes. There are still many unanswered questions in both sectors and it is strongly felt that a more effective process would have ensured that all developmental work was finalised well before changes of such a broad nature were implemented.

Competitive tendering is an extremely blunt instrument to manage change. The peaks involved in the development of this joint submission believe a better planned and effectively resourced change management process is required to assist a timely shift to new service delivery arrangements.

We thank the Community Sector Reform Council for undertaking this work and welcome any further opportunities to explore the issues raised in this submission with the Council and the Minister.