Report on the

Requirements for the Establishment of a new National Peak Body for Alcohol and Other Drugs

June 2015

Contents

1. Introduction

Following the removal of Commonwealth funding for the Alcohol and other Drugs Council of Australia (ADCA) in November 2013, the organisation was placed into voluntary administration and ceased all functions over a period of months, with the exception that the Board of Directors continues to meet on a regular basis with a view to seeing the organisation continue to support the alcohol and drug sector in Australia in some capacity.

In May 2014, the Board of Directors (ADCA Board) convened a meeting of members in Canberra to discuss the way forward. The outcome of this meeting was that the ADCA Board commissioned an Independent Committee to conduct a broad consultation on the potential structure, activities and membership of a newly constituted peak body for the alcohol and other drug sector and report the outcomes of this consultation back to the ADCA Board.

The Independent Committee (the Committee) membership was drawn from the broad range of organisations involved in reducing alcohol and drug related harm across the spectrum. The Committee's Terms of Reference and Membership is included in Appendix 1. The Committee met via teleconference in October 2014 to discuss the role and purpose a national peak, where it was agreed that a smaller working group of individuals willing and able to commit time to the consultation process and proposal write up, who would then come back to the full Committee for endorsement prior to submitting the report to the ADCA Board. Membership of the Working Group is included in Appendix 2.

The Working Group determined that an online survey, supplemented by interviews with key experts in the AOD sector would be manageable within the available resources and the following key questions should be put to as wide a group as possible through the survey:

- Do you believe we need a new national peak body to represent the sector nationally?
- What should be the activities of the national body?
- Who should it represent?
- What were the strengths and weaknesses of the former national peak ADCA
  - How would this body differ from previous model?
- What is the type of structure needed?
  - propose a range of options – federated model, state iterations, membership (org based/individuals, mix)
- How should it relate to other sectors of importance to the AOD Sector?
- Who would contribute to the funding?

An overview of the survey results and key themes from the stakeholder interviews are summarised in the following section. A list of key stakeholders invited to participate in the interview process is included in Appendix 3.

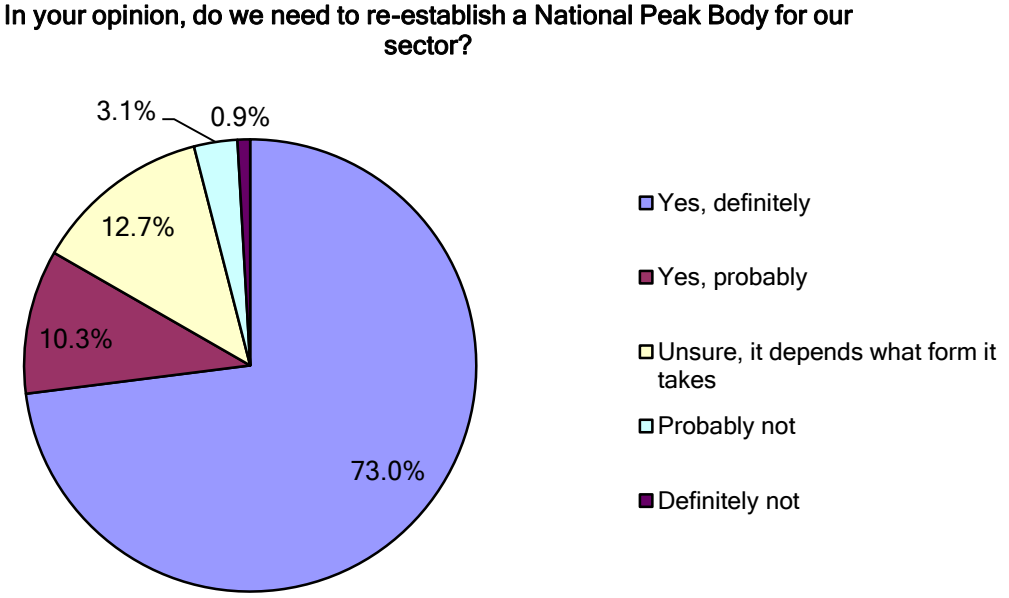
2. Survey Results

The survey was designed by David McDonald (Director, Social Research and Evaluation Pty Ltd) with input from Larry Pierce (CEO, Network of Alcohol and Drugs Agencies) and Rebecca MacBean (CEO, Qld Network of Alcohol and other Drug Agencies).

The survey was available electronically via Survey Monkey from Monday 2 February to Friday 6 March 2015. The survey was promoted by the State and Territory AOD peak bodies, the Public Health Association of Australia (PHAA), the Australasian Professional Society on Alcohol and other Drugs (APSAD), as well as via the ADCA Update mailing list. The survey was completed by 456 individuals across Australia. The following sections summarise the survey results.

2.1 Need for a National Peak Body for the Alcohol and Other Drug Sector

The survey asked respondents to consider the need for a national peak body for the alcohol and other drugs sector.



Graph 1 shows 73% of respondents thought we definitely need a national peak body. A further 10.3% of respondents thought we probably need a national peak body. Only 0.9% of respondents thought we definitely do not need a national peak body.

2.2 Stakeholder Groups Represented by a National Peak Body

Respondents were asked to consider a list of groups who could potentially be represented by a national peak body for the alcohol and other drug sector. The following table lists the stakeholder groups identified, from most frequently selected to least.

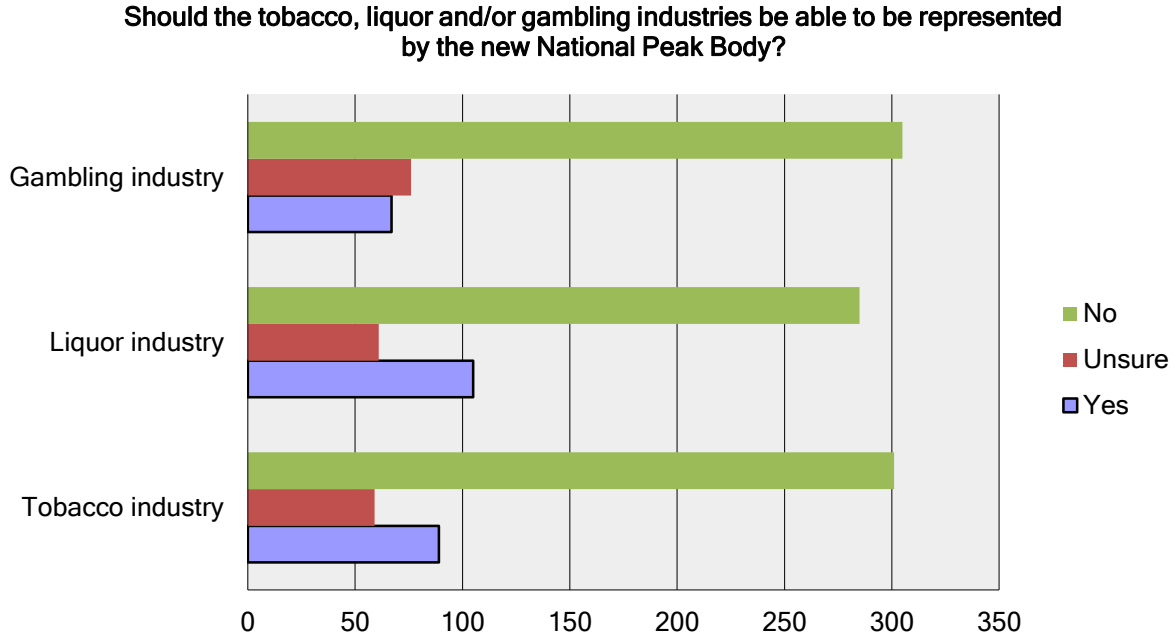
The following questions cover what a new National Peak Body might look like. Whom should the new National Peak Body represent? Please mark one or more of items on this list.

Answer Options	Response Percent
AOD specialist treatment services: NGO	90.5%
Harm reduction services, e.g. NSPs	85.0%
AOD research centres	77.5%
AOD specialist treatment services: government	76.4%
National, state and territory drug user organisations	72.2%
Family-focused treatment/support/advocacy organisations	68.9%
Key AOD organisations such as APSAD, DANA, Chapter of Addiction Medicine	65.6%
Individuals involved in the AOD sector	53.4%
Organisations operating in related industries, e.g. public health, emergency medicine, etc.	40.8%
Other (please specify)	14.8%

There is a high degree of support for including non-government specialist treatment organisations, harm reduction services, AOD research centres and government specialist treatment organisations. More than 60% of respondents also identified drug user organisations, family focussed treatment/support/advocacy organisations and key professional bodies (such as APSAD, DANA and the Chapter of Addiction Medicine) as appropriate constituencies of a national peak body for the AOD sector. Just over half of respondents (53.4%) thought that the national peak should represent individuals involved in the AOD sector. Only 40% of respondents identified organisations operating in related industries as an appropriate constituency for a national peak body for the AOD sector.

Sixty-seven respondents suggested additional constituencies, with 21% (14) suggesting the membership be as broad as possible, 15% (10) suggesting consumers/service users and families be included, 12% (8) suggesting primary health care organisations be included and 10% (7) each supporting law reform organisations and state/territory and national peaks.

2.3 Tobacco, Liquor and Gambling Industries Representation



The majority of respondents indicated they were against including the tobacco, liquor and gambling industries in the membership of a new national peak body.

2.4 Activities of a National Peak Body

Respondents were asked to consider a list of possible activities of a national peak body for the alcohol and other drug sector. The following table lists the activities identified, from most frequently selected to least.

What activities should the new National Peak Body engage in? Please mark one or more of items on this list.

Answer Options	Response Percent
Represent the Sector at the national level	94.0%
Policy advocacy in public, e.g. via the mass media	84.1%
Policy advocacy behind-the-scenes	83.4%
Facilitating networking within the AOD sector	75.9%
Facilitating networking between the AOD sector and other sectors	72.6%
Workforce development, e.g. establishing a national library resource, conducting training	68.4%
Conducting national conferences	68.4%
Represent the Sector at the state/territory level	53.6%
Organising state/territory and regional activities of local relevance	36.6%
Delivering direct services different from or additional to those listed above	12.4%
Other activities (please specify)	11.5%

The most frequently identified activities of a national peak body were representation of the sector at the national level (94%), policy advocacy in public and behind the scenes (84.1% and 83.4% respectively) and facilitating networking within the AOD sector (75.9%) and with other sectors (72.6%).

Of the 31 activities specified under 'other', 29% identified library resources/information dissemination, 16% identified evidence-based policy and practice development and 10% identified accreditation/credentialing, strengthening accountability and standards or community education as other possible activities of a national peak body.

2.5 Perceived Strengths and Weaknesses of the Alcohol and Drug Council of Australia

Respondents were asked to comment on the strengths and weaknesses of ADCA. Of the 248 responses, the most frequently cited strengths were advocacy (19%), the role/existence of a national peak (14%), the National Drug Sector Information Service (13%), representation (12%) and dissemination of information (7%). Evidence based policy development and networking were each identified as strengths by 5% of respondents.

A further 200 respondents identified weaknesses, with 26.5% identifying representation as an issue, with comments like "limited representation of addiction specialists", "was seen to be NGO centric", and "lack of member consultation and engagement". Other weaknesses identified were:

- Limited public profile (23.5%);
- Unfocussed (22%);
- Reliance on government funding (15%); and
- Limited influence on government policy (13.5%).

2.6 How a new National Peak might differ from ADCA

One hundred and seventy four respondents identified ways a new national peak might differ from ADCA. The comments were grouped into themes. 23% of comments related to representation issues, with comments like:

- Greater focus on the needs of members, greater focus on providing a national peak for the S/T peaks, rather than competing with them, Be better skilled in advocacy, not so in-your-face, Use and promote the evidence base better; and
- Need to include workforce representative groups including: DANA, psychologists, addiction medicine, addiction psychiatry, GPs with a special interest in addictions.

15% of comments related to the profile of the organisation, with comments like:

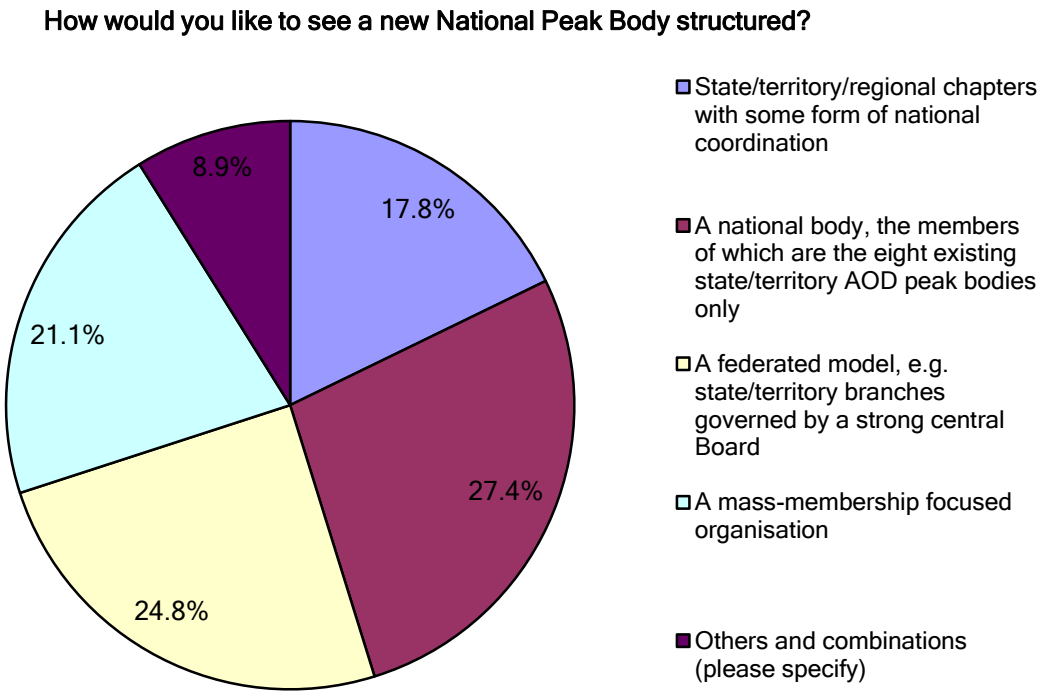
- more active in the public space; and
- Be public and fearless in lobbying government for AOD policy changes that accurately represent what the literature says about harm minimisation principles.

12% of comments related to advocacy or working with and linking the State and Territory AOD peaks, with comments like:

- More involved in treatment services and advocacy at Federal level; attempt to align services and resources across different states and territories; and
- The state peaks should be represented to carry the voice of the AOD sector from a state level.

Other themes from the remaining comments included not relying on government funding (10%), disseminating evidence-based practice (6%), better communication and consultation with members (5%), role clarity (5%), bi-partisan political support (4%) and including a consumer and family voice (2%).

2.7 Possible Structure for a National Peak Body

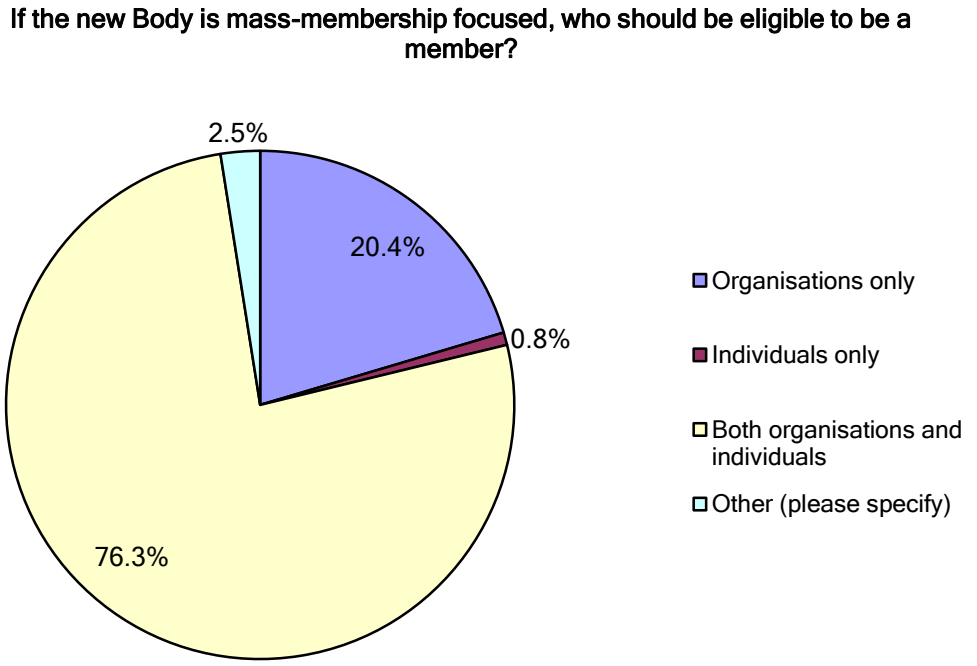


Just over 50% of respondents identified either a national body, the members of which are the eight existing state/territory AOD peak bodies (27.4%), or a federated model (24.8%) as the preferred structure of a national peak. Twenty-one percent identified as mass membership focussed organisation as the preferred structure.

Of the 8.9% of respondents who identified other models or combination models, 47% suggested mass membership plus either state and territory peaks (or some form of jurisdictional representation), plus experts in the field. A small number (8.8%) suggested service users be included in a mass membership based organisation, or in combination with state/territory peaks only.

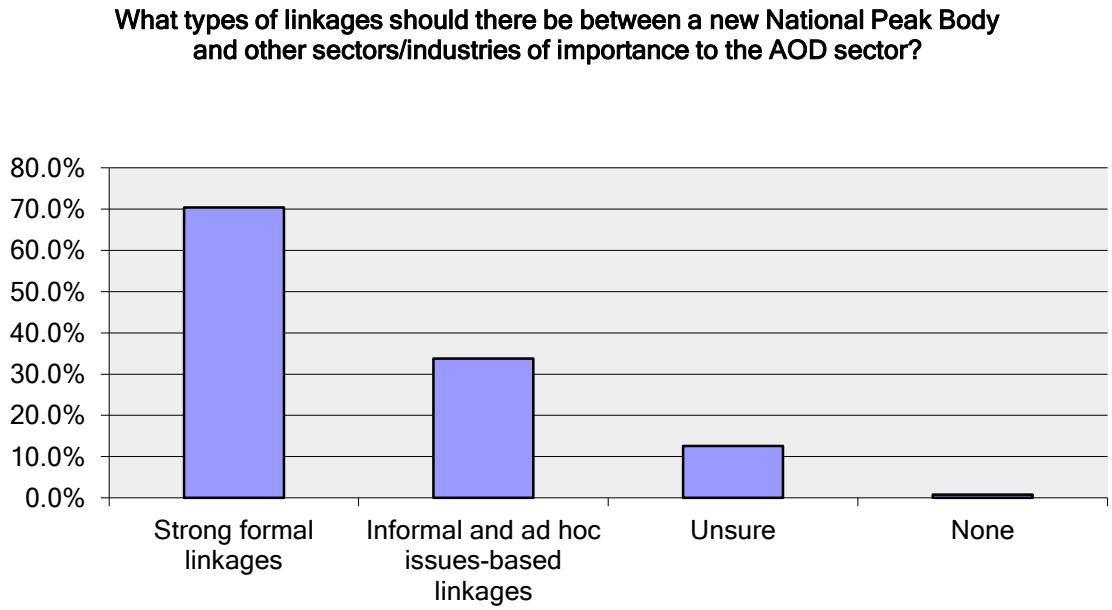
Other comments of note were that the funding model needs to be broader than just dependent upon government grants (10%); industry funding should not be accepted (6%), and financial independence is critical (4.2%).

2.8 Eligibility for Membership



The majority of respondents indicated that if the new body was mass-membership focussed that membership should be open to both organisations and individuals (76.3%).

2.9 Partnerships and Linkages

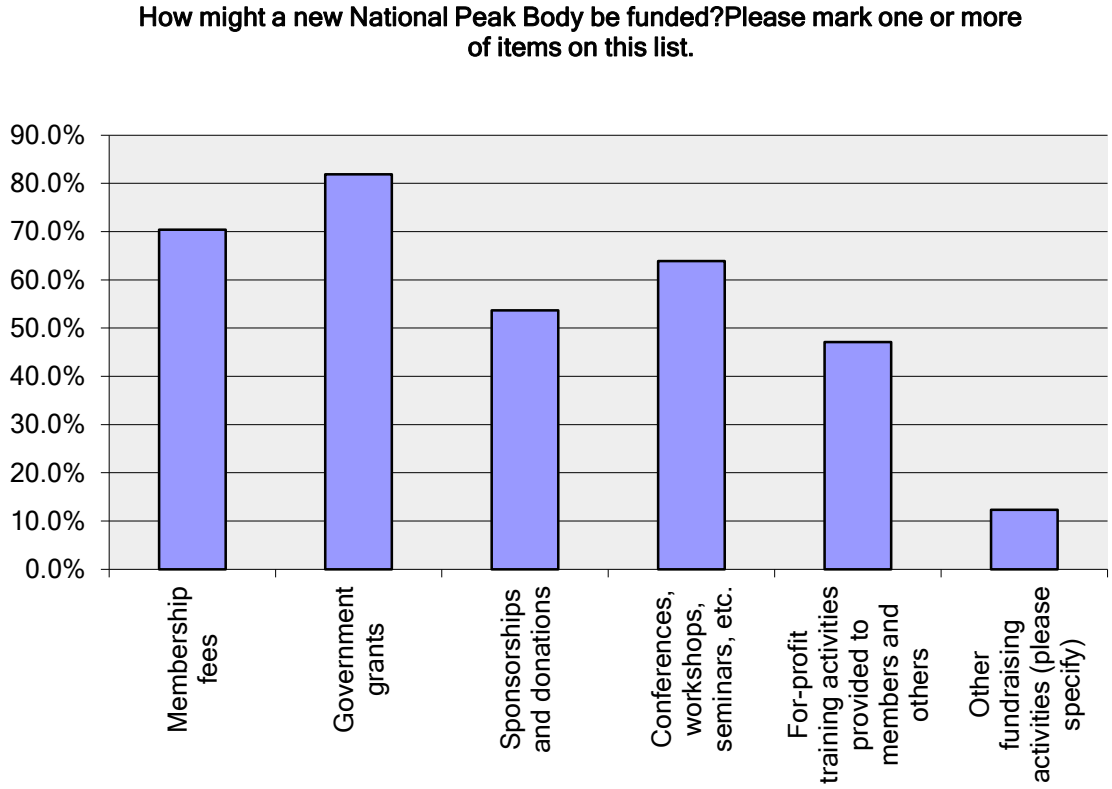


The majority of respondents (70.4%) indicated a national peak should have strong formal linkages with other sectors or industries of importance to the AOD sector, with 33.8% of respondents

indicating support for informal and ad hoc issues-based linkages (respondents were able to select more than one option).

Respondents identified mental health, housing, youth, criminal justice, RACGP, domestic violence, emergency services, private hospitals and child protection as sectors the national peak should have linkages with.

2.10 Potential Funding Sources



The majority of respondents identified government grants (81.9%) as a funding source for the national peak, followed by membership fees (70.4%), conferences/workshops/seminars (63.9%) and sponsorship and donations (53.7%). Just under 50% of respondents (47.1%) identified for-profit training activities provided to members and others as a potential funding source.

As noted above, when discussing possible structures, respondents commented that the funding model needs to be broader than just dependent upon government grants (10%); industry funding should not be accepted (6%), and financial independence is critical (4.2%).

Other sources of funding were identified by 12.3% of respondents. These can be grouped into the following four themes:

- Independent fundraising through events/campaigns/activities (23.4%);
- Selling a product/providing a service/ charging for consultancy (14.9%);
- Utilisation of taxation through a hypothecated tax or government levy (14.9%); and
- Attracting philanthropic grants or working in partnership through social impact bonds (8.5%).

2.11 Other Comments

Respondents were given the opportunity to make any further comments at the end of the survey. One hundred and twelve comments were made, with twelve excluded because they were statements like 'no', or 'nothing further to add'. Of the remaining 100 comments, the majority of additional comments focussed on the role of the national peak (48%), with comments like:

- Need consistency between federal peak body and state peak bodies;
- A new peak should be independent. I believe that this is a very important point and, although I do understand the difficulty of achieving this, I believe that every effort should be put in achieving this independence starting with financial independence;
- Clear national agenda and a coordination role. Would need to conduct mapping of existing peak activities to ensure roles were strengthened and not duplicated;
- Thank you for taking on this task. We need a strong and united voice at the national level to support and promote issues of relevance to the sector - services, public health etc; and
- Appoint experienced and credible key staff if funding is secured otherwise it will have no credibility.

Twenty-two percent of respondents made general positive comments about the work of the Independent Committee and the ADCA Board on seeking to re-establish a national peak, with comments like:

- Thanks for progressing this important initiative;
- Thanks for doing this critically important work. A great shame that it is necessary; and
- Thank you for pursuing the issue of national representation on such a significant issue.

Twenty percent of respondents made comments on the focus of the national peak, with comments like:

- Consider law reform as an issue to advocate on and do it in a visible way. It is very topical given the way the US has gone and this is an opportunity to be more visible to the general public;
- Higher profile within the community, eg. Education, policy and research, a voice for the sector nationally;
- Representation of the NGO treatment sector should be the primary focus. This includes membership of others at the table - ie ATCA, DANA, AIVL along with State/territory peaks and research bodies - all of which contribute to evidence-based and informed practice. However, if the Board is only drawn from these groups how do you have a voice? There needs to be an election process as well as appointed groups - but without making the group too large that it becomes ineffective; and
- Some sort of national planning and coordination of the sector which can be clearly articulated and communicated to the community, with a specific focus on harm minimisation approaches (prevention, early intervention, treatment, harm reduction, law enforcement and policy).

Of the remaining 10 comments, five reiterated views about who the peak body should represent, four reiterated views about membership eligibility or fees and one expressed the view that the Public Health Association of Australia could fill the role of a national peak body for AOD.

3. Key Stakeholder Interviews

The working group identified a range of key stakeholders who it felt were well placed to express a view on the possible role and structure of a national peak body for the AOD sector. Twenty-six stakeholders were identified and invited to participate in an interview (the list of stakeholders can be found in Appendix 3).

The interviews were loosely structured around three questions:

1. What were the strengths/weaknesses of ADCA and how might these be perpetuated/avoided in a new national peak?
2. What are the key issues facing your part of the AOD sector?
3. What could a new peak body do to support your part of the AOD sector?

The strengths identified by stakeholders included:

- The library;
- National profile;
- Drug Action Week;
- ADCA Update and Drugtalk email lists;
- The history of the organisation and credibility with the sector and government; and
- High public profile for key drug and alcohol issues.

The weaknesses identified by stakeholders included:

- Was made somewhat redundant by the success of the State/Territory peaks;
- Moved too far away from the membership base (eg focus on alcohol policy, rather than funding and sustainability of the sector);
- Hard to engage with and participate in.

The issues identified and how a new peak could provide support included:

- Facilitating face to face networking and meetings that the ANCD used to provide;
- Don't duplicate the work of the State and Territory peaks;
- Translational research – hold an annual symposium on how research translates into practice;
- Advocate for a sustainable funding base for the treatment sector and research centres;
- Speak on behalf of the sector;
- Advocate against stigma and marginalisation of drug users in the media.

Other comments provided by stakeholders included:

- It would be good if the new peak worked in genuine partnership with groups that represent user voices;

- Some type of federated model for a new peak makes sense, with members of State and Territory peaks automatically represented by the national peak;
- Engage the celebrity class as patrons of the sector; and
- Important to be proactive rather than reactive.

4. Possible Governance Structures

Based on the results of the survey and interviews with key stakeholders, there are three potential models for a national peak: a federated model; a mass membership model; or a national coordinating body linked with bodies in each state and territory (presumably the existing state and territory AOD peaks).

The advantages and disadvantages of each model are outlined below.

4.1 Federated Model (AOD Peak NGO's)

4.1.1 Membership and funding

Membership would come from directly elected/appointed members of each state/territory peak organisations. Current State and Territory peak members would be represented by virtue of their membership of their state/territory peak. Initially, funding would come from membership fees, while the peak sought funding from the Commonwealth Department of Health.

4.1.2 Advantages and challenges of this model

The advantage of this model is that there is a single organisation that has national reach on alcohol and other drug issues representing the NGO specialist drug and alcohol treatment sector. Further advantages include the collective strength of the NGO memberships of each state/territory peak and the representational strength this will have with the commonwealth government. The organisations represented by these peaks are also the substantial holders of current dedicated state and federal health drug and alcohol funding and provide a substantial amount of direct drug and alcohol services to communities across Australia. It is a very large and substantial sector comprising over 435 member organisations compared to the ADCA membership list of 137 organisations (not all specialist drug and alcohol organisations) and 116 individual members (direct association with specialist drug and alcohol organisations not known). Lastly this is the group the commonwealth had most invested in over the past 15 years and is – like the mental health sector - the sector that most needs expansion if the load on the public hospital sector is to be reduced.

The challenge associated with this model is that it would be restricted to the NGO sector and not represent government workers/specialists and the research and addiction medical workforce. It would also lack the direct input of government specialist drug and alcohol and mental health advocates, consumers, the research sector and BBV specialists. It may also be regarded as a trade union type association that was all about funding and conditions.

4.2 Mass Membership Model

4.2.1 Membership and funding

Membership for this model could take the form of the ADCA model, with a national election process to determine the membership of board of directors. As stated above, the commonwealth may be

less interested in providing establishment and operating costs to such an open mass model as it could use the argument that it used to de-fund ADCA.

4.2.2 Advantages and challenges of this model

The advantage of this model is that it maximises the number of potential members available to the national peak, though a broad membership is also a challenge in terms of ensuring the peak's position is reflective of the majority of members' views. Interestingly, ADCA had a small number of individual members (116), relative to the size of the AOD workforce in Australia.

A broad membership brings with it the challenge of relevance in its scope of activities and policy positions and may be less attractive to Commonwealth funders in that they would view such a wide and diverse membership as being less relevant to their focus. There is also a risk of conflict of interest and controversy of such a broad group of individuals with sometimes policy opposing views.

4.3 Coalition Model

4.3.1 Membership and funding

Membership for this model would be the state and territory AOD peaks, the research centres and AIVL, as well as organisations that represent an AOD sector constituency (eg ATCA, APSAD, DANA, AASW, APS, Chapter of Addiction Medicine, etc). This model is similar to that of the Mental Health Council of Australia, which accepts only organisations as members who have a 'peak' type role, as well as service delivery organisations where they operate across at least four states/territories. Membership of the board could be elected, with the potential to mandate the mix of board members through the constitution (eg, 4 or more positions reserved for the State/Territory Peaks, etc).

Initially, funding would come from membership fees, while the peak sought funding from the Commonwealth Department of Health.

4.3.2 Advantages and challenges of this model

The advantage of this model is that it could build on the work of the existing peaks, as well as provide a structure for ensuring its work is informed by research, practice and user viewpoints. Members of the State and Territory AOD peaks could be represented by virtue of their membership of their relevant peak.

The challenge of this model will be engaging with the diversity of organisations with a recognised AOD constituency, while also engaging the research centres who, although they don't represent a constituency, are in a position to influence Commonwealth policy by virtue of receiving funding from the Commonwealth and the importance of their specialist research activities, as well as being of importance to the treatment sector by building on the evidence base for effective interventions and associated translational research activities.

5. Conclusions and Recommendations

The outcomes of the survey clearly show there is an overwhelming desire by the sector for a new national peak (83%). The survey indicated the peak should represent AOD specialist treatment services (90%), harm reduction services (85%), AOD research centres (77%), government treatment

services (76%), drug user organisations (72%), family support services (68%) and key AOD organisations such as APSAD, DANA and the Chapter of Addiction Medicine (65%).

The survey results suggest the key activities of the new peak should be representation of the sector at the national level (94%), policy advocacy in public spaces (84%), policy advocacy behind the scenes (83%), facilitating networking within the AOD sector and between the AOD sector and other related sectors (75% and 72% respectively) and workforce development activities, including a national conference (68%).

Of the three potential governance structures identified for the new national peak body, the Coalition model brings together a broad membership of organisations working to support the AOD treatment and harm reduction workforce, which will give it the authority and credibility to represent the sectors interests at the national level, but most importantly, be a body with significant state and territory peak representation.

It is abundantly clear from the survey that a new organisation will need to be established, as the key activities of the new peak will involve working with the Commonwealth government (particularly the Department of Health) and it appears unlikely that they will be willing to reinstate funding to ADCA in its current form. Legal advice will be required to determine the most appropriate way to progress this.

The next steps for establishing a new national peak will include developing a constitution and seeking funding to engage a staff member to establish the peak and commence operations (this will need further consultation). There are strategies which could be put in place to minimise operational costs during the establishment phase (eg, the Alcohol, Tobacco and Other Drugs Association of the ACT (ATODA) could be asked to host the staff member at their office). In addition, any surplus funds from the sale of the ADCA building after the payment of existing creditors could be transferred to the new national peak as seed funding as part of the ADCA wind-up process.

Appendix 1: Invitation to Participate in an Independent Committee

The Alcohol and other Drugs Council of Australia (ADCA) Board would like to invite you to be a part of an independent committee that will identify the requirements for the establishment of a national alcohol and other drugs peak body.

Background

The ADCA Board has been discussing the future, talking with members and stakeholders and trying to find the right place to start. ADCA believes it has a mandate from members, following a members' forum, to identify the best way forward for a national peak body.

There is consensus that we need a national peak body for the sector. The rationale for this includes:

- Alcohol and other drug policy is set at the national level, through the National Drug Strategy and coordinating committees
- The federal government in Australia is responsible for AOD policy
- The federal government funds a significant amount of AOD prevention, treatment and research (in the case of treatment and support services about 30% of the total Australian budget)
- National governments liaise with and listen to national peaks (more than jurisdictional peaks)
- State/territory representation, coordination and advocacy occur through various state bodies.

Principles

The principles that are underpinning our intent include:

- Inclusive - making sure we work with all stakeholders
- Focussed - making sure we do something that is achievable given resources
- Relevant - focussing on what the sector needs and where the gaps are
- Energised - working with where the energy and commitment is
- United - working together as one voice
- Forward-looking - rather than focussing on or replicating the past

Consistent with the principle of being relevant and focussed, the Board has undertaken a brief environmental scan, assessing where the current strengths and gaps are in relation to:

- National representation and coordination
- National policy advocacy
- National information and support services

We have identified a significant gap in relation to the representation of treatment and support services and advocating for research informed policy development and planning. This is especially significant at the moment given the anticipated roll-out of Commonwealth funding (through the flexible funds) for treatment and support and research services. We believe effort should be focussed in the treatment and support area as a priority.

The task ahead is to re-establish a national peak body, and in line with the above principles, and identified priority area, ensure that it has an inclusive, focussed, united and relevant brief.

The independent committee

ADCA's intent is to support the establishment of an independent committee which empowers all stakeholder groups, providing a united and forward-looking opportunity. It will need to have members who are energised and willing to work in an un-resourced environment.

This committee will identify the requirements for a national peak body and put forward a proposal for its establishment.

The following organisations have been invited to nominate a representative for the committee:

- State and territory AOD peak bodies (ACT ATODA; NSW NADA; NT AADANT; Qld QNADA; SA SANDAS; Tas ATDC; Vic VAADA; WA WANADA)
- ATCA
- ADCA
- AIVL
- National research centres (NDARC, NDRI, NCETA)
- FDS
- NIDAC/Aboriginal and Torres Strait Islander
- ANCD
- FARE
- PHAA
- Social Research & Evaluation
- APSAD

The ADCA Board anticipates that not all those invited will necessarily choose to directly participate in the committee (or have the time or energy to do so), but may want to be kept informed of progress. The ADCA Board are hoping for 8 to 12 willing and active participants from the above list.

As an independent committee it is expected that the committee itself will nominate a chairperson and other identified roles, agree to the membership in the first meeting (including other possible invitees) and agree on any terms of reference if required. To commence the process, the first meeting will be chaired by the ADCA Vice President.

The role of the ADCA Board is to provide support to the committee. Once a proposal for a national peak body is finalised by the committee, it will be presented to the ADCA Board and ADCA members for an indication of support, providing ADCA with the mandate to support the progression of the proposal.

Appendix 2: Working Group Members

Larry Pierce, CEO, Network of Alcohol and other Drug Agencies (Co-Chair)

Rebecca MacBean, CEO, Qld Network of Alcohol and other Drugs Agencies (Co-Chair)

Jann Smith, CEO, Alcohol, Tobacco and other Drugs Council of Tasmania

Professor Ann Roche, Director, National Centre for Education and Training in Addiction

Anthony Jackson, Operations Manager, Alcohol and Drug Services, South Eastern Sydney Local Health District (representing APSAD)

David McDonald, Director, Social Research and Evaluation

Lynne Magor-Blatch, EO, Australasian Therapeutic Communities Association

Appendix 3: Key Stakeholders Invited to Participate in an Interview

(12 of the stakeholders on this list were interviewed)

Professor Allison Ritter

Dr Alex Wodak

Professor Ian Webster

Associate Professor Robert Ali

Professor Margaret Hamilton

Michael Moore

Scott Wilson

Associate Professor Ted Wilkes

Neal Blewett

Professor Jake Najman

Andris Banders

Gino Vumbaca

Qld Mental Health Commissioner

WA Mental Health Commissioner

NSW Mental Health Commissioner

National Mental Health Commissioner

Neil Guard

Professor Michael Farrell

Professor Ann Roche

Professor Steve Allsop

Professor Dan Lubman

Annie Madden

Louise Grant

Niki Parry

Helene Delany

Frank Quinlan