DRUG ARM submission on the Contribution of the Not for Profit Sector commission 2009

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Executive Summary

This submission is put forward by DRUG ARM Australasia; a drug awareness, rehabilitation and management organisation operating across Australia. Following is a response to the terms of reference pertaining to how best to enhance the effectiveness and efficiency of the not-for-profit or 'third sector' in which we operate. A recurring theme is that of providing funding for organisational infrastructure in all of our major areas of recommendation.
Our major recommendations consist of:

- Continuous improvement through audits, supervision and training
- Organisational development by way of governance progress and funding structures
- Collaboration by means of partnerships and overall shifts in not-for-profit paradigms

A genuine commitment from funding bodies is vital to ensure the expected levels of efficiency and effectiveness for the sector.

Recommendations

Funding bodies:

- Provide infrastructure development funding, and acknowledge that processes and systems put in place as a part of Quality Assurance and other continuous improvement initiatives are necessary for the provision of effective and efficient services.
- acknowledge the usefulness of Quality Audits and how the results of these can demonstrate means of improving organisational systems in both the short- and long-term.
- Include the provision for conducting clinical audits in standard funding applications
- Acknowledge the importance of Clinical Governance systems and audits and provide funding for their implementation and maintenance. Funding Bodies must recognise that identifying and addressing staff training needs leads to the continuous improvement of staff and volunteers and subsequently the increased effectiveness and efficiency of programs.
- Funding requirements must include that clinical supervision be conducted by an appropriately trained and skilled supervisor, as distinct from a line manager.
- Funding must be allocated to ensure every staff member be allocated a minimum of one dedicated hour per month for clinical supervision and one hour for peer or group supervision
- Commit resources beyond to developing and maintaining interagency relationships for all levels of organisation, not just case workers or other frontline staff.
- Recognise that the tendering process should revolve around a collaborative framework in order to holistically meet the needs of complex clients, rather than the prevailing competitive methods of tendering.
- Allow for successful implementation of these recommendations in the not-for-profit sector and AOD field by judiciously supplying the necessary funding.

Not-for-profit Organisations:

- Include Quality Assurance, Quality Audit and accreditation costs as part of infrastructure contingencies included in funding applications.
- Include projected budgets for conducting clinical audits in standard funding applications.
- Examine requests for training, training registries and staff files held by administration to verify training needs are being addressed.
- Demonstrate measurability of staff and volunteer improvement by Clinical Auditing.
- Provision for clinical supervision must be made in the event of unexpected circumstances.
- Adopt and adhere to Clinical Supervision policy and procedure.
- Create MOU's so that external supervision can be offered by suitably qualified staff across organisations.
- Establish a minimum certificate IV in a relevant field for staff at the time of recruitment, with the perspective that this baseline will be built upon with ongoing training and professional development.
- Encourage employees to pursue tertiary education in the form of study leave opportunities and awareness raising of available tertiary courses.
- Implement a peer education system where practice issues and research review can be shared amongst staff in a semi formal setting on a regular basis.
- Record all staff internal training and professional development activities in a staff training registry and records of external training will be recorded in staff files.
- Receive commitment from management to attend conflict resolution and staff supervision training.

Introduction

DRUG ARM Australasia thanks the productivity commission for the opportunity to provide input on such a significant matter.

DRUG ARM Australasia is a not-for-profit, non-government organisation based upon Christian principles. We offer a range of activities and programs which include prevention, education and information dissemination through the Centre for Addiction Research and Education (CARE) as well as provide programs and services that support both clients and their families. The organisation can trace its history back to 1849 and has proudly served the Queensland community for over 150 years. We currently operate in Queensland, New South Wales and South Australia. Over our long history we have shown commitment to implementing and reviewing systems to ensure the clients and the community are provided with effective services. We are committed to helping to reduce the harm of alcohol and other drugs in the community.

It is DRUG ARM Australasia's belief that the efficiency and effectiveness of the community sector would be significantly increased through greater infrastructure support. The sector is currently undergoing a valuable shift in that it is becoming more professional and accountable. This professionalisation is taking place through an increased emphasis on measuring and evaluating outcomes. The call for accountability has resulted in an increased emphasis on operating from a sound evidence base. Therefore greater emphasis has been placed on implementing research into practice. This shift of emphasis is vital for the sector to ensure that it is meeting expected outcomes and goals. This submission will outline three key areas: ongoing continuous improvement; organisational development; and collaboration from the perspective of DRUG ARM and the broader community sector that will improve efficiency and effectiveness. This submission demonstrates that implementation in these three areas is significantly impaired by current funding levels and arrangements which neglect organisational infrastructure. Without adequate infrastructure funding these initiatives are either impossible or undertaken in a reactionary, ad hoc manner that prohibits efficient and effective practice.

1. Ongoing Continuous Improvement

Quality improvement has become a key focus of the not-for-profit Alcohol and Other Drug (AOD) sector, with initiatives such as quality accreditation, workforce development and monitoring and evidence based practice becoming more common. Such initiatives ensure that the sector can measure how it is currently performing and that systems and procedures are in place to ensure that needs identified are actioned. The nature of drug production, availability, patterns of use and effects on the user are ever changing. As a result, the services offered and clinical practice conducted need to be adaptable, responsive and continually improving to address the changing needs of communities.

Movement in this direction is a vital step towards the professionalisation of the sector, and challenges many prevailing attitudes that may have developed over the preceding years. In the past there was an approach undertaken through necessity to provide as high quality service as possible with limited resources. This has resulted in the use of volunteers, often with huge variances in academic background and experience. In time constraints placed upon staff ensured they had little time available for reflective practice. Systems for continuous

improvement acknowledge the progress that the passionate staff and volunteers in the sector make with clients and within the community. When an organisation implements systems for continuous improvement, issues are identified barriers and limitations are transformed into opportunities for training, research, reinvention and innovation. This arises because the systems demand that issues are addressed. By nature these systems are create flexibility and growth by the process of continual review and by response to identified needs. This continual identification and actioning of needs continues to improve practice and services which improve outcomes for clients. Furthermore, the improvements are measurable and easily documented because of quality improvement systems and improvements in practice, services and outcomes will be demonstrated regularly.

The nature of continuous improvement is such that it needs to be continuous. Funding for initiatives like quality accreditation can not be limited to a 'one off' sum that covers initial set-up of the system only. The costs of continuous improvement are ongoing, just as the review and actioning of issues should be. The costs of having such systems in place can only be viewed as an investment, with the improvement of services leading to the improvement of outcomes for clients and the community with associated lowering of welfare, public health and correctional services costs. Some AOD services already measure the employment, health and legal status of their clients and use these to evaluate their services. They can therefore effectively measure improvements in these areas with the implementation and continuation of quality systems, making the return on investment a fact that can be demonstrated.
DRUG ARM is currently seeking to implement systems up to ensure practice and services are of the highest standard and that improvement is ongoing and continual in response to research relating to drug use patterns and demographic changes. To ensure continuous improvement, five areas that are currently under review at DRUG ARM will be discussed: Quality Assurance, Clinical Audit, Clinical Supervision, Clinical Effectiveness and Education and Training.

1.1 Quality Assurance

Quality Assurance processes ensure that organisations have systems and standards of documentation in place to enact and record continuous improvement in services and processes. A system of documented continuous improvement ensures that not-for-profit organisations are able to be effective and efficient when providing services and provide a means through which continual improvement is an expectation and a measurable, documented outcome of the system. Quality Audits provide a measurable means of ensuring processes are in place and being used to ensure efficiency and effectiveness. The Quality Assurance process requires that Quality Audits are conducted periodically to ensure that systems and practice guidelines are being adhered to consistently. Such audits are necessary for the success of a Quality Assurance system and an ongoing expense to the organisation. It is essential that Clinical Audits are incorporated into funding agreements such that the organisation can continue to provide effective, continuously improving services.

Quality Assurance is a necessary process for all health and allied heath services, to ensure continuous improvement in services and systems. "It is important that the (AOD) workforce is recognized as competent and equal to other health professionals" ALAC (n.d.: 31). It is therefore important that the AOD not-for-profit sector implement systems and standards that reflect the quality standards and improvement systems adopted by other health services.
In regards to funding requirements "All services delivered or recurrently funded by Disability Services Queensland must implement their own quality management system and achieve

certification against the Queensland Disability Service Standards, Queensland Disability Advocacy Standards or ISO 9001:2000, as appropriate to their service." DSQ (2008)

In an effort to ensure services, systems and processes continue to run effectively and efficiently DRUG ARM Australasia (DAA) is currently undergoing a process of preparing for Quality Assurance auditing using the ISO9001 standards. The preparation of systems and processes for Quality Assurance has led to the organisation identifying a number of new duties that will be created by this system. The new duties include a centralised review of complaints and ensuring that recommendations are followed-up, the upkeep of systems and document review and conducting internal Quality Audits to ensure the continuous improvement of services. When negotiating task allocation and auditing schedules it has become apparent that time and money allocation is necessary to ensure the process is both meaningful and promotes organisational effectiveness. It is necessary for organisations like DRUG ARM to be able to allocate funding to the improvement of services and Quality Audits. The investment made on the upkeep of quality systems will lead to more effective and efficient services. These systems will document issues that arise and actions that are subsequently taken to improve services. This will result in a clearly documented and measurable improvement in the effectiveness and efficiency of service delivery.

It is evident that the ground work, implementation and ongoing maintenance of a Quality Assurance system ensures that services and processes are reviewed periodically and as such contribute to the improvement and effectiveness of programs. Many funding bodies have acknowledged the importance of Quality Assurance measures and require that organisations in the not-for-profit sector gain accreditation to be able to access future funding. The impact of the continuous review and improvement of services as a part of Quality Accreditation requirements results in ongoing costs for the organisation.

Recommendations:
For funding body

1) Funding bodies provide infrastructure budget and acknowledge that processes and systems put in place as a part of Quality Assurance and other continuous improvement initiatives are necessary for the provision of effective and efficient services.
2) Funding bodies acknowledge the measurable nature of Quality audits and how such systems can demonstrate both short and long term continuous improvement of systems

For an organisation

1) All not-for-profit organisations include Quality Assurance, Quality Audit and Accreditation costs as part of infrastructure contingencies included in funding applications.

The process of preparing for Quality Audit has led the organisation to create documentation systems to ensure that the improvement of services and the professional development of staff is recorded.

1.2 Clinical Audit

Another means by which not-for-profit organisations can undertake continuous improvement is to audit their clinical practice through a process of monitoring and measuring their clinical methods and outcomes. This process is designed to ensure that workers are able to reflect on their practice in a formalised manner and action training needs. This system enables the identification of training needs in a timely and recordable manner.

Clinical Audits include the audit of client files to examine the practice of workers in the field and compare strategies and tools used to best practice research and organisational guidelines. This ensures that individual workers can assess their work practice in collaboration with a manager and together identify training wants and needs. The audit follows the worker through to training completion to provide evidence that the requirements necessary for improvement are being met. A record of competencies and training undertaken will be kept in staff files. This process requires that client records and case files are filled out and detailed appropriately and that managers and coordinators have the time and resources to allocate to reflecting on practice.

Consistent clinical auditing is required to enhance the not-for-profit sector efficacy. "...quality issues; e.g. evidence-based practice (at the individual, team, organisational level, and systems level), clinical governance, and credentialing... Australia needs to systematically address the above areas in relation to AOD workforce development." (Roach 2002: 8). Clinical auditing ensures that there is accountability within an organisation for the clinical practice that its staff and volunteers provide.

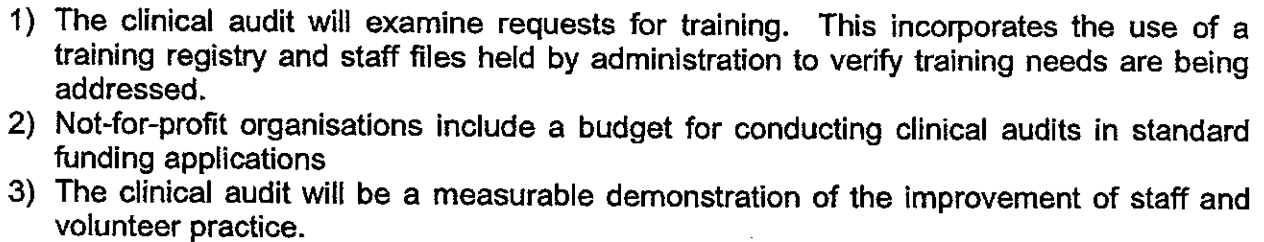
DRUG ARM is committed to ensuring that the clinical practice that is conducted within its programs is of the highest standard achievable. It is for this reason that a Clinical Governance policy is currently being drafted and reviewed, detailing the importance of clinical audits. It is clear that the organisation historically had little time or funds to examine related literature or educate its staff about the meaning and implications of a Clinical Governance framework. Clinical Governance frameworks in allied health organisations are often interrelated with Quality Assurance systems, both focusing on ongoing continuous improvement. It became apparent in DRUG ARM that the aforementioned challenges identified with the implementation of Quality Audit are also evident when implementing Clinical audits.

The implementation of a formalised clinical audit system will measurably demonstrate that clinical practice training needs are identified through a review of both staff and client files and then put into action ensuring the improvement of services.

Recommendations:
For funding body

1) Funding bodies acknowledge the importance of and provide funding for implementation and maintenance of Clinical Auditing systems
2) Funding bodies recognise that identifying and addressing staff training needs leads to the continuous improvement of staff and volunteer skills and effectiveness.

For an organisation



1) The clinical audit will examine requests for training. This incorporates the use of a training registry and staff files held by administration to verify training needs are being addressed.
2) Not-for-profit organisations include a budget for conducting clinical audits in standard funding applications
3) The clinical audit will be a measurable demonstration of the improvement of staff and volunteer practice.

1.3 Supervision

The provision of clinical supervision is a key issue to ensure ongoing continuous improvement of clinical practice. Clinical supervision decreases work related stress and improves clinical practice. Together, these practices enhance effectiveness and efficiency of staff and the best outcome for clients. The provision of clinical supervision will also increase staff retention, which in turn will result in a body of experienced and well-trained staff capable of offering professional and effective services.

Clinical supervision has been defined as: "a working alliance between practitioners in which they aim to enhance clinical practice, [to] meet ethical, professional and best practice standards . . . while providing support and encouragement in relation to professional practice." (Kavanagh et al., In Roche, Todd and O'Connor, 2007). It involves "observation, evaluation, feedback, the facilitation of self-assessment, and the acquisition of knowledge and skills by instruction, modelling, and mutual problem solving. In addition, by building on the recognition of the strengths and talents of the supervisee, supervision encourages self-efficacy" (Roche, Todd, & O'Connor, 2007).

Clinical supervision needs to be distinguished from managerial supervision, with research evidence confirming that the best outcomes from clinical supervision result when it is delivered by someone other than the line manager. The clinical supervisor needs specific skills and training in clinical supervision in order to minimise conflicts of interest and foster a collaborative approach. Where it is unavoidable for the line manager to offer clinical supervision, it is essential to distinguish the two roles (Roche et al., 2007). In turn, supervisors should be subject to quality control and they are advised to have supervision themselves from a peer or other supervisor.

NADA reported that staff recruitment and retention are particular issues in the not-for-profit AOD sector because typical salaries in this sector are less than government salaries. Job satisfaction was generally high, but stress and salary dissatisfaction were significant (Gethin, 2008). An earlier study by NCETA who surveyed 1345 AOD workers concluded that individual and organisational strategies are needed to address work stress in this field. Identified strategies were those that focus on building the capacity of workers to cope with stress, manage heavy workloads, and deal with violent and aggressive clients and client with complex presentations (Pidd, Roche & O'Connor, 2006). The provision of regular clinical supervision would be a significant way to address these identified needs.

Best practice dictates that adequate supervision of clinical staff is necessary to ensure staff retention, satisfaction and performance, and to mitigate clinical burnout. Demonstration of

commitment to the growth and development of the workforce by creating opportunities for continuing personal and professional development through clinical supervision improves recruitment and retention and in turn increases efficiency and effectiveness.

Documentation of this commitment is essential to ensuring integrity. In order to meet best-practice requisites for clinical supervision, a dedicated supervision role is required with supervision hours recorded in monthly reports in order to be measurable. Currently, budgetary constraints prohibit a dedicated supervision position with the less-favourable alternative of line-management or senior practitioners filling this role. Sometimes peer and group supervision is available, but none of these models meets professional standards nor achieves the best outcomes for the worker or the client. It has been proposed that MOUs be set up with outside organizations for a reciprocal clinical supervision program. This requires further training of staff in clinical supervision and an analysis of the external agency's ability to provide quality supervision.

The recognition of the need for these processes in the not-for-profit sector is understood and valued but the means are not available due to sparse funding. In fact, the inadequacy of service funds prohibits the ability to meet continually increasing demands. Combined with the almost total lack of continuous improvement of services, this has resulted in some difficulties in recruitment and retention of staff and the lessening of effective service delivery in the AOD sector.

Specific funding is required for clinical supervision in the not-for-profit AOD sector to improve effectiveness and efficiency in line with best practice

Recommendations:
For funding body

1) Funding must be allocated to ensure every staff member is allocated a minimum of one dedicated hour per month for clinical supervision and one hour for peer or group supervision
2) Funding requirements must include that clinical supervision be conducted by an appropriately trained and skilled supervisor, as distinct from a line manager.

For an organisation

1) That there be a written clinical supervision policy and procedure which is adhered to by the not-for-profit organisation.
2) That MOUs be created so that external supervision can be offered by suitably qualified staff across organisations.
3) Provision for clinical supervision must be made when unexpected circumstances/critical incidents arise.

1.4 Clinical Effectiveness

Evaluations are a process by which services can measure their contribution and the quality of that contribution. Particularly, evaluations measure how clinically effective a service/program is. Evaluations provide a number of recommendations for change to ensure the continuous improvement of service delivery and the effectiveness of services. The process of undertaking an evaluation lacks meaning if the recommendations that are meant to facilitate continuous

improvement are not able to be implemented. The cost of evaluation and the further cost of implementing recommendations is a barrier to ensuring that the task is undertaken.

"Evaluators should not merely be neutral recorders of program processes and outcomes. They should be catalysts for organizational change by providing regular feedback, facilitating discussions of their findings, and offering alternative solutions to issues raised by their findings... Involving program managers, front-line staff, and participants in the evaluation can foster a "learning organization," in which staff continue to evaluate their performance after the evaluators leave." (Hasenfeld et. al, 2002) "Program evaluation is important not only because it informs decision makers about whether the program is successful, but also because it is a major tool for learning" and established that "it can also be a catalyst for program innovation." (Hasenfeld, et. al, 2002)

DRUG ARM is in a fortunate position, in that it has a Centre for Addiction, Research and Education (CARE) that has the ability to undertake the evaluation of all DRUG ARM's programs. The "separate" nature of the CARE division in the organisation ensures that a conflict of interest is not present in the undertaking of evaluations. However, DRUG ARM receives minimal government funding to undertake the evaluation of each of its programs. Therefore, a dedicated position does not exist. While it is internally acknowledged that evaluation improves measurability, accountability, efficiency and effectiveness it is impossible to undertake evaluations on frequently enough to genuinely employ the concept of continuous improvement. Often, evaluations are done at the end of a funding period to be submitted to the funding body in conjunction with the final report. Again, this does not allow for continuous improvement. Furthermore, when and if evaluations are able to be conducted more regularly than the funding cycle it is difficult, if not impossible, to implement the recommendations of the evaluations. This is due to a lack of resources. Some common themes that are recommended as a result of DRUG ARM's evaluations are education and training for staff; improved information technology and more staff resources, all of which require funding to implement.

The lack of resources/funds provided for evaluation results in not being undertaken as often as necessary to ensure continuous improvement. Clearly defined goals and objectives are required for effective evaluations. Evaluation matrices should be developed during the funding application process to inform data collection and analysis. Evaluation funding must cover implementation costs in order to make the evaluation process meaningful. Periodic evaluations are needed to identify needs and issues and generate recommendations for immediate implementation. More flexibility from funding bodies is required so that these recommendations can be implemented expediently to improve programs and services in a continuous manner.

Recommendations:
For funding body

1) Funding bodies provide budget for periodic and end-of-program evaluation
2) Funding bodies allow funding variation based on evaluation findings

For an organisation

1) Not-for-profit programs must clearly define, as part of its proposal and application process, what goals it plans to achieve and the desired outcomes.

2) These program goals should be codified in an evaluation matrix developed for each program, outlining what specific targets are necessary to meet individual program objectives.

1.5 Education & Training

Ongoing training for volunteers and staff would greatly benefit the not-for-profit sector's contribution to the community and certainly enhance how socially inclusive that contribution is. Staff must remain informed of emerging research on the complex and shifting AOD client population and related issues. This can be achieved via continuous education and training of staff and volunteers. It is a challenge in the not-for-profit AOD sector to attract qualified persons to positions due to pay rates. The implementation of internal and external training as a means to addressing identified needs improves the standard of clinical practice and delivery of services by staff.

Systems need to exist to ensure that training needs are delivered. "Educating, training and developing staff are an integral part of clinical governance. It's not just about helping staff to develop their clinical skills though – it's also about helping and supporting staff to work in different ways. These different ways of working include partnerships and collaborations with patients and managers, across disciplines and professions. Good staff development needs the provision of adequate resources, including both money and protected time." RCN (N.D.) In order for the not-for-profit sector to remain effective and efficient, a demonstration of support for staff undertaking further study is required. Research findings state that the workforce development in the AOD sector is reliant on the creation of policy, legislation, resources and support mechanisms to ensure development can happen (Roach, 2002). Not-for-profit staff don't just learn formally but informally from their peers. The not-for-profit sector relies heavily on volunteer staff; therefore their induction requires both specific and general knowledge training. "A patient is entitled to be cared for by health care professionals with relevant and up-to-date skills and expertise" (Kennedy Report, 2001, 322).

DAA is in the process of documenting a Clinical Governance policy which will acknowledge as one of the fundamental principles of Clinical Governance, the need for ongoing education and professional development. When examining the details and implementation strategies needed to enact such a policy it has been found that the maintenance of having a system of ongoing training will be costly. The organisation acknowledges that continuous education and training is best practice but is finding the implementation a challenge. Ensuring continuous training is undertaken and recorded for auditing purposes is difficult without allocated resources.
A Clinical Governance policy contains reference to clinical audits. This process involves staff members auditing their clinical practice and identifying training needs. These audits contribute to the continuous improvement of services for clients. As previously mentioned the implementation of such policy requires extra resources to maintain effectiveness and ensure that through continuous training and education of staff, services are effective and efficient.

It is important in maintaining best practice standards that voluntary and paid workforce members receive not only introductory and sporadic <u>but continuous</u> training in all areas affecting their particular role. Ongoing education is highly valuable and opportunities should be made available for long term staff to participate in obtaining formal, accredited and academic qualifications. To maintain staff and volunteer effectiveness and efficiency, managers must

receive manager specific training. Identified training needs require annual appraisal with prioritization according to demand. These improvements can be made measurable through record keeping. Record keeping requires resources, which require funding.

Recommendations:
For funding body
1) Funding should be available for implementing systems that identify and record training needs.
2) Funding should be allocated to allow organisations to provide ongoing education and training to their workforce.

For an organisation
1) Organisations should develop systems to identify and record the training needs of their workforce
2) Organisations should implement continuous and appropriate education and training to their workforce.

2. Organisational development

Community organisations grow and develop over time. As social issues evolve and funding priorities shift so too does the nature, face and size of community organisations. Further, new trends, philosophies and best practice ideals are presented to the community sector with the expectation that they be employed. However, new ideas and developments require a process of research, education within the organisation and implementation. A current example is the shift towards community organisations implementing clinical governance frameworks. Good governance can often determine the success or failure of a business/organisation. Specific funding is needed to support the ongoing strategic development of the organisations, particularly in relation to areas of governance.

2.1 Governance

"The collapse of some prominent corporations over the last ten years has been attributed to poor governance. Not-for-profit agencies are now examining their own governance policies and practices in an attempt to prevent the calamities that have plagued the private sector (http://www.emeraldinsight.com/Insight/viewContentItem.do?contentType=Article&hdAction=lnkhtml&contentId=1718907&dType=SUB&history=false)." A recent development for the not-for-profit sector is the formulation of clinical governance frameworks. While most community organisations have governance policies that manage their corporate issues and responsibilities, clinical matters and decisions are often left undocumented. The establishment of clinical governance frameworks is setting benchmarks and instituting systems of ongoing improvement for organisations that employ them.

The importance of the concept of clinical governance is that it brings clinical decision making into a management and organisational framework. This is absolutely essential for the new approach to quality improvement. (Donaldson & Muir Gray, 1998)

Understanding the value of continuous improvement systems and strong governance, DRUG ARM has begun the process of developing a clinical governance framework. This decision is important in ensuring DRUG ARM maintains its commitment to best practice. The process has been challenging for a number of reasons. Clinical governance is a relatively new concept. Time is required to research, clarify and communicate the concept. Also, time is required to highlight the benefits of a new innovations such a clinical governance framework and that information needs to be disseminated throughout organisations.

Systems of ongoing continuous improvement are fundamental to clinical governance. There are costs involved with implementing the systems outlined in a clinical governance framework. Without allocated resources to develop and deliver the commitments of clinical governance, organisations can not make the policy a priority.

Recent initiatives to establish clinical governance frameworks as a part of overall governance is the development of efficient and effective organisations. However, without further education around the concept and benefits and funding to implement the clinical governance framework, organisations risk stagnation, inefficiency and ineffectiveness.

Recommendations:

For funding body

1) Funding bodies need to commit infrastructure funds to facilitate the research, education and communication of new organisational concepts and their benefits, in particular clinical governance.
2) Funding bodies need to allocate funding for development and delivery of clinical governance frameworks.

For an organisation

1) Organisations need to be open to innovation and ongoing organisational development based on evidence of best practice.
2) Organisations need to allocate time to the research, clarification and communication of the concept and benefits of a clinical governance framework.
3) Organisations need to highlight the importance of organisational development, for example clinical governance, in their funding applications.

3. Collaboration

The community sector as a whole is working together to create positive social change. At a broad level, it is most beneficial to tackle such an enormous task collaboratively. In doing so, each agency brings its specialisation but has a finite capacity with which to address the complex needs of clients. By working together, agencies would better meet all the needs of their client's not just address the issues within their specialisation. Ideally, this collaboration would work towards ensuring that individuals do not fall through gaps. However, to ensure collaboration at all organisational levels, a shift in the not-for-profit sector is required. The barriers to greater collaboration are the negative effects and implication of competitive tendering. Furthermore, collaboration requires resources (chiefly human resources) to establish and maintain partnerships that are beneficial to clients.

One community agency working in isolation is unlikely to provide the breadth of expertise required to adequately respond to the complex needs of clients and their communities (Taylor, Wilkinson & Cheers, 2008). Establishing partnerships usually leads to the sharing of new resources, such as financial support from external agencies, technical advice from consultants and provision of opportunities to network regionally and nationally (Taylor, Wilkinson & Cheers, 2008). As a result of more collaboration, there are benefits for not-for-profit organisations working together can be identified. The areas of administrative streamlining , better client support, enhanced client service, combined specialist and generalist service delivery, integrated cross agency referral systems and seamless client pathways are some of the benefits of collaboration that have been identified (Childs, 2007). The benefits of collaboration between not-for-profit organisations are many, yet the number of meaningful collaborations is few. Particularly with minority client populations, collaborations have been identified as the preferred method of service delivery. Fore example, the Aboriginal Medical Services alliance in the Northern Territory found that holistic and integrated treatments lead to better health outcomes (Aboriginal Medical Service a Northern Territory-AMSANT, 2008). Partnerships are an ideal manner by which to integrate treatment and address the whole needs of the individual client. The Australian Capital Territory Department of Health has outlined a number of recommendations to assist the sector to work together under a case management model to improve client outcomes. These findings centre on common understanding of terms, tools, client feedback, evaluations and audits within the sector to enhance collective case management. Also suggested is sector wide professional development on the coordination of cases between agencies (ACT Health, 2005).

Ultimately, collaboration provides improved and efficient access to the range of services required in response to client needs, offering a more holistic approach to service delivery (Childs, 2007). It is acknowledged that along with the benefits come the barriers of time, cultural misfit, personality clashes, power imbalances, geographical boundaries and differing opinions of standards and ethics (Childs, 2007). Not-for-profit organisations also have not previously pursued formal partnerships due to the cost involved in setting up the legal relationships (Ash, 1999). Recently, the Aboriginal Medical Services Alliance Northern Territory reported an increasing fragmentation of services with multiple new providers entering "the market." Further reported is the move away from the established collaborative needs-based planning approach through the Northern Territory Aboriginal Health Forum, resulting in the increased service fragmentation (AMSANT, 2008). Strategies to promote establishing effective partnerships are essential. Identifying barriers to relationships, negotiating differences and highlighting the benefits for the partners involved is a starting point (Taylor, Wilkinson & Cheers, 2008).

Clements (2007) provides a clear example of the need for collaboration between AOD & Mental Health services.

"NGOs report that there is a need for increased collaboration between AOD services and staff with those from mental health agencies. Greater collaboration and shared care between staff from both sectors would further facilitate better outcomes for the client. AOD NGO staff have reported feeling isolated from the mental health (predominantly government) sector and cite examples where their clients have been referred to mental health agencies who do not contact AOD agencies with any follow-up shared care arrangements. NGO staff have raised at several occasions the need for increased and stronger networks with mental health agencies

due to the increase in co-morbid presentations at NGOs. A coherent stepped care approach with improved screening and assessment within AOD services and clear referral protocols will assist in addressing this system failure"

Clements, 2007.

The not-for profit sector needs to work collaboratively in order to create positive social change. Working in isolation acts as an impediment to effective client outcomes. Collaborative partnerships increase efficiency and enable a holistic approach to service delivery and the possibility of meeting the complex needs of clients.

Recommendations:

For funding body

1) Commit resources for networking at all organisational levels.
2) An advantageous approach for delivery of government funded services would be that tendering processes revolve around collaborative framework as opposed to the prevailing competitive means to tender.

For an organisation

1) Place value and commit time and resources to networking and establishing effective partnership.
2) Include and prioritize, in finding applications, specific funding for networking and development of partnerships.

Conclusion

This submission has examined three areas that DRUG ARM has identified as central to enhancing effectiveness and efficiency in the not-for-profit sector. Matters of ongoing continuous improvement, organisational development and collaboration have been demonstrated to be significantly impaired by current funding levels and arrangements which neglect organisational infrastructure. The provision of adequate infrastructure funding will stimulate more proactive and ongoing service delivery improvements.

It is important to emphasise that investments must be made in the implementation and upkeep of quality systems will to ensure more effective and efficient service delivery. It is essential that Clinical Audits are accounted for in program budgets such that not-for-profit organisations can continue to provide effective, continuously-improving services. It is therefore important that the AOD not-for-profit sector adopt quality standards and improve services in a clearly documented and measurable way. Maintaining formalised systems of continual review and reflection (and an organisational structure which facilitates this) creates ongoing costs which must be accounted for by funding bodies.

Accountability within a not-for-profit organisation is maintained through the auditing of the clinical practice of its staff. Challenges identified in implementing Clinical Audits may be evident, but these are not insurmountable given the appropriate infrastructure and a proportionate commitment from government.

Enabling the provision of Clinical Supervision increases staff retention and this will produce a body of well-trained and experienced staff who offer professional and effective service delivery. Support and encouragement from supervisors in relation to professional practice must be subject to quality control, and it is advised that supervisors also have access to quality supervision. Regular clinical supervision in the not-for-profit sector is a highly suggested method of identifying organisational needs, and as such is highly recommended as an aspect of continual organisational improvement.

Raising the standards of clinical practice and delivery of services by staff requires the implementation of internal and external training as a means of addressing identified needs. The not-for-profit sector is characterised by a largely volunteer-based staff, so their induction requires both specific and general knowledge training. Policy implementation warrants extra resources to ensure improved effectiveness through continuous training and education of staff.

It is noted in this submission that collaboration is an effective way to ensure that individuals do not fall through the gaps and remain accessible to not-for-profit services. Collaboration provides clients with access to a breadth of services most able to address their specific needs, and offers a more holistic approach to service delivery. Extensive collaboration and shared care between staff from within and between sectors is advised in order to achieve better outcomes for the client.

It is therefore submitted that these recommendations must at least be considered if not implemented for increased not-for-profit efficacy. If an effective and efficient third sector is truly desired by the government, it is essential that:

Funding bodies:

- Provide infrastructure development funding, and acknowledge that processes and systems put in place as a part of Quality Assurance and other continuous improvement initiatives are necessary for the provision of effective and efficient services.
- acknowledge the usefulness of Quality Audits and how the results of these can demonstrate means of improving organisational systems in both the short- and long-term.
- Include the provision for conducting clinical audits in standard funding applications
- Acknowledge the importance of Clinical Governance systems and audits and provide funding for their implementation and maintenance. Funding Bodies must recognise that identifying and addressing staff training needs leads to the continuous improvement of staff and volunteers and subsequently the increased effectiveness and efficiency of programs.
- Funding requirements must include that clinical supervision be conducted by an appropriately trained and skilled supervisor, as distinct from a line manager.
- Funding must be allocated to ensure every staff member be allocated a minimum of one dedicated hour per month for clinical supervision and one hour for peer or group supervision
- Commit resources beyond to developing and maintaining interagency relationships for all levels of organisation, not just case workers or other frontline staff.
- Recognise that the tendering process should revolve around a collaborative framework in order to holistically meet the needs of complex clients, rather than the prevailing competitive methods of tendering.
- Allow for successful implementation of these recommendations in the not-for-profit sector and AOD field by judiciously supplying the necessary funding.

Not-for-profit Organisations:

- Include Quality Assurance, Quality Audit and accreditation costs as part of infrastructure contingencies included in funding applications.
- Include projected budgets for conducting clinical audits in standard funding applications.
- Examine requests for training, training registries and staff files held by administration to verify training needs are being addressed.
- Demonstrate measurability of staff and volunteer improvement by Clinical Auditing.
- Provision for clinical supervision must be made in the event of unexpected circumstances.
- Adopt and adhere to Clinical Supervision policy and procedure.
- Create MOU's so that external supervision can be offered by suitably qualified staff across organisations.
- Establish a minimum certificate IV in a relevant field for staff at the time of recruitment, with the perspective that this baseline will be built upon with ongoing training and professional development.
- Encourage employees to pursue tertiary education in the form of study leave opportunities and awareness raising of available tertiary courses.
- Implement a peer education system where practice issues and research review can be shared amongst staff in a semi formal setting on a regular basis.
- Record all staff internal training and professional development activities in a staff training registry and records of external training will be recorded in staff files.

- Receive commitment from management to attend conflict resolution and staff supervision training.

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