

Board of Turning Point Centre
and Victorian Department of
Human Services

*Review of Turning Point
Alcohol and Drug Centre*

ROBERT GRIEW



THINK CHANGE

Submitted by
Robert Griew, Director
Robert Griew Pty Ltd
PO Box 433, Waverley NSW 2024
The Charing Cross Centre
199 Bronte Road, Waverley NSW 2024
T: 02 9389 1779
F: 02 9389 3779
E: info@robertgriew.com

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Executive Summary

The Review team was provided with six key Terms of Reference for the Review of Turning Point Centre (TPC). This summary provides our principal findings and recommendations against these Terms of Reference.

TOR 1: Identify changes in TPC's operating environment and assess the relevance of TPC's existing charter;

While there has been change in the operating environment of TPC, the most significant factors impacting on TPC, its role and future, reflect the gradual evolution of features that have been present throughout TPC's life.

These factors include:

- The ever-changing patterns of drug use, such as a significant decline in heroin supply and overdoses in the early years of this decade, an increasing prevalence of psycho-stimulants and a re-emergence of heroin supply.
- An increase in funding, from the Commonwealth and Victorian Government, for non-government organisations (NGOs) working in the illicit drugs field, with a growth and maturation of the sector across Australia partly resulting from this.
- On the other hand, the decentralisation of public sector infrastructure in the Victorian alcohol and other drug (AOD) sector at the same time TPC was established, resulting in relatively less developed specialist medical services and a greater reliance on GPs and non-medical NGOs than other State jurisdictions.
- A weakness in networking, coordination and planning of alcohol and other drug services across Victoria, with uncertain referral pathways, reporting and support roles within the sector, exacerbated by the emphasis on competition in Victorian health funding since the early 1990s.
- Lack of clarity and a perception of contradictions and tensions in TPC's roles from the outset, for example as leader and advocate for the sector, as a competitor for training and research funds and as the agency responsible to evaluate other NGOs for Government.
- The Victorian Government has recently responded to some of these issues through the development of a new Blueprint for AOD treatment services.
- The apparent lack of benefits and other tangible outcomes from the original partnerships with St Vincent's Hospital and the University of Melbourne.

- An increase in interest by Governments in issues of dual diagnosis and co-morbidity between the mental health and alcohol and other drugs field and some additional funding available in this area.
- A waxing and waning of Government interest in alcohol as a significant public health and social issue, with signs again of interest in policy-related research in this field.
- A growing interest by Government in the research evidence linking effective inter-sectoral action in maternal and child health and wellbeing to preventive outcomes across a whole range of health and social outcomes, including alcohol and other drug use.
- Workforce shortages and skills deficits across the AOD field, partly exacerbated by this funding growth.
- Greater competitiveness in the research world in general, with a trend to centralisation of resources in larger institutions and collaborations and, in the AOD sector, with the growth of the national research centres and the greater presence of other institutions, such as the Burnet Institute.

TOR 2: Identify opportunities to redefine the charter and mandate of TPC in the light of changes and assess the capacity of TPC to deliver on its new role;

There are opportunities for TPC in this range of developments. Before TPC exploits these opportunities, however, the overwhelmingly immediate priority is to address the organisation's current structural and operational situation. There are parts of TPC (notably the Training and Development and telephone-based services) that have demonstrated an ongoing ability to identify and consolidate business opportunities.

However, for the organisation as a whole, it is possible to identify a number of missed opportunities over the life of TPC, for example, to become the premier clinical research centre in the alcohol and other drug field before the national research centres built their capacity and activity in this area. Recent examples include the failure, with St Vincent's Hospital, to appoint a shared clinical Director position and the failure to maintain a key epidemiological research role with the loss of the IDRS (Illicit Drug Reporting System) surveillance program to the Burnet Institute.

These lost opportunities reflect a lack of sufficient attention at a number of key junctures to organisational identity, health and development issues. The TPC clinic is in difficulty with a loss of key senior clinical personnel, a loss of clarity in scope and a strong sense of

alienation from management and TPC as a whole. The research unit has also lost a critically high number of senior people, revenue and roles.

There are many important issues that arose during the course of this Review. The first set of strategic recommendations address the most crucial decisions requiring immediate attention. Following these urgent recommendations is a range of others all of which can be considered as important, if not of the same level of urgency.

TOR 3, Recommend changes in strategic direction and priorities which will strengthen its sector leadership role

The first issue is the question of TPC's identity and business model, the vision of the organisation in the Victorian AOD sector and whether the component parts of the organisation should be kept together. The originally ascribed role of TPC to provide clinical and policy leadership in a substantially decentralised sector in Victoria is sound, in fact essential. The vision of TPC as an organisation that offers its unique contribution from the synergy of clinical, research and training activity is also sound.

The synergy between the three sides of the TPC 'triangle' (clinical, research and training activity) is, however, misrepresented when the three sides are presented as equal. TPC is more usefully described as a specialist clinical service, with research and training arms. The research and training arms are an essential part of the organisation's vision and mandate but can only offer their potentially unique contribution when the clinical service is functioning at full capacity. Given this, the current weakened state of the clinical service is of fundamental concern to the whole model (and therefore the future of TPC) and is the highest priority to rectify.

The Review Team does not, therefore, recommend any fundamental change in the TPC vision or business model, although there are important evolutionary developments that are proposed in the course of this report. Rather the Review Team supports a consolidation of the model based on a rebuilding of weakened components and a resolution of key long term structural weaknesses.

Recommendation 1) That DHS and the TPC Board endorse a model of TPC as a specialist/tertiary referral AOD clinical service with integrated research and training arms, with a mission in the Victorian alcohol and other drugs field to:

- Provide leadership to the sector;

- Develop, provide and disseminate specialist treatment services;
- Undertake high quality commissioned and competitive research across clinical and public health domains;
- Provide training and development services to the sector in Victoria; and
- Provide policy advice to Government.

Thus the TPC Board and DHS would reject further consideration of closing or breaking up the current TPC, transferring parts of its budget to other institutions or setting individual units up as stand-alone businesses.

TOR 4 Recommended changes to external relationships

A foundational decision that needs to be considered early in the rebuilding process arises from one of the long term structural problems that has always confronted TPC. This is whether to continue with TPC being an independent corporate entity (but with a stronger integration with other NGOs and renegotiated key partnership relationships) or whether TPC should become a relatively autonomous part of a larger organisation, a university, research institute or a major teaching hospital.

Submissions were received from a number of entities either interested in further discussion, keen to avoid TPC folding and happy to 'lend a hand' or offering to take TPC over as part of an alternative corporate structure. These included the Victorian Addiction medicine Interhospital Liason Association (VAILA) hospital liaison group, the Victorian Division of the Chapter of Addiction Medicine of the College of Physicians, St Vincent's Hospital, Neurosciences Victoria (NSV), the University of Melbourne, through the Faculty of Medicine, Dentistry and Health Sciences and representatives of the NGO sector arguing that a number of the problems that have faced TPC have been based in a lack of sufficient community ownership. This decision is complex. It is, however, the right time to consider such a change if it might be of assistance.

There are theoretically four options, as follows:

- Status Quo, continuing as an independent NGO with a Board appointed by the Minister;
- Continuing as an independent NGO but with a change in corporate structure so that the Board includes representatives of the AOD sector, possibly even based on a membership structure from within the sector;
- Merging with a university or research institute; or
- Merging with a major teaching hospital.

A table summarising possible advantages and disadvantages of each option is included at Appendix B.

Timing is a critical consideration. The options set out above might take some time to process. It is a crucial decision and given the history of less than satisfactory partnership experiences some form of competitive tendering might be required. A prolonged period of uncertainty would, however, very likely be a serious disincentive to quality applicants for positions that TPC needs to fill urgently. For this reason the Review Team suggests that the TPC Board and the Victorian Government, in consultation with the Commonwealth, make an in-principle decision on the structural future for TPC, which it then take some time to consult and implement with stakeholders and partners. Key vacant leadership positions could then be immediately advertised with a clear indication about the reform path to rebuild TPC and the future affiliations offered to incoming senior staff.

Recommendation 2) That the Board of TPC and the Victorian Government, in consultation with the Commonwealth, make an in-principle decision about the future structure for TPC between two options:

- Option 1 being a reconstituted NGO structure with a Board which includes representatives of the AOD sector in Victoria, and possibly a membership structure to support this (and with renegotiated relationships with St Vincent's Hospital and the University of Melbourne); and
- Option 2 being a merger with a major teaching hospital, based on TPC's continued identity and operation as a community based service with three interrelated arms and a high degree of autonomy and budget integrity guaranteed both by an ongoing Advisory Board and specific requirements from funders.

Recommendation 3) That the preferred option from Recommendation 2 be discussed and developed in consultation with all stakeholders and implemented progressively over the next one to two years.

In summary, the two options represent two different developmental pathways for TPC, both of which are legitimate responses to the needs of the Victorian AOD sector. With appropriate appointments to clinical and organisational leadership positions, Option 1 would support the rebuilding of a centre that can provide clinical excellence, sectoral development services and an applied research / outsourced policy development role for DHS. Given the challenges facing the AOD sector in Victoria this is a worthwhile role. Such a centre may

also attract relationships with researchers keen to use both data gathered at TPC and its clinical services as a site for research if TPC is able to attract senior clinical staff sympathetic to research and training. The Review Team's view, however, is that Option 1 is unlikely to sustain an in-house research capacity that will be competitive in the research sector or researchers capable of attracting major competitive research grants. It may also be less attractive to leading clinicians and leave TPC clinical services (and clinicians) still at arm's length from the hospital sector.

Option 2 embraces a more ambitious vision, including greater in-house clinical and research capacity, especially the ability to sustain senior clinicians engaged in competitive research and researchers capable of winning competitive research funding. This is closer to the original TPC vision and might also sustain more effectively specialist clinical training capacity. The viability of option 2, however, requires effective guarantees, protections and synergies for a number of important aspects of the TPC model, as outlined in the recommendation.

Once the future structural direction of TPC has been determined, and in any case within a short period of time, there are a number of steps that need to be taken to commence the rebuilding process.

Recommendation 4) That the Board of TPC should appoint three key senior staff including a new Director of TPC, a Deputy Director (with no other responsibilities) and a Director of Clinical Services, as a matter of urgency.

- The Director needs to be of the highest credibility in the AOD field. He or she should ideally be a senior AOD clinician or public health practitioner with a research track record and international standing within the field. However, equally crucial is that he or she will need exemplary leadership and management skills; the skills to rebuild trust in Government, among partners, stakeholders, staff and clients, to drive service integration and provide overall vision for TPC;
- The Deputy Director should have a proven track record in management in a complex health service environment and to be recruited unencumbered by other responsibilities; and
- The Director of Clinical Services should be medically qualified specialist in Addiction Medicine, with a track record in clinical leadership and experience in a clinical research environment.

Recommendation 5) That a key first step in rebuilding the clinical service is for DHS and the TPC Board to provide a clear direction and scope for its services. This should be as the leading community-based, specialist, tertiary referral clinical AOD service in Victoria, working to support, jointly manage and take referrals from GPs and other frontline service providers.

Recommendation 6) That TPC recruit a full complement of senior clinical staff in order to provide a specialist referral AOD service, to maintain the capacity to train addiction medicine specialists and to support research activity based in the clinical services.

Recommendation 7) That DHS and TPC Board endorse the urgent need for a plan to rebuild and sustain a core clinical research function that is linked to the patient population that it serves (through both its clinic and HealthLink) and to wider public health research. Noting that the scope of this plan will be set to some extent by the decision on TPC's structural future in response to Recommendation 2, the new TPC Executive Team recommended below at Recommendation 13 should prepare a paper for the TPC Board on a strategy to rebuild and sustain its core research function.

Other important directions

There are also a number of important issues, relating to external relationships, which need to be identified beyond the immediately urgent issues outlined above.

The funding model for AOD clinical services in Victoria, which requires medical services to be funded through claims against the Medicare Benefits Schedule (MBS), appears to have exacerbated a number of internal problems together causing a significant part of the structural budgetary problems within TPC. These flow on to the organisation's ability to resource its integration functions and could impact on recruitment.

Similarly the proportion of TPC funding that is tied to projects or clinical Episodes of Care (EoCs) and the lack of funding for sufficient management depth was identified in both the 2000 and 2001 reviews, with both recommending DHS separately fund (or allow diversion of funds for) a Deputy Director position. This will be necessary both to provide internal management coherence and to drive synergies from the three arms of TPC's activity.

It should be noted that the Review Team has not been in a position to examine if the overall level of the TPC budget is correct or if it is all being used at optimum efficiency. This

was neither within our terms of reference nor would it have been possible within the time available. Justifying an absolute increase in funding level would require further work and might be seen as 'rewarding failure'. TPC does, however, need to have the flexibility internally to resource its management and coordination functions without prejudicing its delivery of funded outputs.

Recommendation 8) That DHS consider allowing TPC flexibility sufficient to employ from core funding a Deputy Director position (as recommended by the internal and external Reviews in 2000 and 2001) and a Clinic Director position, not tied to specific projects or services.

It would be worth DHS involving the Commonwealth Department of Health and Ageing in this discussion, as DOHA might also be able to untie some of its regular funding also to support a model from which it has sourced considerable work over the years.

Recommendation 9) That DHS review its strategy for the funding exclusively via the MBS for community-based AOD medical positions, noting that this is a very longstanding policy position in Victoria.

A similar set of issues affects the Research Unit, at least while it is rebuilt. In principle, once operating, most of the Research Unit's revenue would come from commissioned or competitive project related grants. However, while capacity is rebuilt and consolidated a more direct and assured source of support is worth DHS considering.

Recommendation 10) That the capacity to produce recurrent and ad hoc commissioned reports on AOD usage, consequences and service delivery is essential and should be maintained. As such DHS should consider, for a time limited rebuilding phase, investing a guaranteed component of State AOD research funding in TPC to redevelop its capacity.

There are also a number of other key relationships identified in the review process to which attention is needed.

Recommendation 11) That TPC management liaise regularly with local residents and businesses to ensure effective management of any public space issues adjacent to TPC facilities and community awareness of strategies being implemented in this regard.

Recommendation 12) That Advisory Panels in Clinical Services, Research and Training (including external members) be established (in the case of research re-established) to report to the TPC Board, to engage key stakeholders and provide strategic advice and direction.

TOR 5: Recommended changes to internal governance arrangements

The following recommendations are intended to indicate the priority reforms identified by the Review Team to consolidate the urgent directions set out in Recommendations 1 to 7. The first set of recommendations is directed to consolidating the leadership structure needed to rebuild TPC.

Recommendation 13) That TPC reform its Executive Team immediately as smaller group with the Director, Deputy Director, senior representation from the clinical, research and training arms, and a consolidated corporate management representation. The current Chief Operating Officer should continue on the Executive for the duration of his tenure.

Recommendation 14) That the Terms of Reference for the reformed TPC Executive Team include responsibility for business planning, priority setting and making decisions whether to apply for new funding, including project based funding.

Recommendation 15) That the TPC Executive Team put a high priority on initiatives to break down the 'silos' within TPC, including ensuring that all projects are run by teams with cross unit representation.

It is then recommended that, as a preparatory phase for the next round of business planning, that the new TPC Executive Team prepare a set of papers, in addition to the one recommended at Recommendation 7 regarding a strategy to rebuild and sustain TPC's core research function. These papers provide a substantive work plan for the new Executive Team addressing the issues of greatest importance identified in the review process. It is crucial that the new Executive Team address these priority issues and be seen by TPC staff and partners to do so.

Recommendation 16) That the TPC Executive Team prepare a paper for the TPC Board considering transfer at least service review component of the evaluation section of the Research Unit to a re-focused Training and Development Unit, with health service and program outcome research still a focus within the Research Unit.

Recommendation 17) That the TPC Executive Team prepare a paper on options to develop stronger coordination of the TPC clinic and telephone services, including such options as joint Executive Team management representation and coordinated staff management, rostering, training and development.

Recommendation 18) That the TPC Executive Team should prepare a paper on priorities for TPC clinical services, addressing the following issues:

- Maintenance of core services including opioid substitution pharmacotherapy with return to full time pharmacy dispensing service for IDUs referred by GPs or other clinicians who have “complex specialist needs” strictly according to the definition of the clinic’s scope and the needle syringe program;
- Opportunities to host specialist clinics in Infectious Diseases (Healthy Liver/Hep C Clinic, immunisation of ‘at risk’ clients), Dual Diagnosis and Chronic Pain Management and Antenatal/Reproductive/Sexual Health (entering ‘shared care’ arrangements with GPs where appropriate) provided by appropriately qualified multidisciplinary teams;
- Exploring feasibility of providing “outreach specialist clinics” in community-based/primary health care settings as a way to better partner with these agencies, thereby also ensuring appropriate referrals to TPC;
- Opportunities to assume primary responsibility for accreditation of pharmacotherapy prescribers in Victoria i.e. conduct training courses (using medically trained staff) and offer clinical placements;
- Opportunities to make a contribution and seek funding in the two high priority areas of alcohol and co-morbidities, for example in the use of pharmacotherapies for alcohol treatment;
- The need for a more complete range of specialist services, including sexual health, prevention of all the hepatitis, including through immunisation of at risk clients; and
- Providing comprehensive clinical activity data including both Episodes of Care (as already required by DHS) and Occasions of Service according to clinical discipline for planning and internal management purposes.

TPC must also respond to the demands of service users for a more structured consultation mechanism between clients and the organisation.

Recommendation 19) That TPC develop a structured complaints mechanism, a deliberate strategy for communication with clients about decisions that affect them and a forum for ongoing engagement with service users through which client input is actively sought and considered by management across each of the arms of TPC and its Executive Team as a whole, as well as being fed back to the Board.

TOR 6, Recommended implementation plan and timeline

The Review Team has proposed that a prior step to pursuing the opportunities that undoubtedly present themselves for TPC's future is the rebuilding of the organisation. There are a number of steps that are both urgent and important. Without progress on Recommendations 1 to 7 above, there is a significant danger that, despite the desires of Government and key partners and stakeholders, the future of TPC cannot be assured.

Implicit in this strategy is that the TPC Board and the Victorian Government, in consultation with the Commonwealth, make a decision more quickly than might otherwise be the case as to the future structure for TPC. The implementation of this structural direction, coupled with the urgent Recommendations 4 to 7 and then the remaining recommendations, will require clear and cohesive leadership at a number of levels. The Review Team suggests that a number of actions be taken to facilitate this process.

Recommendation 20) That DHS initiate discussions with the Commonwealth DOHA about the important role DOHA can play at a number of levels in assuring the future role and contribution of TPC, an organisation in which various agencies of the Commonwealth have seen fit to invest repeatedly over the years. This could include discussion about funding flexibility, support for organisational reform and restructuring.

Recommendation 21) That DHS and the TPC Board decide on the best governance of this rebuilding process. This consideration might usefully include the appointment of an interim Transition Board to oversee the implementation process, including if that decision is taken the merger of TPC with a major teaching hospital.

Recommendation 22) That an interim Transition Board be formed through a number of Board members agreeing to make way for a number of new members appointed from a wider range of backgrounds, including greater depth in clinical service management, including in AOD, while allowing for some continuity from the existing Board.

1. Background

1.1 The Turning Point vision

The restructuring of the Victorian drug treatment services sector commenced in the early 1990s. This involved the devolution of the State-operated service system (Drug Services Victoria), with the non-government sector being contracted for drug and alcohol treatment service delivery. Two government services were closed to meet budget savings targets before reform started. Two others were closed and new services established also in the context of re-tendering much of the non-government sector. This restructuring had a number of acknowledged benefits, including a number of improved and/or new withdrawal and specialist methadone services, the establishment of the Youth Substance Abuse Service (YSAS) and a well regarded set of justice system interventions.

As a result however, even more heavily than elsewhere, Victoria has relied on general practitioners (GPs), community pharmacies and a large number of small non-government organisations (NGOs) to provide its alcohol and other drug (AOD) services. The Victorian Department of Human Services (DHS) views the Commonwealth as financially responsible for all but inpatient medical services, through the Medicare Benefits Scheme (MBS). The GP sector actively involved in AOD treatment is, however, very concentrated and involves a quite a small number of GPs some of whom have extremely heavy caseloads. This is a brittle and fairly high risk situation for Victoria. Other investments over the course of reform of the sector included the injection of additional funding so that DHS funding of the AOD sector has increased from \$24 million at the time the devolution reform process began to over \$100 million now. This funding does not, however, include direct funding of specialist addiction medicine or pharmacotherapy prescribing in the community.

As part of the redevelopment process, it was envisaged that a specialist drug and alcohol centre would be established to “provide vision and leadership in therapeutic innovation, research, education, training and evaluation to the alcohol and drug sector in Victoria”. The Victorian Government document, *New Directions in Alcohol and Drug Services* (1994) presented the notion of a “Centre for Leadership” in the sector, proposing that the core activities of the centre would be:

- Specialist clinical services;
- Telephone services;
- Primary care programs;

- Education and training;
- Research; and
- Information and epidemiology.

Turning Point Centre (TPC) was established as a result by a network of key individuals working in the sector and in DHS at the time. Their vision included the following:

- Providing leadership to a vulnerable and decentralised sector, both from clinical and advocacy perspectives;
- Providing training and developing a workforce with low level base skills;
- Nurturing the development of the embryonic Addictions Medicine speciality in Victoria;
- Creating a more effective clinical research environment;
- Delivering quality specialist clinical services;
- Being an outsource for DHS activities (e.g. policy development, public health surveillance); and
- Developing a significant national and international profile.

The service model proposed for TPC was one based on a high degree of linkage and synergy between the three principal activity streams of the centre:

- Clinical service provision (including telephone services);
- Education and training; and
- Research and development (including epidemiological monitoring and analysis).

1.2 Turning Point history and previous Reviews

The model of the three sides of TPC's activity interacting with synergy to produce more than the sum of the parts has always been seen as a "unique aspect" and "key strength" of the TPC model. For the first half of its life TPC is widely acknowledged as having gone from strength to strength. Budgets grew, training progressed to produce a number of key researchers and clinicians in the Victorian AOD sector, papers from TPC staff dominated national conferences and the training operation and telephone service won new contracts. The model of the Turning Point triangle became iconic, at least within TPC, and the foundation Director was well-respected and indeed sought out for national and international committee work and other engagements.

Two substantial reviews of TPC took place in the early 2000s. The first was an internal review undertaken in 2000 by Farrell, Adams and Alberti while the second was commissioned by DHS and undertaken in 2001 by Health Outcomes International. There were similarities in a number of findings, although perhaps a difference in the emphasis of the recommendations. Both reviews noted that TPC had made, in a relatively short time since its creation, significant advances in meeting the original DHS expectations.

However, both reports also raised a set of issues and made a number of recommendations, a number of which were not addressed in the immediate years following the reviews. Most of those issues remain pertinent today. Indeed, many of the earlier review reports' observations are now of greater urgency. These issues included the following.

First, the constitution and skills base of the Board was not wholly reflective of the organisation's business and relationships and its lack of a membership constituency (being appointed by the Minister) was felt by many to be problematic for a sectoral lead agency. The Director's national role, while important, was viewed as a risk for the internal management of the organisation. Senior management was too thinly resourced for such a complex organisation and separate funding for a Deputy Director position was urgently required.

Second, affiliation agreements with its key partners, the University of Melbourne and St Vincent's Hospital, had not produced the outcomes needed to sustain TPC. There were always questions about the viability of the organisation given its mid-size, and the need to compete with larger clinical and research organisations for funds, profile and personnel. While the research record was impressive it appeared tenuous given the lack of a successful alliance with the academic research sector.

It was therefore essential to secure consensus on a precise definition of the organisation's business model (and the scope of operations of its three arms) and to broker a set of strategic partnerships on this basis in order to ensure the future viability of the organisation. This was essential but had always proved elusive. There were potentially conflicts between some of TPC's prescribed responsibilities. For example, on the one hand it was to be a leader and an advocate for the sector and, on the other hand, a service/program evaluator for DHS.

Third, TPC had a tendency to evolve into three separate 'silos'. As argued by Farrell, Adams and Alberti, "the three main strands of activity involve substantial focus and investment of time and energy and the focus on one area of activity can detract from achievements in other areas...There is a danger that the different strands of activity run in competition with each other, resulting in conflict, stress and differential status for different streams of activity".¹

A third review of TPC was undertaken by Growth Solutions Group in 2005, during the time of the then new Director. While this review ostensibly examined HealthLink it also made a number of comments and recommendations that were more generic to the larger organisation. While noting the TPC was one of the largest and best-connected alcohol and drug services in Victoria it concluded that TPC had not met some of the "lofty expectations set when it was established over decade ago".²

It assessed that the viability of a small stand-alone organisation like TPC with its large span of activities was problematic given the changing funding landscape, the increasing service competition and a research sector's increasing consolidation in bigger institutions. As such it foresaw that each of TPC's key areas of operation faced major strategic challenges to survive.

The GSG Review concluded that each of TPC's silos had the potential to play a leading role in the future, provided that the organisation was prepared to set a more focused direction and proactively seek out the right strategic partners. They noted that in the past the organisation had under-managed some of its stakeholder relations, a recurring theme through all three reviews. Finally, and most concerning, it reported that, "Turning Point's internal culture and systems may not yet be well aligned to meet the next generation of demands".³ While matters appear to have deteriorated since 2005, the GSG Review was a clearer warning sign still that there had always been some tensions in the TPC model and that all was certainly not well by this stage.

During the last three years the organisation has seen a number of developments as important problems become critical, including the following list.

- A very high turnover of senior staff. Based on information provided to the review team, five senior staff left the organisation in the three years prior to the retirement

¹ Farrell, Adams and Alberti (2000), *An Internal Review*, p. 23.

² Growth Solutions Group (2005), *Strategy Review*, p. 5.

³ Growth Solutions Group (2005), *Strategy Review*, p. 5.

of CEO Margaret Hamilton in August 2004 while 28 senior staff departed in the three years after her leaving.

- The departure of key research personnel (and some of their current grants and programs), with significant research credibility and grant pulling power.
- The departure of senior clinical staff; a lack of clarity on the clinic's service role and the (further) alienation of the clinical service and its remaining clinicians from the rest of the organisation.
- Remaining personnel losing faith in the centre's purpose and direction. This has resulted in staff retreating inwards and, while they have (quite heroically in some cases) kept TPC going, some have also exhibited symptoms of disaffection and mistrust in management and being overly critical of the other strands of the organisation.
- Notwithstanding the personal commitment and efforts of the Chair, the Board also appears to be somewhat disconnected from the organisation.
- A number of high profile misadventures. For instance, the failure to appoint a joint clinical head with St Vincent's Hospital, the apparently mishandled reduction in pharmacy hours (now partly reversed) and the doubts staff have about the future of the Liver Clinic.
- The alienation of not just existing clients but also user groups, who have felt devalued and not listened to with respect to service changes.
- A heightened ambivalence by the NGO, clinical and academic sectors towards TPC.

In summary, the Review Team's assessment is that the TPC, in terms of organisational health, is at a critical juncture. The resignation of one or two more senior or longstanding staff would make it virtually impossible to maintain the centre in its current form and would force the need to consider breaking up the various strands of the organisation and merging them into larger academic and service networks. This is the context for this Review.

1.3 Turning Point Centre finances and staffing

In addition to the core funding from DHS via its Funding and Service Agreement (FaSA), TPC receives funding from a number of other sources, including other parts of DHS, other Victorian Government Departments, Commonwealth and other State/Territory Governments for a range of separately tendered projects, fee for service activities and commissioned grants.

The following two tables summarise both FaSA and non-FaSA income and expenditure over the last four years.

Summary table of income & expenditure for last 4 years

Income stream	2004/05 (\$actual)	2005/06 (\$actual)	2006/07 (\$actual)	2007/08 (\$budget)
FaSA recurrent	4,168,578	4,274,068	4,296,125	4,334,772
FaSA non-recurrent	734,437	150,145	222,388	422,390
Other grants	3,626,866	4,229,216	4,304,025	5,692,789
Clinic fees	229,889	315,588	398,913	635,000
Other income	457,158	381,173	406,378	431,600
Total income	9,216,928	9,365,693	9,627,829	11,377,741
Total expenses	8,998,342	9,642,776	9,783,820	11,300,113
Operating surplus/deficit	218,586	(277,084)	(155,990)	216,438

Summary table of non-FaSA grant details for last 3 financial years

Service area	2005/06 (\$,000)			2006/07 (\$,000)			2007/08 (\$,000)		
	B/f	year	total	B/f	year	total	B/f	year	Total
<i>Training</i>	905	971	1906	673	1006	1969	1476	301	1836
<i>Clinical research – medical</i>	336	513	850	0	197	197	814	0	814
<i>Clinical research – other</i>	383	705	1087	702	1110	1812	1460	80	1540
<i>Evaluation</i>	316	113	429	239	294	533	239	0	239
<i>Epidemiology</i>	923	940	1863	1553	515	2068	1125	(31)	1092
<i>HealthLink</i>	1943	762	2706	1865	654	2519	333	4004	4337
<i>Total</i>	6594	6810	13435	7218	4764	12072	7154	5014	12226
<i>% HealthLink of Total</i>		11%			14%			80%	

There are a number of points of interest that arise from these data. The annual increases in the recurrent FaSA income appear predictable although there does appear to have been some injection of funds in the FaSA non-recurrent stream in 2007/08, which is itself less predictable. There was a significant cost pressure against revenue experienced in 2005/06, some of the consequences of which are discussed later in the report. There has clearly been a big effort to improve fee-based revenue in the clinic but this is still insufficient to fund a clinic of this size and mission.

The non-FaSA income data demonstrate a decline in research revenue, which will be more apparent again in 2008/08 with the full implications of the loss of the IDRS and significant parts of the surveillance function to the Burnet Institute. This decline is being offset by a big increase in the absolute and proportional contribution of revenue obtained by HealthLink, the TPC telephone-based service. This shows up in the first table as the significant increase in other grants.

The following table summarises the current staffing profile of TPC. As discussed later in the report these numbers are, in the clinic and research units, significantly below previous operating levels.

Service area	Total number of people, some part time	Full Time Equivalent
Corporate	22	16.37
Clinic	43	23.56
HealthLink	59	28.4
Education & Training	23	14.0
Research	24	18.51
TOTAL	171	100.84

1.4 Terms of Reference

During the second half of 2007 the Board of TPC and DHS agreed that a review of the strategic direction of TPC was required. The Board's deliberations on the need for a review coincided with DHS's development of a new blueprint for alcohol and drug services, which would afford a context for defining strategic priorities for TPC into the future.

A steering committee was established to oversee an independent review. The role of the committee was to assist in the selection of a consultant to undertake the review, ensure the review's terms of reference are implemented and the review findings are actioned. The membership of the committee included representation from the TPC and DHS and an independent member.

Steering Committee members:

Chair Paul Shannon, TPC Board Chair
Ray Judd, TPC Board member
Professor Terry Nolan, TPC Board member
Paul Smith, Director Drugs Policy and Services, DHS
Sue Brennan, Mental Health Branch DHS
Jane Fenton, Chair VicHealth, independent member

The following objectives formed the Terms of Reference for the review, which guided the focus and content of background reading, consultation interviews and information requests.

- Identify changes in TPC's operating environment and assess the relevance of TPC's existing charter as a centre of excellence in alcohol and other drugs research; training and development; and prevention and clinical practice leadership, in this context;
- Identify opportunities to redefine the charter and mandate of TPC in the light of changes in the Victorian and national AOD policy, research, addiction prevention and service delivery landscape and assess the capacity of TPC to deliver on its new role;
- Recommend changes in strategic direction and priorities which will strengthen its sector leadership role;
- Recommend changes in external organisational arrangements which will strengthen its capacity to deliver on its new role and to partner with external stakeholders;
- Recommend changes in internal governance arrangements which will strengthen its capacity to deliver on its charter;
- Recommend an implementation strategy and timeline (including transitional arrangements) to facilitate the execution of any organisational or strategic changes arising from the review.

1.5 Methodology

To undertake this assignment Robert Griew Consulting (RGC) engaged a five person team, led by RGC Managing Director, Associate Professor Robert Griew. Other team members included Dr Hugh Burke, public health physician and RGC Consultant; Dr Ingrid van Beek, public health physician and specialist in addiction medicine who directs the Kirketon Road Centre and the Medically Supervised Injecting Service in Sydney; Professor John Kaldor,

Deputy Director of the National Centre for HIV Epidemiology and Clinical Research; and Ms Nicole Skeltys, independent consultant in Melbourne.

The Review Team's approach to the task of reviewing Turning Point Centre involved four stages. These included:

1. Initial meetings and discussions with the Steering Committee and DHS officers and review of background documentation;
2. Wide consultation with key stakeholders, including TPC Board members, TPC management and staff and some ex-staff, TPC partners and NGOs in the AOD field, service users and drug user representatives, researchers and clinicians in the AOD field, Commonwealth and Victorian officials, local business and resident representatives, and others. A number of submissions were also received by the Review Team. A list of those consulted and submissions received is at Appendix A.
3. Preparation of a draft report, the ideas in which were then discussed with the Steering Committee and groups of key informants from the first round of consultation.
4. Preparation of a final report.

Timing was a challenge for this assignment. RGC was engaged late in 2007, at a point where issues at Turning Point Centre had become quite acute and the Steering Committee was conscious of the need for a report as quickly as possible. It was agreed to provide the final report by early February 2008. This did present some challenges in accessing people for consultation. It was for this reason that RGC engaged Ms Skeltys, to undertake some consultations locally in Melbourne when people were not available at times the rest of the team could visit Melbourne. The Sydney and Canberra based members of the Review Team spent 13 consulting days in Melbourne and, with Ms Skeltys' assistance, were able to consult over 60 people.

The Review Team supported the Steering Committee's urgency to receive the final report and, while it would have been ideal in one sense to consult more people or spend more time on the review, we are confident in the recommendations we have made and in the priority that needs now to be given to moving forward.

The Review Team's analysis and our report is organised against the Terms of Reference for the review.

In Chapter 2 we start by examining changes in the operational environment of TPC before turning to the main operational arms – clinical, research and training, as well as HealthLink. In relation to these four business units we have looked separately at their history and operating model, results and pressure points and issues.

In relation to these four business units we have looked separately at their history and operating model, results and pressure points and issues. Lastly in Chapter 2 we turn to the overarching issue of governance, leadership and management.

In Chapter 3 we present our recommendations for future strategic directions and priorities, against Terms of Reference 3 to 6.

2. Overview of issues

As noted in the previous section, this Chapter addresses the first two Terms of Reference for the TPC Review. These Terms of Reference direct the Review's attention respectively to changes in TPC's operating environment, the continuing relevance of TPC's charter and opportunities to redefine that charter.

2.1 Turning Point Centre in its changing environment

TPC was reviewed twice, in 2000 and 2001, both at the instigation of its Board and DHS. As noted above a number of the issues raised in these reviews are still relevant and a number of the recommendations made are still germane. The earlier Reviews highlighted a credibility problem faced by TPC with the AOD sector in Victoria.

TPC was established, in the context of the decentralisation of public funded AOD services, to provide clinical and policy leadership to the sector in Victoria. This has inflated TPC's perceived close connection to DHS and claims of an unlevel playing field. Some had the view that TPC was established by government and not the sector and therefore has a conflicted leadership or advocacy role. This was compounded by a feeling that TPC has maintained a degree of isolation from the rest of the sector, which in many cases is seen as elitism and entrepreneurialism (in a sector predominately marked by an anti-elitist view of the world).

The compulsory competitive tendering environment, introduced in Victoria at the same time as the decentralisation process, is believed by many to have heightened suspicion and competitiveness between NGO services, at the very time when TPC was being asked to establish a leadership role in the sector. TPC was being asked to compete for resources with the same services it was being asked to lead and which it was also required to evaluate as a separate service to DHS.

While TPC was relatively successful in attracting funding, these funds are tied to projects that use at least all of the funds provided. They do not allow of sufficient contribution to the TPC organisation's wider role. For its sector wide role as a clinical and developmental leader it is in fact not well funded, has like other services struggled sometimes to appoint key staff and has not always, therefore, been able to fulfil its leadership charter. TPC was being asked to play this elitist role in a sector with a culture that includes elements of anti-elitism and a tendency to a hypercritical, even somewhat nihilistic attitude toward notions of

excellence. Being legitimately vulnerable to critique has led to particularly harsh criticism in such an environment.

As noted earlier, the size and sophistication of the Victorian AOD sector has also grown substantially over the years since TPC's establishment. Thus the sophistication and quality of leadership that the sector expects from TPC has changed over time, a potent driver of dissatisfaction when TPC is also a competitor. In such an environment TPC's shortfalls will inevitably be very visible and draw comment.

As one manager from another NGO, himself quite critical of TPC over the years, put it, "There is an extent to which Turning Point just can't take a trick. Some of that is their own doing. Much of it is our attitude to the whole idea of leadership and our own negativity as a sector."

More than once people we consulted suggested carving up TPC and diverting the funding to other services or sectors, only then to seek a further meeting with the Review Team to recant. The follow up view from these participants in the consultation process was to recognise that without TPC the Victorian AOD sector would be worse off. Yet they badly wanted TPC to perform more strongly and to fulfil its leadership charter, notwithstanding some having a kind of cultural discomfort with the notion.

A more useful way to explore the question of TPC's future role within the AOD sector in Victoria is to examine the sector's needs and how TPC might relate to these. There are a number of specific features of the AOD sector in Victoria that give rise to a clear role for an organisation such as TPC. These features differentiate the Victorian AOD sector from other States. Since the decentralisation process in the early 1990s, Victoria has had an unusually high level of reliance on the GP sector to manage pharmacotherapy for AOD clients, supported by a less developed and resourced specialist addiction medicine sector than in other States. Addiction medicine specialists do not have the same level of access to training positions, especially in community settings, public clinical posts or career structures. GPs not only manage a higher proportion of the caseload, they are relatively less supported by specialist referral services in doing so. This high caseload on GPs is also shared among a relatively small number of GPs.

The AOD sector is very decentralised, with over 100 NGO services in the AOD program, and relatively less coherent planning, networking and support from specialist public sector services. Like NGO AOD sectors in other States, there has been a relatively low level of

training of staff in this part of the sector, although TPC and some other AOD training providers have delivered a fairly successful competency-based training program over the years, at certificate and diploma level. There are four public specialist methadone services attempting to provide a medical service across Melbourne, with TPC occupying a nominal but rather ill-defined leadership role among them. Sometimes the emphasis on the other sides of TPC's mandate has led people to view the clinic as important in its support of these activities, which it is. However, the relative lack of other public funded specialist medical services in the Victorian sector in fact makes TPC clinical services important in their own right.

Alcohol and other drug use patterns are continually evolving in Victoria, as elsewhere. Like elsewhere in Australia, Victoria experienced a "heroin drought" in the early years of this decade, with a consequent reduction in overdoses and other heroin related morbidity. Heroin supply does appear, however, to be increasing again. During these years psycho-stimulant use has become more prevalent among drug users and TPC has been involved, as have similar services in other States, in attempts to develop clinical and other management models to address this. Notwithstanding the particular challenges of this shift to psycho-stimulants, the feared impact of the drug "Ice" has not eventuated at this point at least.

Over the years, alcohol has been neglected as a major public health issue, in the face of interest in illicit drugs, in Victoria as elsewhere. This has been a problem at both the Commonwealth and State levels. There may, however, be some opportunity in the next few years with Governments indicating some interest in input on policy to tackle the health and social impacts of alcohol misuse in the community. TPC is well resourced to contribute to this issue, hosting an internationally credentialed researcher in alcohol policy. It has also been involved in some interesting clinical research on prescribing patterns among GPs for pharmacotherapies for alcohol addiction.

Another recent area of expressed priority to Government is the group of clients with dual diagnoses/co-morbidities in mental health and AOD. This area of co-morbidity is currently attracting funding for service innovation and the client group and, at least at various points, TPC's clinical capacity gives it an opportunity to make a contribution. Previous work in this area, with St Vincent's Hospital, has not always gone well but it is an area of great relevance to the clinical needs of TPC's target population.

Likewise (and in fact related) are a set of connections between AOD issues and problems in family violence, child abuse and neglect and homelessness. Over the course of TPC's existence there have been considerable advances in the science of child development and in our understanding of the way these interrelated health and social issues transmit from one disadvantaged generation to another. The NGO part of the AOD sector in Victoria is relatively well networked and connected itself to a wider set of service networks interested in these family issues. This sector perceives TPC, if anything, to lag behind the sector in embracing service and research agendas pertinent to the expansion of knowledge in this area over the last fifteen years.

There have also been changes in the research environment over the time of TPC's existence. While the national centres in both AOD and HIV have existed as long as TPC they have developed and secured strong funding bases and highly productive research faculty. They are now allowed to compete for NHMRC and other competitive research funding and have advanced in productivity and capacity in clinical research, an area that TPC might have gained a greater dominance in at an earlier time when it still had a competitive advantage in this regard. This competitiveness is heightened by the emergence as significant competitors of new institutes, such as the Burnet Institute, which has gained responsibility, funding and staffing for a significant part of TPC's former role in surveillance – the IDRS. It is further heightened, notwithstanding the Commonwealth Government's recent rejection of the Research Quality Framework in university funding, by a tendency over time to a consolidation of competitive and infrastructure research funding in larger research centres and with bigger collaborations.

Finally in terms of TPC's role in its changing environment, local neighbourhood and business groups met the Review Team to express frustration at slow perceived progress on some public order issues. These relate not only to TPC but a range of social services and issues in the area but TPC is the highest profile service against which to prosecute these issues. Again this is not a new issue, or one unique to Victoria, however, when it emerges, it is one that needs to be managed proactively with a clear strategy for community engagement and management of the relevant issues.

In summary, there are a significant number of changes that have occurred in TPC's operating environment over the course of its existence. Some are powerfully specific to the Victorian AOD and health funding system. Most are not, however, new and many have been previously identified. Some of those were present in the initial design of TPC and the

context of its inception. Some of those previously identified have escalated recently to a greater state of urgency.

There are opportunities in these changes as well and these should be pursued. As will be discussed in the following sections, however, this will not be possible until a number of pressing problems in TPC are addressed. The remaining sections of this chapter explore the history, operating model, performance and key issues facing each of TPC's main operating arms.

2.2 Clinical services unit

History and operating model

In this section, we outline the history of TPC Clinical services, their performance and the key issues and pressure points facing those services at present. Because it operates autonomously and has not been as affected by the same pressure points, the TPC telephone services are separately discussed in the following section. These should, however, be considered as a part of the TPC total clinical service.

TPC's clinical service was originally envisaged to be State-based service, however, its limited ability to deliver direct clinical services state-wide due to obvious geographical limitations have meant that, with the exception of some outreach, a number of clients who do seek TPC services from other areas of the State and the telephone-based services, TPC clinical services have been mostly confined to Melbourne's metropolitan NW area. TPC's clinic accepts referrals from GPs, other frontline clinicians and community organisations, prison system, police diversion, and its various telephone services, and clients are also able to self-refer/drop-in.

TPC's clinic provides opioid substitution pharmacotherapy service (e.g. methadone, buprenorphine) with on-site pharmacy dispensary, although on-site dispensing capacity has recently reduced since the pharmacy became part time as part of a strategy to contain costs. Eligibility criteria for opioid substitution pharmacotherapy include:

- Complex patients (co-morbid medical problems, co-morbid psychiatric problems, psychosocial issues e.g. homelessness);
- Complex poly-substance use (multiple in a hazardous manner, unstable other drug use e.g. severe alcohol misuse);
- Care taken on from GPs due to instability; and
- Forensic clients (mandated clients involved in the criminal justice system).

TPC's clinic also provides treatment for alcohol, opioid and benzodiazepine withdrawal, cannabis and amphetamine case management, relapse prevention and AOD counselling service. TPC's clinic supports GPs in opioid prescribing for chronic pain management. Other specialist clinics that have operated include Health Liver Clinic (infectious diseases with a Hepatitis C focus) and Dual Diagnosis/Anxiety clinic (psychiatry).

The TPC clinic has hosted training placements of GPs (advances skills training) and Addiction Medicine registrars (rotated from St Vincent's Hospital) as well as nursing (University of Melbourne and Deakin University), psychology (Monash University) social worker (La Trobe University) student placements. TPC's clinic has also hosted the "peer helpers on placement" program.

Results

The Review Team was informed that the clinical service has continued to meet AOD industry quality standards as part of a formal service accreditation process undertaken by the organisation as a whole on a triennial basis, the most recent occasion being about a year ago.

Funding for the TPC clinic is provided (mainly by DHS) on a "casemix" basis, against capped targets of Episodes of Care (EoC). An EoC is a completed clinical plan, delivering a clinical goal from that plan. An EoC can, therefore, include very complex activity or a more straightforward clinical intervention. The Review Team was also initially surprised by the similarity of EoC data from year to year until it was explained that the returns are only designed to demonstrate that sufficient activity had occurred to justify capped funding targets, which has consistently been the case. While such "outcome" indicators are useful, it is potentially problematic only to use these to assess clinical activity, or indeed clinical efficacy, especially given that the same client can be subject to multiple EoCs.

The following table lists the services and EoCs funded by both the DHS and the Commonwealth at October 2007.

<p>Funded by DHS:</p> <ol style="list-style-type: none">1. Outpatient Withdrawal – total funded Episodes of Care (EoC) = 274 (\$149K)2. Home-based Withdrawal – total funded EoC = 118 (\$146K)3. Specialist Pharmacotherapy Service – total funded EoC = 100 (\$342K)4. Counselling, Consultancy and Continuing Care – total funded EoC = 515 (\$606K)5. Needle Syringe Program – no targets, but approx 100 clients/week (\$34K)6. Forensic Program – total funded EoC = 110 (\$100K)7. Acquired Brain Injury - total funded EoC = 33 (\$90K) <p>Client categories funded by Commonwealth grants:</p> <ol style="list-style-type: none">1. Drug Responsive Outreach Program (DROP) 0.8 FTE "outreach" position – total funded EoC = 62 (\$65K)2. Dual Diagnosis and Complex Care (DDACC) (Anxiety Clinic) – total funded EoC = 62 (\$105K).
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Clinical service targets have been met by TPC over the past 5 years, totalling about 1,500 EoCs per annum. However assessing trends in the level of clinical activity over this time

period was not straight forward as there didn't appear to be a routine reporting system in place to measure clinical activity levels beyond these targets once reached. EoC reporting also does not measure the actual number of occasions clients were seen by different kinds of clinicians such as to enable an assessment of the respective outputs of the various disciplines (e.g. medical, nursing, counselling). Such "process" indicators of clinical activity were not available to the Review.

Data regarding pharmacotherapy-dispensing occasions at TPC were also not readily available, although this information is apparently routinely reported by TPC's pharmacist to comply with DHS requirements in relation to the regulation of such (schedule 8) substances. However dosing occasions have decreased substantially from about 100 to about 30- 35 per day since the reduction in TPC's pharmacy operating hours.

Main pressure points and issues

On the positive side, the TPC clinic is well-located geographically in close proximity to an area affected by AOD issues, a hospital inpatient AOD service and primary health/ community health services. The clinical environment is attractive, spacious and appeared well set out to be functional. The clinic has been meeting its targets and has maintained industry standard accreditation.

There is a widely held belief among clinical staff, however, that the clinical service aspect of the TPC model not considered important by the TPC executive or Board. Clinicians (past and present) feel somewhat sidelined and not heard, citing the current absence of representation at executive level as evidence of this. A particular concern among medical staff is that they have been viewed differently to others in the multidisciplinary clinical team, principally as being much more expensive in terms of salary level.

EoC funding does not include funding for the costs of medical staff as such. The DHS policy position is that medical services are a Commonwealth responsibility that should be funded through the MBS. This creates a financial pressure point, because it is an anomalous view compared to other States which do not regard MBS funding as either adequate or an appropriate source to fully fund specialist medical positions in community AOD, particularly not while the recently recognised medical specialty of Addiction Medicine has yet to gain recognition by the Health Insurance Commission for the purpose of charging fees at "specialist" level. Medical staff being relatively expensive in terms of salary level but on the other hand being seen as having potential revenue-raising capacities (dependent on level of

qualification) also creates a tension for medical staff within the multidisciplinary team environment of the clinic. Such fee-for-service based funding also creates different and potentially perverse incentives among medical staff compared to other salaried staff.

While specialist medicine may have an awkward place (and currently an understaffed place) within TPC's clinical team it has often also sat oddly alongside the specialist addiction service at St Vincent's Hospital, despite their physical proximity and formal partnership. Interviewees reported a number of instances of fault lines in the relationship, most notably the process that failed to appoint a joint clinical Director.

The clinic's staff profile has decreased significantly over the past 5 years from about 35 FTE to 23 FTE in order to manage increasing salary and other clinic costs. Apart from this reduction, TPC appears to have also been slow to recruit to vacant positions. Particularly serious has been the failure to replace longstanding senior medical specialists in recent times. At current medical staffing levels concerns were expressed that TPC may be unable to maintain accreditation for registrar-training placements due to lack of specialist-level supervision. Morale is very low and staff turnover high even for this sector. Concern was expressed that "good people have left" and that those who remained will burn-out more rapidly given the extra workloads inherited. The Review Team shares this concern.

There is a lack of clarity within the TPC clinic and elsewhere regarding what "complex" clients actually means. There is a perception among other NGOs that TPC receives large amount of core funding for clinical service provision on the basis that it treats "complex" clients and yet other services look after exactly the same clients. It would be more useful to describe TPC's target clients as those with "specialist" medical and psychosocial needs in this health service context.

Related to this confusion is a lack of clarity about whether the TPC's clinic should be meeting the wide and complex range of health needs at a local community level i.e. be a "low threshold" easily accessible "drop in" primary health care service or a specialist referral service. While there is a network of primary health care services targeting the health needs of injecting drug users (IDUs) in areas of high IDU prevalence with one of these (North Yarra Community Health Service) located close-by, these services are apparently often operating beyond capacity with consequent client overflows.

There is a risk that drop-in clients' very immediate needs potentially dominate service provision at TPC. There is also a danger that, in the absence of greater clarity on this issue,

TPC's clinic will be seen as an alternative or even competition, to other frontline primary care services, rather than as a specialist support service to those other frontline services. TPC and other frontline primary care services need to recognise that TPC's primary role is to provide such specialised support.

This does not of course mean that TPC should be any more exempt than other services from being responsive to the needs of its clients, including those not within its principle charter. This is encapsulated in the emphasis in the current Government emphasis in both AOD and mental health of a no wrong door' policy to clients. Indeed there is a concern among clinical staff that especially the more "difficult" clients who drop-in from the street are seen as a "nuisance" with little value to this service, or even a potential risk to the other aspects of the service. This is related to a perception (from without and within TPC) that the clinic is mostly valued as a feeder for TPC's research interests i.e. that clinic clients are primarily seen as "subjects". There appeared to be an "upstairs/downstairs" separation with limited contact or other opportunities for integration between research and clinical staff efforts.

At a time when there is low morale and a sense of disempowerment among clinical staff these issues are likely to be more destructive and less easily resolved than if clinic staff felt more valued within TPC as a whole.

As previously noted the operating model most consistently used to describe TPC over its history is based on the synergy between the three sides of the TPC "triangle" (clinical, research and training activity). This model is, however, misrepresented when the three sides are presented as if two are not dependent on the third. We believe that TPC is more usefully described as a specialist clinical service, with research and training arms. This does not mean that the research and training arms are some sort of added extra, which TPC could do without and still be unique. TPC is (or could and should be) much more than a clinical service. However, without a high performing clinical service it is hard to envisage what would be so unique about either the research or training TPC could undertake.

Given this, the current weakened state of the clinical service is of fundamental concern to the whole model (and therefore the future of TPC) and is the highest priority to rectify. The TPC executive presented a proposal to the Review Team that suggested that TPC's triangle model be recast with the three sides no longer representing clinical, research and training but rather knowledge development, application and transfer. However, on balance, the

Review Team felt that a greater priority at this time is to focus on rebuilding the capacity and operations of TPC, starting with the clinical service.

This is not to downgrade research or training (sections below explore these two areas in detail). However, the current state of the clinical service imperils the whole organisation and its operating model in a way that neither other arm can. For this reason the Review Team proposes no change to the “TPC triangle” model except a recognition of the integral and foundational nature of the clinical service and a priority on fixing that element.

As part of the Review the Team consulted with a group of service users and ex-users convened by the Association of Participating Service Users (APSU) and the Victorian drug user advocacy group VIVAIDS. Predictably both of these key client groups also judged TPC by the functionality of its clinical service and reported a marked deterioration since earlier years, despite some promise of in fact improved engagement with them and their needs at various points. Another important benchmark to clients is the manner in which they interact with service staff. Client groups expressed concern at trends in the approach of some staff towards clients, feeling that TPC was moving away from a client focus (for example client groups noted that some staff were less proactive towards clients).

Service users stressed that TPC’s strength in the past was in fact the clinic’s fast response to clients – e.g. clients could be initiated into methadone treatment quickly (as opposed to waiting months through GP track) and treatment for Hepatitis C much faster than through hospital-based clinics. Service users reported a mixed record on the issue of “user input” although stressing that TPC generally compared favourably with hospital based services from their perspective. Nevertheless, some reported that they believed that many TPC staff were “scared of clients” but others cited examples of very good practice, e.g. the Healthy Liver Clinic where current IDUs could access treatment was seen as very positive, as were its support groups which were a very good addition to the usual hospital treatment approach. Both organisations and the focus group of clients highlighted the need for structured organisational engagement with clients.

2.3 HealthLink

History and operating model

HealthLink is one of the key operating areas of TPC. HealthLink operates telephone counselling, referral and consultancy services, providing the general community and health

and welfare professionals across Victoria with immediate, 24 hours a day, seven days a week access to professional support.

HealthLink is a leading Australian provider of specialist helpline and telephone support services. The statewide services of DirectLine and DACAS (the Drug and Alcohol Clinical Advisory Service) operate as a vital component of Victoria's AOD treatment service system. HealthLink also provides the equivalent helpline services for Tasmania and the Northern Territory. In addition, a range of satellite helpline services target young people (YSAS Line), family members (Family Drug Helpline) and other groups in the community (Drug Diversion Appointment Line, Disposal Helpline, Gamblers Helpline). HealthLink is also the provider of a national AOD online counselling program (CounsellingOnline).

HealthLink runs out of a location different to that of the other operations of TPC, including the centre's clinic. Furthermore, within the organisational structure of TPC, HealthLink and the clinic have different managers.

Results

HealthLink has been and continues to be a highly successful part of TPC operations. As the GSG review noted, it has been the major contributor to TPC's group overheads from among the four key operating areas, as well as, having an extremely impressive track record in winning new contracts and adding services to its portfolio of telephone services. The 2005 report noted that HealthLink had acquired 15 additional services in the previous 8 years. Based on a budget analysis of the TPC non-FaSA grants presented as part of this current review, HealthLink accounted for 80% of non-FaSA grant funding in the 2007/08 financial year.

Main pressure points and issues

GSG Review

While this 2005 review noted HealthLink's success, it also highlighted the business risks associated with the operations. These included HealthLink's competitive disadvantage against global players with greater depth of capital and technological resources, and noted that firms such as McKesson might not only compete with TPC for new services, but also their existing operations. Furthermore, the GSG report warned the present cost and remuneration levels for HealthLink services exceeded a number of services benchmarks and

there was a clear risk that future funding from DHS and others may be less generous. It should also be noted that the Commonwealth and States/Territories are still considering the establishment of a national call centre. A decision either way on this initiative would radically change HealthLink's business environment. As such, GSG's risk analysis in 2005 remains as true now as it did then, perhaps more so.

The GSG review concluded "that the competitive and strategic evidence in support of an expansionary business strategy is insufficiently compelling" and concluded "there are multiple reasons for an increased focus on improving workplace practices, productivity, service delivery and cost outcomes across the core Victorian AOD services provided by HealthLink".⁴

Organisation versus Business unit

While the HealthLink business unit has thrived, in the same period the parent organisation has struggled. This does raise the question as to whether the strategic needs of the business unit have been considered by its managers independent to those of the wider organisation, and whether the expansion of TPC business units (not just HealthLink) has come at a cost to the organisation as a whole. As the Farrell report noted "the focus on one area of activity can detract from achievements in other areas...There is a danger that the different strands of activity run in competition with each other, resulting in conflict, stress and differential status for different streams of activity". Clearly this potential for an island mentality cannot be helped by HealthLink's different geographical location and its disconnect from TPC's direct clinical services.⁵

HealthLink's success should not be underestimated, nor devalued as an asset by the rest of TPC. No-one spoken to by the Review Team would wish to do so, however, it is emblematic of a wider issue. The Review Team's view is that the Executive Team should really be responsible for endorsing the strategic decisions of its various streams, silos, strands, services areas or business units, including bids for external project funding. Without this then lip service is largely being paid to TPC's unique model.

Greater coordination of TPC's direct and telephone services

As mentioned, there is an obvious disconnect between the clinic and HealthLink services. This is seen in the fact that the two services have different locations and no integrated staff management systems.

⁴ Growth Solutions Group (2005), *Strategy Review*, p. 8.

⁵ Farrell, Adams and Alberti (2000), *An Internal Review*, p. 23.

Obviously, there are efficiencies that are being missed in separately running the two clinical services. Furthermore it is obvious that the clinic and its staff feel alienated from the rest of the organisation, a situation that could be improved by partnering with the other clinical service in the rest of the organisation, particularly one that is seen much success in recent times. For these reasons it would be important to consider ways to develop stronger integration of the clinic and telephone services within the organisation.

2.4 Research unit

History and operating model

TPC was established with research as a core element of its charter. There was an understanding among those involved in its establishment that there was a need for targeted, strategic research in the AOD sector that was not being funded or conducted through other means. The TPC model was based on the assumption that there would be a high degree of linkage and synergy between research and its two other central functions, clinical service and training. The important role of research at TPC was also emphasised at the time of its foundation by the agreement with the University of Melbourne, and the establishment of the Directorship as a Professorial-level appointee of the University. More recently, the University has been the conduit for funding the appointment of a new Chair in Alcohol Studies at TPC, and has granted affiliation to some senior research staff at TPC.

The research agenda

Funding arrangements for TPC have always had a strong link to the research function. The annual contract with DHS has specified research outputs as deliverables. These outputs are negotiated on an annual basis between Departmental officers and the TPC Director, and do not appear to have involved a formal peer-review process.

Beyond the core contract, TPC has been funded to conduct other research projects by a number of agencies, most prominently the State Government. Motivation for research beyond the core contract has come from a number of sources, including the TPC clinical setting, opportunities arising through calls for tenders, and the particular interests of individual researchers.

The research team

Research is conducted by a designated Program within TPC, as well as some staff from the other units. The Research Program is headed by Dr Nicole Lee, and functionally divided into the areas of Epidemiology, Evaluation and Clinical Research. Numbers of staff directly employed in research increased steadily over the first ten years following the establishment of TPC, and then decreased over the past year. At the end of 2007 there were 24 (or 18.5 FTE) staff directly employed in research at TPC. Of the research program staff employed at the end of 2007, nine were recorded as having some form of academic qualification at the Masters level or higher, and there were four with doctorates. The Acting Director, Robin Room, is an internationally credentialed researcher.

The research activities have been carried out under a variety of operational models. Clinical Research has generally closely linked to the clinical service, with research participants being recruited from among TPC clients. The opiate substitution trials represented an exception, in that TPC coordinated a network of general practice and primary care sites to recruit and follow clients. The Epidemiology and Evaluation areas have operated to a large extent independently of other TPC programs.

Results

Research grants

Detailed information was provided by TPC on the numbers of research grants awarded since 2004-5, in addition to the core grant. There were a total of 69 such grants recorded for this period for a total value of \$6.4m. The most frequently recorded source of funding has been the State Government. Contracts have generally been for one year's work or less, and the majority (43) have been worth under \$50K, but there have also been 17 awards of \$100K or more, for a total of \$4.91m, including six grants from the Australian Government totalling \$1.8m, two from the Alcohol Education and Research Foundation (\$1.6m), five from the State Government (\$800K) although only one from the NHMRC (\$337K). Of the 11 individuals designated as being responsible for obtaining the awards worth \$100K or more in this period, only four (Lee, Clemens, King and Room) are still working at TPC. Although not large in annual monetary terms, the loss in 2007-8 of the IDRS contract, which TPC had held with NDARC, was symbolically important as an indicator of a shift in TPC's leading role in the collection of Victorian AOD data.

Research dissemination

The TPC annual reports document a steady output of publications and presentations from the research team. A large number of the reports are produced by TPC as a formal part of

contractual obligations, particularly in the areas of health service evaluation and epidemiology. For example, the 2006 Annual Report lists 43 TPC technical reports, including guidelines, statistical compilations on various aspects of alcohol and drug use, and evaluations of clinical and community AOD services. Some of the statistical reports form series on specialised topics.

Another form of dissemination has been via publications in journals or books, which reflect research initiated and led by TPC, as well as collaborative projects. The 2006 Annual Report lists 31 such publications. A more specialised indicator is the number of publications in peer-reviewed journals with a first author from TPC, with the highest number of these being 21, although this was in 2001. Generally, the peer-reviewed publications have been in specialist AOD or public health journals, often Australian-based.

In addition to written communication, TPC research staff have regularly made themselves available to present research findings and interpretation at symposia, conferences and other lectures, with over 90 such appearances reported for 2006.

Research collaboration

Based on its published output, there is evidence that TPC has undertaken collaboration with investigators from other research organisations. The main links have been to NDARC, which has collaborated on pharmacotherapy trials and epidemiological analyses, and to a lesser extent NDRI. There do not appear to be extensive or ongoing collaboration with other Victorian organisations, and in particular, not with St Vincent's Hospital or with researchers at the University of Melbourne who do not have a direct affiliation at TPC.

Research impact

The research carried out by TPC has had an impact on practice and policy in a number of ways. The epidemiological data provided by TPC reports on AOD usage, consequences and service provision have been regarded as the definitive source of such information for Victoria, and have therefore been routinely called upon to guide the development and implementation of government policy. The ambulance attendance database that has been analysed on a regular basis by TPC is seen as a uniquely valuable resource for examining drug-related overdoses in a community setting.

In the clinical area, the most frequently cited impact of TPC's research program is the wide availability of buprenorphine for as opiate substitution therapy in Victoria, in contrast to its more limited use in other parts of Australia. More generally, TPC research staff make the

case that their experience in the investigation of drug treatment has led to the development and production of clinical guideline documents that play a key role in guiding practice and supporting training of AOD clinicians.

Main pressure points and issues

Previous reviews

As noted above, two substantial reviews of TPC took place in 2000 and 2001. The 2001 review commissioned by DHS focused largely on process, management and relationships, and had little to say that was specific to research, apart from checking whether contractual obligations to conduct research had been formally met in terms of report preparation, which they had.

The internal review in 2000 by Farrell, Adams and Alberti had a greater emphasis on the research area. It recognised TPC's research achievements, particularly regarding the pharmacotherapy trials and the epidemiological analyses of AOD usage and consequences in Victoria. It also recognised the unique research opportunity afforded by the integration of the clinical function within TPC, but found that there was room to develop stronger collaborations with other academic entities with relevant expertise. The review identified several areas that could benefit from further investigation, including psychosocial aspects of AOD intervention, the use of structured treatment manuals in clinical practice, and the link to criminology research and a focus on younger people.

That review also identified a series of issues for young researchers attempting to advance a research career at TPC. Both the organisation's understanding of its funding agreement (and subsequently its enterprise agreement) devalued journal publication compared to meeting report writing deadlines for clients (mainly DHS), thus stunting the apparent research productivity of otherwise efficient researchers.

As with a number of the other issues raised in these earlier reviews the issues raised are still pertinent and have come further to the fore in the intervening period. As the departure of a number of senior research staff has shown TPC has clearly remained a vulnerable research enterprise, despite its at times impressive productivity and contribution. Its dependence on commissioned research and its need to adjust work practices to align with this reality has not allowed a depth of research capacity to develop that could robustly compete for top level investigator driven research funding following the departure of a few

critical staff. This brittleness is demonstrated in the fluctuating number of peer reviewed grants obtained and papers published.

This vulnerability has been exacerbated by the difficulty TPC has faced in establishing a partnership with the University of Melbourne (or any other university) that has provided a buttressing against this size related vulnerability. In addition to this the university sector itself has undergone considerable change over the same period, including a substantial tightening of competition for investigator driven research funding.

The now departed second TPC Director Dr Nick Crofts was focused on this vulnerability and pursued a new range of collaborations with universities and research institutes, precisely because he could see the dangers for TPC in its dependence on a few senior researchers and on commissioned research. Ironically one of the final blows to the organisation during his time as Director was the departure, with the IDRS contract of one of the senior research epidemiologists Dr Paul Deitz, with that contract to the Burnet Institute. As previous reviews had warned, it is possible to spend a great deal of time and resources pursuing new partnerships without making real progress. For TPC is that this is not an optional activity but has not been wholly productive.

A further key issue for TPC that this set back for the Epidemiology section brings into focus is the balance of different topic areas within the research engagement. TPC has conducted epidemiological, clinical, public health policy and evaluation research and its capacity in these areas has varied over time. Different funders have also sought different kinds of research, for example the Alcohol Education and Research Foundation and DHS have commissioned important public health policy research, DHS has commissioned evaluation research and clinical research has been funded from a number of sources.

In preceding sections the Review Team has stressed the unique opportunity (for all of these types of research) of the clinical setting at TPC. It is essential to the productivity of the TPC model that TPC clinical services are rebuilt and operate at a high performing level, including as a base for clinical research. Without that the competitive advantage inherent in the TPC model does not operate. This would be to lose the key advantage TPC should enjoy relative, for example, to the national research centres. This will require both researchers and clinicians on staff at TPC and available through effective partnerships with the skills and orientation to conduct significant clinical research in both biomedical and psychosocial areas.

As well though, TPC has a key opportunity, including with existing research staff and data sources to continue to contribute to public health policy, for example in the key area of alcohol policy. The Review Team's stress on the need to rebuild the clinical services arm and clinical research capacity is not intended to downplay the importance of TPC's potential to contribute more strongly in public health research. For this reason a priority should be placed on strengthening the epidemiology section again and continuing to support Professor Room and his colleagues work on alcohol policy.

Further the Farrell, Adams and Alberti Review asked whether the evaluation unit really belongs in the research unit or whether it would be more usefully conceived as a sectoral development function and located in a (possibly renamed) Training and Development Unit. This might both broaden the engagement and function of that unit, connect it to a skill base clearly not already present in the sector and make clear that this is a service to the sector, not a conflicted, quasi-government function to pass judgment on other NGOs with which TPC must also compete for funding. If this option were pursued it would be sensible to maintain within the Research Unit a clear mandate and capacity for methodologically robust program outcome evaluations. These might more appropriately be described as health services research, the third arm of the Research unit, in addition to clinical research and surveillance.

In considering what has been achieved by TPC in the area of research, and how it might move into its next phase of operation, several questions present themselves.

1. Is TPC's research appropriate for the AOD sector? The evidence gathered from Annual Reports, document review and stakeholder consultations demonstrated that the research conducted by TPC has generally been of high quality and, certainly in key instances, relevant to the sector, and had impacts at the policy and program level in Victoria. For this to continue rebuilding clinical operations and clinical research capacity are a priority. As well epidemiology and public health research need to be strengthened. The structure and placement of evaluation and health services research, as raised by Farrell, Adams and Alberti, also warrants further consideration.
2. Have stakeholders been appropriately engaged in TPC's research? Based on the information provided for the review, it appears that the TPC research agenda is set and implemented largely through a process that is determined internally and in consultation with DHS. Formal input from community and external professional bodies does not have a clear place in the process. Also, there is an absence of academic peer-review at the granting stage

over much of the work that is conducted under contract, although the outputs are generally subject to some form of peer review at the dissemination stage.

3. What are the advantages to the TPC research model? The provision of a commissioned research budget by the State Government has allowed TPC to conduct work that would not generally be funded by other sources. In the area of clinical research, a direct link to the TPC client basis has been beneficial in the development of new initiatives, and has allowed findings to be translated quickly into clinical practice. Being outside the formal academic setting, TPC is able to focus on research that is directly related to the needs of the AOD sector.
4. What are disadvantages? As a relatively small, autonomous research entity, TPC appears to have difficulty in providing an appropriate career structure for motivated public health and clinical researchers. It may also have difficulty in maintaining research infrastructure because of its size and constitution. This brittleness of the TPC research establishment without a more productive alliance with a university or research institute has already shown dramatic negative consequences for TPC. The loss of significant research revenue and the capacity to win competitive research funding with the departure of a number of key senior research personnel has been very destructive for TPC's Research Unit.
5. Are there alternative models? There are few organisations that bear a resemblance to TPC, even outside the AOD sector or outside Victoria. Locally, the closest parallel may be the Melbourne Sexual Health Centre, which has a mandate to provide a similar range of services, including research and is also funded primarily by DHS, but is established as a department of a major teaching hospital rather than being an autonomous entity. The core contract of the MSHC is for service provision only and does not provide funds for research. The Director is appointed through a grant to the University of Melbourne that is separate from the core contract. Other researchers are employed through NHMRC Fellowships and research grants.

Another model is the alliance set up by Neurosciences Victoria (NSV) – the “marketing organisation for an Australian world class cluster” offering a single point access to a “series of neuroscience technology-based platforms and disease specialisations, backed by leading neurology and psychiatry resources and clinical expertise.”⁶ NSV is a different model to a Centre, offering strength in collaboration to its members, who individually take a number of forms. NSV itself includes members interested in the area of addiction and might provide

⁶ Neurosciences Victoria (2007), *Annual Report 2006-2007*, p. 4.

another model of a relationship that provides greater strength to TPC's research effort than has thus far been achieved.

The University of Melbourne, through the Faculty of Medicine, Dentistry and Health Sciences also pointed out in a submission that there are many parts of the university with an interest in establishing a stronger collaboration in addiction studies. The university is considering setting up an Institute of Addiction Studies based around the numerous parts of the university with an interest in the area from a range of disciplinary perspectives, an overlapping group with members of the NSV group.

There is a range of models. At one end of the spectrum a university could set up an Institute for Addiction Studies, which could either incorporate or support TPC. At another point on the spectrum, a university could provide a route of funding and an academic home (as University of Melbourne does now for Professor Room and the head of the Melbourne Sexual Health Centre) for research leaders in a TPC either independent or located in a mainstream clinical setting. At yet another a collaboration such as NSV could provide more effective support for researchers in TPC.

Professional researchers in TPC need to be given access to joint appointments, team memberships, collaborations and to attract infrastructure funding on competitively won research funding. They also need to publish. These are the outcomes that need to be achieved whichever model is pursued.

2.5 Education and training unit

History and operating model

One of TPC's core activities has been to provide education and training to enhance the knowledge and skills of workers who deliver AOD interventions. The delivery and evaluation of their training programs has utilised staff from the clinical service and research arms of the organisation.

As earlier discussed, the history and origins of TPC has made some other AOD organisations resentful of TPC. Throughout its existence, there have been claims of an unfair playing field and of elitism. The training arm has also been subject to some of these perceptions. Furthermore, while TPC is considered by many people in the field to be too

academic focused, some from within academic institutions consider that the TPC has too strongly a service provider background and focus.

As discussed earlier, while the TPC was established in conjunction with the University of Melbourne, the relationship with the university has not developed in the way that it was probably originally envisaged. The 2000 Farrell, Adam and Alberti Review report noted, "The agreement with the University of Melbourne has been particularly disappointing as there are still only informal involvements in that university's teaching programs and the university does not appear interested in resourcing any significant teaching activity through Turning Point, little research collaboration of significance, and no academic titles granted to deserving staff members at Turning Point".⁷ While these observations were scribed in 2000, little appears to have changed in the intervening period.

Since the establishment of TPC the AOD training landscape has, however, changed considerably, as demonstrated in the following timeline:

- Mid-1990s: Redevelopment of AOD services, including a reduction in Government runs services and a rapid growth in NGO sector;
- Late-1990s: Limited professional training opportunities for AOD workers. TPC plays influential role in Government shift to preference accredited training;
- 2000: TPC established as first AOD industry based RTO in Victoria;
- 2000-2005: DHS launch Minimum Qualification Strategy. Commence 3 year period of competitive tendering for additional training activities. Big increase in number of AOD training providers (e.g. all TAFEs delivering certificate courses, 5 AOD agencies in Victoria gain RTO status). Some friction between TPC and other training providers.
- 2005+: Decline in number of AOD training providers and priority of Government funding. TAFE courses scarce, University courses either discontinue (RMIT) or do not consistently offer subjects (Deakin, Victoria). Of the RTOs, only Odyssey House (purely on-line courses) & TPC remain "active" in delivering D&A courses).

While the five industry-based RTOs have retained their accreditation to deliver AOD courses, the activity levels have reduced considerably in all with the exception of TPC, which has grown considerably in Victoria and has now expanded into other States/territories. TPC has emerged as the dominant provider of VTE and tertiary education

⁷ Farrell, Adam and Alberti (2000), *An Independent Review*, p. 19.

to the AOD workforce in Victoria. TPC informants estimate that they provided “85% of accredited AOD training in Victoria last year”.

Accordingly, funding for training activities has been an established and growing part of the funding and service agreement (FASA) with DHS since 2001. In addition, the training unit receives funding from a number of other sources (e.g. DHS (other than the Drug & Alcohol section), other Victorian Government Departments, Commonwealth & other State/Territory Governments for a range of separately tendered projects and fee-for-service training of particular professional groups).

The education and training program

The organisational chart from the 2007 Annual Report divides the education and training unit in to three sections:

- Tertiary programs (coordinated by Kieran Connolly):
TPC has developed and delivers post graduate tertiary courses in alcohol and other drug studies (Graduate Certificate & Graduate Diploma).
- Training & information resources (coordinated by Kieran Connolly):
TPC develops and disseminates information resources, training manuals and multimedia products, and delivers professional development courses. The aim is to raise awareness of alcohol and other drug issues across the community and to develop skills in specialist areas for AOD workers and health & welfare workers, so they can respond effectively to alcohol and other drug issues.
- Vocational & technical education (coordinated by Wendy Dodds):
TPC has been contracted by DHS to provide nationally accredited training and assessment, from units of competency located in the Certificate IV/Diploma in AOD work embedded in the Community Services Training package, to the Victorian AOD workforce to meet a minimum qualification standard (MQS). The MQS acts as a benchmark to ensure all workers have a common minimum level of alcohol and drug attributes, skills and knowledge.

Results

There are a number of markers that demonstrate the significant history of achievement of the training arm of TPC over the last 10 years:

1. Sustained growth in its vocational and higher education training programs as demonstrated in the following timeline:

- 2000: TPC accredited as an AOD Registered Training Organisation
- 2000+: Delivery of nationally approved, vocational based training courses of two days to two years
- 2003: TPC accredited private provider of higher education courses
- 2004: First cohort of students graduate with a Graduate Certificate in Alcohol & Other Drug Studies
- 2004+: TPC offer higher education & vocational training subjects online
- 2005+: TPC offer scholarships for the Graduate Certificate
- 2006: TPC offer Graduate Diploma in Alcohol & Other Drug Studies
- 2007: TPC considering the development of a Masters in AOD Studies
- Over the course of these years TPC has gained competitive grants to expand its training offerings across Victoria and to other States and Territories (e.g. ACT and Tasmania).

2. Training outputs

The following table provides summary information of some of the training outcomes for last three financial years.

Year	04/05	05/06	06/07
Professional Development List courses - No of participants (p)	Party Drugs – 107p Pharmacotherapy training – 119p ABI Training – 50p Motivational Interviewing – 54p	Drug Diversion – 54p ABI Training – 66p Youth Outreach - 35p Party Drugs – 37p Pharmacotherapy training – 70p Working with groups – 46p Koori Drug Diversion – 47p	CALD – 55p Advanced Interviewing – 44p Party Drugs – 37p Pharmacotherapy training – 59p Working with groups – 50p Volunteer training – 49p GO to WHOA/train the trainer – 140p GO to WHOA worker training – 260p PsyCheck training – 56p
VET List units - No of enrolments (e) - No started (s) - No finished	2C – 93e, 80s, 74f 6B – 42e, 42s, 42f 7C – 8e, 8s, 8f 8C – 95e, 71s, 49f 9C – 8e, 8, 6f 10A – 40e, 35s, 32f 11A – 15e, 13s, 13f AERF mentoring Project – 16	2C – 82e, 74s, 54f 6B – 40e, 36s, 29f 7C – 15e, 9s, 5f 8C – 55e, 21s, 15f 9C – 19e, 8, 4f 10A – 67e, 53s, 27f 11A – 20e, 20s, 15f	2C – 86e, 57s, 47f 6B – 93e, 54s, 26f 7C – 7e, 2s, 2f 8C – 45e, 29s, 21f 9C – 10e, 5s, 3f 10A – 49e, 23s, 17f 11A – 15e, 6s, 5f

Year	04/05	05/06	06/07
(f)			
Tertiary Education For Certificate & Diploma - No commenced (c) - No new (n) - No re-enrolled (r) No finished (f)	2004 Calendar year Certificate – 55c, 22n, 33r, 11f La Trobe and ACU students - 44	2005 Calendar year Certificate – 43c, 10n, 33r, 21f Diploma was new course in 2006 La Trobe and ACU students -58	2006 Calendar year Certificate – 55c, 35n, 20r, 17f Diploma – 4c, 4n, 0r, 0f La Trobe and ACU students - 62
Product Development	Induction Resource for AOD workers Student Resources CHCAOD7B from GO to WHOA training package Online subjects for two tertiary subjects Animation on heroin	Queensland Health Resources NSW Health Resources PsyCheck Resource	City of Melbourne web site

3. Previous reviews

As already mentioned two substantial reviews of TPC have been done. The responses to the recommendations relating to training have been positive and proactive.

- Need to provide more advanced training

TPC has responded by developing and delivering an expanded range of vocational based and higher education courses since those reviews. In the early 2000s TPC also developed the clinic as a training environment for medical personnel in addiction medicine as a means to supply a continual stream of trained senior clinicians to the organisation and the wider sector. Unfortunately, this initiative has faced set backs in recent years with a decline in the number of senior addiction medicine specialists in the TPC clinic.

- Need to improve access to training for rural and remote personnel

TPC responded in a number of ways including the delivery of some of the training modules at regional sites, the introduction of on-line training and the establishment of rural and

remote scholarships (e.g. 7 of 20 of the 2008 scholarships are for rural and remote students).

4. Continued accreditation of training courses

As an RTO, all of TPC's courses are audited annually. Both the Certificate Four course (Alcohol and other drug work) and the two postgraduate courses (Graduate Certificate in Alcohol & Other Drug Studies and the Graduate Diploma in Alcohol & Other Drug Studies) have continued to be accredited successfully.

5. Staff retention

In contrast to the research and clinical service arms of TPC there appears to have been far less turnover of staff from the training section of the organisation. This demonstrates a level of stability in this part of the organisation that is not evident in the clinic and research arms.

Main pressure points and issues

Despite the relative success of the TPC Training and Education Unit there are still a number of pressure points and issues affecting it.

Impact of pursuit of training contracts

Based on the initial figures provided by TPC training management, it appears that this arm is financially self-sufficient and does not require cross subsidisation from other parts of the organisation. As such it looks as if it would theoretically survive as a stand-alone organisation.

Program	2004/05	2005/06	2007/08	2008/09 (forecast)
Tertiary	\$209,036 combined	(\$108,847)	\$16,703	\$65,367
TAIRP		\$105,872	\$151,957	\$80,069
VTE		(\$2,380)	\$158,343	\$126,894
TOTAL	\$209,036	(\$5,355)	\$327,003	\$272,330

Figures do not include corporate overheads costs

TPC's increasing activities in undertaking a range of projects outside those provided for in its core funding from DHS (e.g. interstate work) reflect their efforts to find additional sources of revenue to support their training program. This also has the advantage of

developing opportunities for and utilising the expertise of its professional staff. However there is a need to ensure these activities are structured in a manner that contributes to the longer-term strategic direction of the wider organisation and not just the needs of the training unit. It would seem appropriate for funding bids from TPC business units to be a matter of discussion and approval at Executive meetings.

Higher level training and education

TPC training staff articulate clearly the importance of the clinical groundedness of the training they provide. They cite this as their market competitive edge. The previous Reviews, as noted, recommended the development of education activities at a higher level to complement TPC's strength in VET level training.

TPC Training staff have developed some additional diploma and university based courses and have been considering the establishment of a Masters level course. There is some enthusiasm for the development of a Masters level program, which would have to be delivered in collaboration with a university, to complement other higher education programming that has been developed following earlier reviews. The Review Team would not put a greater priority on these discussions than has already occurred. The main advantage in such a program would be that it would require a deepening of TPC's relationship with a university. The Review Team would put a greater priority on the redevelopment of the clinic as a training site for more senior clinical training.

Reinvigorating the TPC clinic as a structured training environment

The TPC clinic is a unique resource for the training of medical personnel (and other clinical disciplines) in addiction medicine. While significant progress has been made with course based training it would appear the capacity for the TPC, with the departure of senior clinical staff, to provide recognised training for medical, and other, personnel has diminished. Training staff report that clinic staff previously on average had 5+ years experience and had provided a skilled cohort of trainers. Now clinic staff had on average less than 2 years experience and there was substantially less potential to use clinical staff as trainers.

This is in fact a problem for the capacity of the TPC model to work because without senior clinical specialist staff the clinic is relatively less able to engage with either the training or research arms. However, it was interesting for the Review Team to note that while the training arm saw the demise of clinic as a problem for them from the point of view of recruiting potential trainers to deliver their programs, they did not appear to see the issue

as one that they were responsible for. This seems surprising given their promotion of the integrated model.

Improved training linkages with non-TPC clinical services

Previous reviews and many informants during our consultations expressed the view that TPC needed to develop stronger links with other services (e.g. establish joint appointments/staff exchanges between TPC training arm and services other than just the TPC clinic and HealthLink). However TPC training staff commented that this would need to be managed carefully as it had the potential to create greater tension with other services, as it would be perceived as TPC poaching valuable clinical staff from these other services. Indeed, the internal arrangements had created tension with the TPC clinic in the past. This concern was supported by the 2001 Review report that noted "The fact that individuals have accepted positions with Turning Point from other organisations in the field is also seen to have caused some resentment".

Potential development of a Training and Development Arm

As noted earlier, the 2000 Farrell, Adams and Alberti Review questioned whether the evaluation section really belongs in the research unit or whether it would be more usefully conceived as a sectoral development function and located in a (possibly renamed) Training and Development Unit. This might broaden the engagement and function of the Training and Education Unit, connect it to a skill base clearly not already present in the sector and make clear that this is a service to the sector.

This would help address the perception that the Training Unit is a conflicted, quasi-government function charged with passing judgment on other NGOs with which TPC must also compete for funding. If this option were pursued the Training Unit would be able to emphasise that its evaluation activity was in fact a service to the sector, developing this function as a organisational review and development consultancy service for AOD services.

From a technical point of view it is often the case as well that an organisational development response can complement training in helping in service or sector development. The Review Team would urge TPC to reconsider this previous recommendation.

2.6 Governance, leadership and organisational management

As illustrated in the first five sections of this Chapter, TPC faces a number of serious problems in its organisational health before any of the significant opportunities identified

can be pursued. To a significant extent these problems have their roots in a number of unresolved issues that go back to the establishment of TPC. A number of these were identified in previous reviews, especially the Farrell, Adams and Alberti Review in 2000, not all of which have been addressed. As well, it has to be concluded that the current problems represent issues that need to be resolved in governance, leadership and management over the last several years.

Even allowing for the somewhat critical culture of the AOD sector the Review Team was struck by the degree of alienation between the key stakeholders whose solidarity is essential to rebuilding TPC and its capacity to fulfil its crucial role. Staff, especially but not exclusively clinical staff, expressed a high level of frustration, indeed some anger, toward management, the Board and DHS. As noted and despite significant efforts especially by the Board Chair, the Board is too distant from management and staff.

Management do not convincingly express a resolve or feel they have the support from the Board or DHS to lead the organisation, although they did present the Review Team with a vision for its rebuilding into which they had clearly put a great deal of effort. The effectiveness of the current Executive Team is critically compromised by the lack of clinical leadership representation. Whatever the reasons for this decision, it is an ultimately destructive situation, especially given the current alienation of clinical staff. NGO partners expressed great frustration with TPC without articulating their responsibility to support management to rebuild TPC to meet other stakeholders' needs.

While there were clearly unresolved issues identified in the two reviews completed well before her departure, there was clearly great loyalty to the first TPC Director. The Review Team was told that in the three years leading to her departure, five senior staff members left TPC, whereas in the three years following her departure 28 senior staff left. Many of these people have not been able to be replaced and a significant number have been followed by significant research funding, functions and other staff. This turnover level is reflected in resignations data shown to the Review Team covering the whole staff group.

There is an extent to which the departure of a long term Director will inevitably and properly precipitate some refreshing of personnel and a reconsideration of direction. As identified above in the discussion of pressure points facing the Research Unit many of these issues were the focus of the second Director's tenure. The Board has obviously made a strategic decision to allow such a process to evolve and has quite properly been supportive of this happening. However, the scale of the turnover that has impacted TPC for the past

several years should probably have signalled that the organisation's challenges have been growing not abating and heading to a crisis point for some time.

Addressing this growing problem has been somewhat hampered by a critical sense in the AOD sector and within TPC itself that the organisation needed to overcome elements of its "culture" and "resistance to change" rather than being supported to revert to old ways. There are undoubtedly elements of truth in this and the Review Team does not support the simplistic conclusion that the now departed second Director was mistaken or irresponsible in attempting to lead the organisation to a refreshed vision. This was his job. The pattern of a second Director, following a successful, long term foundation predecessor and struggling to redirect organisational habits and patterns is not unique to TPC. However, the review team believes that the point has for quite a time been passed when the fact that this process has not been working needed to be recognised, named and acted upon.

The decision of the Board and DHS to establish this review process is a welcome acknowledgement of this fact, as is their determination to act now to rebuild the organisation without losing essential elements of a new forward direction. The Commonwealth and its agencies appear to have been almost absent from discussion about the issues facing TPC. It will be necessary for the Commonwealth to involve itself, as both a major funder, and as a partner in drug strategy with the Victorian Government, in the rebuilding process.

It is now absolutely necessary, if TPC is to survive and rebuild, for those with a stake in the organisation to rally around the people who still work there and support management in rebuilding the core of the organisation. This must include DHS, the Board, all elements of management and staff and service partners. Ironically, the strongest unsolicited statement of such a sentiment came from the two organisations representing service clients and drug users, groups with perhaps the most legitimate case for feelings of frustration and disempowerment.

3. Strategic options

3.1 Recommended priority strategic directions

The purpose of this Chapter is to set out the Review Team's recommended strategies for TPC to rebuild, to reclaim its position and role within the Victorian AOD sector and to pursue opportunities for reform and repositioning identified in Chapter 2. Undoubtedly there are opportunities for TPC in this range of developments. Before TPC exploits these opportunities, however, the overwhelmingly immediate priority is to address the organisation's current state.

There are parts of TPC (notably the Training and Development and telephone-based services) that have demonstrated an ability to identify and consolidate business opportunities. However, for the organisation as a whole, it is possible to identify a number of missed opportunities over the early life of TPC, for example: to become the premier clinical research centre in the alcohol and other drug field before the national research centres built their capacity, activity and reputations in this area. There are also recent examples, including the failure, with St Vincent's Hospital, to appoint a shared clinical Director position; and the loss of the IDRS (Illicit Drug Reporting System) surveillance program to the Burnet Institute. These lost opportunities reflect a lack of sufficient attention at a number of key junctures to organisational identity, health and development issues.

The originally ascribed role of TPC to provide clinical and policy leadership in a substantially decentralised sector in Victoria is sound, in fact essential. The model of TPC as an organisation that can make this unique contribution from the synergy of clinical, research and training activity is also sound. It is worth recalling the observation made in the 2000 Farrell, Adams and Alberti Review that this synergy is both difficult to achieve and requires specific leadership action that has a cost, not adequately specified in TPC's funding and outcomes agreement with DHS.

As the 2000 Review stated, "The challenge of managing three separate strands of activity that inter-link is substantial and onerous. It is clearly the unique aspect of Turning Point and is both its key strength but also to some extent one of its burdens. The three main strands of activity involve substantial focus and investment of time and energy and the focus on one area of activity can detract from achievements in other areas...There is a

danger that the different strands of activity run in competition with each other, resulting in conflict, stress and differential status for different streams of activity".⁸

The synergy between the three arms of the TPC "triangle" (clinical, research and training activity) is also misrepresented when the three arms are presented as if two of them are not dependent on the third. TPC is more usefully described as a specialist clinical service, with research and training arms. This is not to understate the specific importance of research and training to the TPC model but simply to acknowledge that without a high performing clinical service the other two arms cannot deliver on their potential. The clinical service is most usefully understood as the foundation of the whole enterprise, informing and being informed by excellent training and research arms, providing that the clinic is functioning at full capacity. Given this, the current weakened state of the clinic is of fundamental concern to the whole model (and therefore the future of TPC) and is the highest priority to rectify.

There are many important issues that arose during the course of this Review. These are included under the range of Terms of Reference in the following sections of this Chapter. The first seven strategic recommendations headlined in this section, address the most crucial decisions requiring immediate attention. Following these urgent recommendations are a range of others all of which can be considered as important, if not of the same level of absolute urgency.

Recommendation 1) That DHS and the TPC Board endorse a model of TPC as a specialist/tertiary referral AOD clinical service with integrated research and training arms, with a mission in the Victorian alcohol and other drugs field to:

- Provide leadership to the sector;
- Develop, provide and disseminate specialist treatment services;
- Undertake high quality commissioned and competitive research across clinical and public health domains;
- Provide training and development services to the sector in Victoria; and
- Provide policy advice to Government.

Thus the TPC Board and DHS would reject further consideration of closing or breaking up the current TPC, transferring parts of its budget to other institutions or setting individual units up as standalone businesses.

⁸ Farrell, Adams and Alberti (2000), *An Internal Review*, p. 23.

3.2 Recommended changes to external relationships

Previous reports and many informants during our consultations raised the need to enhance working relationships with a range of academic, health/medical, drug treatment service providers and other organisations in order to create mutually beneficial outcomes. While the review team found evidence of effective collaboration with other organisations on specific projects, there does not appear to have been as much progress made in developing strategic organisational partnerships over the last decade. As such, this has left TPC vulnerable.

As the 2000 Farrell, Adams and Alberti Review forewarned “The politics of partnerships are complex and finding deep, trusting and enduring organisational partnerships can be very sustaining but also very elusive...There are likely to be more stakeholders and more organisations competing for the growing cake, increased competition and increased rivalry may accrue. Choosing a number of key long term partners will be important in building strength and capacity”.

Arising from the analysis of both the situation of TPC overall and of each of its arms, the following recommendations focus on key external relationships that need to be considered to support the rebuilding of TPC and its repositioning to deliver its charter in the Victorian AOD sector.

A foundational decision that needs to be considered early in the rebuilding process arises from one of the long term structural problems that has always confronted TPC. This is whether to continue with TPC being an independent corporate entity (but with a stronger integration with other NGOs and renegotiated key partnership relationships) or whether TPC should become a relatively autonomous part of a larger organisation, a university, research institute or a major teaching hospital.

Submissions were received from a number of entities either interested in further discussion, keen to avoid TPC folding and happy to ‘lend a hand’ or offering to take TPC over as part of an alternative corporate structure. These included the Victorian Addiction medicine Interhospital Liason Association (VAILA) hospital liaison group, a multidisciplinary membership group working in addiction services in acute hospitals, and the Victorian Division of the Chapter of Addiction Medicine of the College of Physicians, both critically conscious of the deficit in community based specialist addiction services in Victoria. These

groups strongly supported the TPC model but were very concerned about whether rebuilding is possible.

VAILA proposed, on this basis, that one option would be the use of the clinical service provision, clinical research and clinical training components might be reallocated to establish community based specialist outpatient services, possibly attached to community mental health sites. The Review Team appreciated the concerns of the VAILA group and the alternative proposal but was equally concerned that such a decentralisation of the budget might further prejudice the chances of Victoria establishing and staffing viable specialist services.

St Vincent's Hospital also provided a submission to the Review Team proposing that TPC become part of the hospital, aligned with mental health and addiction services but with a number of guarantees of the integrity of the current operating model and direct community engagement. St Vincent's management expressed to the Review Team an awareness of a number of the difficulties in the past relationship. They also identified a number of shared opportunities, including: the sense of sharing both clinical appointments and infrastructure (for example clinical governance resources, corporate support and so on); collaborating in key priority areas such as co-morbidity and alcohol treatment development; and of working with research and teaching from both the University of Melbourne and the collection of relevant health research institutes in Victoria.

As discussed in Section 2.4 above another model is the alliance set up by Neurosciences Victoria (NSV) – itself a translational research oriented collaboration describing itself as “an Australian world class cluster” offering a single point access to a “series of neuroscience technology-based platforms and disease specialisations, backed by leading neurology and psychiatry resources and clinical expertise.” NSV is a different model to a centre, offering strength in collaboration to its members, who individually take a number of forms. NSV itself includes members interested in the area of addiction and might provide another model of a relationship that provides greater strength to TPC's research effort than has thusfar been achieved.

The University of Melbourne, through the Faculty of Medicine, Dentistry and Health Sciences also pointed out in a submission that there are many parts of the university with an interest in establishing a stronger collaboration in addiction studies. The university is considering establishing an Institute in Addiction Studies based on a number of parts of the university with an interest in the area, from a range of disciplinary stances, an overlapping

group with members of the NSV group. There are a range of models. At one end of the spectrum a university could set up an Institute for Addiction Studies which could either incorporate or support TPC. At another point on the spectrum, a university could provide a route of funding and an academic home (as University of Melbourne does now for Professor Room and the head of the Melbourne Sexual Health Centre) for research leaders in a TPC either independent or located in a mainstream clinical setting. At yet another a collaboration such as NSV could provide more effective support for researchers in TPC.

Representatives of the NGO sector argued that a number of the problems that have faced TPC have been based in a lack of sufficient community ownership. The Board structure, with the Minister appointing Directors on recommendation is seen by the NGO partners as one of the origins of TPC's distance from the AOD sector, its alleged elitism and its closeness to Government. Some of these people suggested that TPC be reincorporated as a more genuinely community based organisation with a membership structure, likely based in the various sectors with which it works, and / or appointment to the Board either from this membership or on some sort of mixed basis. The Review Team certainly does agree that the expertise base of the Board needs to be broader and more closely aligned to the business of the organisation.

Other NGO partner representatives with whom the Review Team met, however, acknowledged that this reform would not offer a lot to the critical mass problems or to strengthening the leadership staffing base in critical clinical and research areas. Acknowledging that a merger (on strict terms) with a hospital was a likely "least worst option" one NGO representative the team met expressed his "bottom line" as the need for "a totally new regime of transparency. Just tell us what is going on every step of the way as you think this through. We will need to own this one."

This decision is complex. It is, however, the right time to consider such a change if it might be of assistance.

There are theoretically four options, as follows:

- Continuing as an independent NGO with a Board appointed by the Minister;
- Continuing as an independent NGO but with a change in corporate structure so that the Board includes representatives of the AOD sector, possibly even based on a membership structure from within the sector;
- Merging with a university or research institute; or
- Merging with a major teaching hospital.

Advantages of merging with a larger, stronger institutional structure might include sharing corporate services support with a bigger agency; consolidating access to specialist clinical staff and trainees and access to clinical governance and other health system support in the case of a merger with a teaching hospital; or with stronger research capacity in the case of a university or research institute. The Review Team's view, on balance is that the most viable alternative structure to the status quo that should be evaluated would be for TPC to become a Division of a major teaching hospital because of the strength this would add to core clinical and clinical research capacity, upon which other key strengths and alliances might more successfully be built. Merging with a teaching hospital would also of course bring a close relationship with whichever university that hospital provided a teaching campus.

On the other hand, the integrity of TPC as a complex organisational entity, with three distinct but related businesses and a community-based focus is worth protecting. Any move to absorb TPC into a larger entity would have to be accompanied by clear requirements from DHS and the Commonwealth as funders that TPC not lose its discrete identity and the synergy of its parts. It would be appropriate for TPC to be a separate Division of a larger body, not a sub-program of a single entity focused on a narrow field. If TPC were to disincorporate as an NGO and become a Division of a larger organisation the Board would take on an advisory nature but would still be very important in protecting and rebuilding relationships with NGO partners. A Board would provide some protection against TPC being absorbed into a hospital structure without maintaining sufficient integrity in its internal business model. As well, Government funders would need to specify their requirements for this outcome to be protected directly with that hospital.

If Government were to decide against a merger with a larger institution (probably a teaching hospital for the reasons outlined above) the Review Team would not support a status quo option. TPC is weakened by its lack of integration with the NGO sector it is charged to lead and by continued questions from that sector about its independence from Government. A minimum reform of TPC's structure would involve both a restructuring of its Board to more fully represent the AOD sector and a renegotiation of key partnerships, including with St Vincent's Hospital and the University of Melbourne.

A table summarising possible advantages and disadvantages of each option is included at Appendix B.

Timing is a critical consideration. The options set out above might take some time to process. It is a crucial decision and given the history of less than satisfactory partnership experiences some form of competitive tendering might be required. A prolonged period of uncertainty would, however, very likely be a serious disincentive to quality applicants for positions that TPC needs to fill urgently. For this reason the Review Team suggests that the TPC Board and the Victorian Government, in consultation with the Commonwealth, make an in-principle decision on the structural future for TPC, which it will then take some time to consult and implement with stakeholders and partners. Key vacant leadership positions could then be immediately advertised with a clear indication about the reform path to rebuild TPC and the future affiliations offered to incoming senior staff.

Recommendation 2) That the Board of TPC and the Victorian Government, in consultation with the Commonwealth, make an in-principle decision about the future structure for TPC, between two options:

- Option 1 being a reconstituted NGO structure with a Board including representatives of the AOD sector in Victoria, and possibly a membership structure to support this (and with renegotiated relationships with St Vincent's Hospital and the University of Melbourne); and
- Option 2 being a merger with a major teaching hospital, based on TPC's continued identity and operation as a community based service with three interrelated arms and a high degree of autonomy and budget integrity guaranteed both by an ongoing Advisory Board and specific requirements from funders.

Recommendation 3) That the preferred option from Recommendation 2 be discussed and developed in consultation with all stakeholders and implemented progressively over the next one to two years.

In summary, the two options in Recommendation 2 represent two different developmental pathways for TPC, both of which are legitimate responses to the needs of the Victorian AOD sector. With appropriate appointments to clinical and organisational leadership positions, Option 1 would support the rebuilding of a centre that can provide clinical excellence, sectoral development services and an applied research / outsourced policy role for DHS. Given the challenges facing the AOD sector in Victoria this is a worthwhile role. Such a centre would also attract relationships with researchers keen to use both data gathered at TPC and its clinical services as a site for research provided that TPC is able to attract clinical leaders supportive of the research process. The Review Team's view, however, is that Option 1 is unlikely to sustain an in-house research capacity that will be competitive in

the research sector or researchers capable of attracting major competitive research grants. It may also be less attractive to leading clinicians and leave TPC clinical services (and clinicians) still at arm's length from the hospital sector.

Option 2 embraces a more ambitious vision, including greater in-house clinical and research capacity, especially the ability to sustain senior clinicians engaged in competitive research and researchers capable of winning competitive research funding. This is closer to the original TPC vision and might also sustain more effectively specialist clinical training capacity. The viability of option 2, however, requires effective guarantees and protections for a number of important aspects of the TPC model, as outlined in the recommendation.

Immediately the future structural direction of TPC has been determined, and in any case within a short period of time, there are a number of steps that need to be taken to commence the rebuilding process.

Recommendation 4) That the Board of TPC should appoint three key senior staff including a new Director of TPC, a Deputy Director (with no other responsibilities) and a Director of Clinical Services, as a matter of urgency.

- The Director needs to be of the highest credibility in the AOD field. He or she should ideally be a senior AOD clinician or public health practitioner with a research track record and international standing within the field. However, equally crucial is that he or she will need exemplary leadership and management skills; the skills to rebuild trust in Government, among partners, stakeholders, staff and clients, to drive service integration and provide overall vision for TPC;
- The Deputy Director should have a proven track record in management in a complex health service environment and to be recruited unencumbered by other responsibilities; and
- The Director of Clinical Services should be medically qualified specialist in Addiction Medicine, with a track record in clinical leadership and experience in a clinical research environment.

Recommendation 5) That a key first step in rebuilding the clinical service is for DHS and the TPC Board to provide a clear direction and scope for its services. This should be as the leading community-based, specialist, tertiary referral clinical AOD service in Victoria, working to support, jointly manage and take referrals from GPs and other frontline service providers.

Recommendation 6) That TPC recruit a full complement of senior clinical staff in order to provide a specialist referral AOD service, to maintain the capacity to train addiction medicine specialists and to support research activity based in the clinical services.

Recommendation 7) That DHS and TPC Board endorse the urgent need for a plan to rebuild and sustain a core clinical research function that is linked to the patient population that it serves (through both its clinic and HealthLink) and to wider public health research. Noting that the scope of this plan will be set to some extent by the decision on TPC's structural future in response to Recommendation 2, the new TPC Executive Team recommended below at Recommendation 13 should prepare a paper for the TPC Board on a strategy to rebuild and sustain its core research function.

Other important issues

There are also a number of important issues that need to be identified beyond the urgent issues identified above.

The funding model for AOD clinical services in Victoria, which requires medical services to be funded through claims against the Medicare Benefits Schedule (MBS), appears to have exacerbated a number of internal issues and caused a significant part of the structural budgetary problems within TPC. These flow on to the organisation's ability to resource its integration functions and could prejudice the chances of rebuilding suitably senior clinical leadership.

Similarly the proportion of TPC funding that is tied to projects or clinic EoCs and the lack of funding for sufficient management depth was identified in both the 2000 and 2001 reviews, with both recommending DHS separately fund a Deputy Director position. This will be necessary both to provide internal management coherence and to drive synergies from the three arms of TPC's activity.

It should be noted that the Review Team has not been in a position to examine if the overall level of the TPC budget is correct or if it is all being used at optimum efficiency. This was neither within our terms of reference nor would it have been possible within the time available. Justifying an absolute increase in funding level would require further work. In consultation it was put to the review Team that supporting an increase in total funding might attract criticism from the AOD NGO sector that this would be to "reward failure." There is, however, a clear problem in the allocation of the budget almost entirely to projects and clinical EoCs. This is widely acknowledged. TPC needs to have the flexibility

internally to resource its management and coordination functions without prejudicing its delivery of funded outputs.

Recommendation 8) That DHS consider allowing TPC flexibility sufficient to employ from core funding a Deputy Director position (as recommended by the internal and external Reviews in 2000 and 2001) and a Clinic Director position, not tied to specific projects or services.

It would be worth DHS involving the Commonwealth Department of Health and Ageing in this discussion, as DOHA might also be able to untie some of its regular funding also to support a model from which it has sourced considerable work over the years.

Recommendation 9) That DHS review its strategy for the funding exclusively via the MBS for community-based AOD medical positions, noting that this is a very longstanding policy position in Victoria.

A similar set of issues affects the Research Unit, at least while it is rebuilt. In principle, once operating, most of the Research Unit's revenue would come from commissioned or competitive project related grants. However, while capacity is rebuilt and consolidated a more direct and assured source of support is worth DHS considering.

Recommendation 10) That the capacity to produce recurrent and ad hoc commissioned reports on AOD usage, consequences and service delivery is essential and should be maintained. As such DHS should consider, for a time limited rebuilding phase, investing a guaranteed component of State AOD research funding in TPC to redevelop its capacity.

There are also a number of other key relationships identified in the review process to which attention is needed.

Recommendation 11) That TPC management liaise regularly with local residents and businesses to ensure effective management of any public space issues adjacent to TPC facilities and community awareness of strategies being implemented in this regard.

Recommendation 12) That Advisory Panels in Clinical Services, Research and Training (including external members) be established (in the case of research re-established) to report to the TPC Board, to engage key stakeholders and provide strategic advice and direction.

TOR 5, Recommended changes to internal governance arrangements

The following recommendations are intended to indicate the priority reforms identified by the Review Team to consolidate the urgent directions set out in Recommendations 1 to 7. The first set of recommendations is directed to consolidating the leadership structure needed to rebuild TPC.

Recommendation 13) That TPC reform its Executive Team immediately as smaller group with the Director, Deputy Director, senior representation from the clinical, research and training arms, and a consolidated corporate management representation. The current Chief Operating Officer should continue on the Executive for the duration of his tenure.

Recommendation 14) That the Terms of Reference for the reformed TPC Executive Team include responsibility for business planning, priority setting and making decisions whether to apply for new funding, including project based funding.

Recommendation 15) That the TPC Executive Team put a high priority on initiatives to break down the silos within TPC, including ensuring that all projects are run by teams with cross unit representation.

It is then recommended that, as a preparatory phase for the next round of business planning, that the new TPC Executive Team prepare a set of papers, in addition to the one recommended at Recommendation 7 regarding a strategy to rebuild and sustain TPC's core research function. These papers provide a substantive work plan for the new Executive Team addressing the issues of greatest importance identified in the review process. It is crucial that the new Executive Team address these priority issues and be seen by TPC staff and partners to do so.

Recommendation 16) That the TPC Executive Team prepare a paper for the TPC Board considering transfer at least service review component of the evaluation section of the Research Unit to a re-focused Training and Development Unit, with health service and program outcome research still a focus within the Research Unit.

Recommendation 17) That the TPC Executive Team prepare a paper on options to develop stronger coordination of the TPC clinic and telephone services, including such options as

joint Executive Team management representation and coordinated staff management, rostering, training and development.

Recommendation 18) That the TPC Executive Team should prepare a paper on priorities for TPC clinical services, addressing the following issues:

- Maintenance of core services including opioid substitution pharmacotherapy with return to full time pharmacy dispensing service for IDUs referred by GPs or other clinicians who have “complex specialist needs” strictly according to the definition of the clinic’s scope and the needle syringe program;
- Opportunities to host specialist clinics in Infectious Diseases (Healthy Liver/Hep C Clinic, immunisation of “at risk” clients), Dual Diagnosis and Chronic Pain Management and Antenatal/Reproductive/Sexual Health (entering ‘shared care’ arrangements with GPs where appropriate) provided by appropriately qualified multidisciplinary teams;
- Exploring feasibility of providing “outreach specialist clinics” in community-based/primary health care settings as a way to better partner with these agencies, thereby also ensuring appropriate referrals to TPC;
- Opportunities to assume primary responsibility for accreditation of pharmacotherapy prescribers in Victoria i.e. conduct training courses (using medically trained staff) and offer clinical placements;
- Opportunities to make a contribution and seek funding in the two high priority areas of alcohol and co-morbidities, for example in the use of pharmacotherapies for alcohol treatment;
- The need for a more complete range of specialist services, including sexual health, prevention of all the hepatitises, including through immunisation of at risk clients; and
- Providing comprehensive clinical activity data including both Episodes of Care (as already required by DHS) and Occasions of Service according to clinical discipline for planning and internal management purposes.

Finally TPC needs to respond to the demands of service users for a more structured consultation mechanism between clients and the organisation.

Recommendation 19) That TPC develop a structured complaints mechanism, a deliberate strategy for communication with clients about decisions that affect them and a forum for ongoing engagement with service users through which client input is actively sought and

considered by management across each of the arms of TPC and its Executive Team as a whole, as well as being fed back to the Board.

TOR 6, Recommended implementation plan and timeline

The Review Team has proposed that a prior step to pursuing the opportunities that undoubtedly present themselves for TPC's future is the rebuilding of the organisation. There are a number of steps that are both urgent and important. Without a quick start to the urgent Recommendations 1 to 7 above, there is a significant danger that, despite the desires of Government and key partners and stakeholders, the future of TPC cannot be assured.

Implicit in this strategy is that the TPC Board and the Victorian Government, in consultation with the Commonwealth, make a decision more quickly than might otherwise be the case as to the future structure for TPC. The implementation of this structural direction, coupled with the urgent Recommendations 4 to 7 and then the remaining recommendations, will require clear and cohesive leadership at a number of levels. The Review Team suggests that a number of actions be taken to facilitate this process.

Recommendation 20) That DHS initiate discussions with the Commonwealth DOHA about the important role DOHA can play at a number of levels in assuring the future role and contribution of TPC, an organisation in which various agencies of the Commonwealth have seen fit to invest repeatedly over the years. This could include discussion about funding flexibility, support for organisational reform and restructuring.

Recommendation 21) That DHS and the TPC Board decide on the best governance of this rebuilding process. This consideration might usefully include the appointment of an interim Transition Board to oversee the implementation process, including if that decision is taken the merger of TPC with a major teaching hospital.

Recommendation 22) That an interim Transition Board be formed through a number of Board members agreeing to make way for a number of new members appointed from a wider range of backgrounds, including greater depth in clinical service management, including in AOD, while allowing for some continuity from the existing Board.

Appendix A – People consulted and submissions received

Individuals consulted from within Turning Point Centre

- Paul Shannon, Chairperson of the Board
- Ray Judd, Board member
- Terry Nolan, Board member and Chair of Research Advisory Committee; Professor and Head, School of Population Health and Department of Public Health, University of Melbourne
- Professor Robin Room, Acting Director
- Mr Trevor King, Deputy Director
- Mr Leon Kurup, Chief Operations Officer
- Kieran Connolly, Program Leader: Training and Information, Tertiary Programs
- Dr Nicole Lee, Head of Research
- Ms Susan Clemens, Research Fellow
- Ms Wendy Dodd, Program Leader: Vocational and Technical Education
- Ms Amy Swan, Acting Program Leader / Research Fellow: Health Services Research and Evaluation
- Ms Pauline Wright, Manager - Clinical Services
- Dr Kate Hall, Clinical Psychologist (on leave)
- Dr Chris Walsh, Consultant Psychiatrist

Individuals consulted from outside Turning Point

- Professor Ian Anderson, Deputy Head of the School of Population Health, University of Melbourne)
- Dr Michael Aufgang, Royal Australian College of General Practitioners Drug and Alcohol special interest group
- Mr Sam Biondi, Victorian Alcohol & Drug Association (VADA)
- Dr Yvonne Bonomo, Physician in Adolescent and Addiction Medicine at St Vincent's Health
- Ms Vera Boston, CEO of North Yarra Community Health
- Ms Regina Brindle, Association of Participating Service Users & group of service users
- Mr Damon Brogan, Manager of Victorian Drug Users Group (VIVAIDS)
- Major Michael Coleman, Coordinator for Drug and Alcohol Services, The Salvation Army

- Professor Nick Crofts, ex Director of Turning Point
- Professor Jon Currie, Director of Addiction Medicine at St Vincent's Health
- Ms Katrina Currie, Manager of Drugs Strategy Group, Drugs Policy & Services, Victorian Department of Human Services
- Dr Paul Deitz, Burnett Institute (ex Turning Point Centre)
- Dr Adrian Dunlop, Director of Drug and Alcohol Services at Hunter New England Health (ex Turning Point Centre)
- Associate Professor John Fitzgerald, Senior Research Fellow at the Centre for the Study of Health and Society, University of Melbourne
- Mr Bernie Geary, Victorian Children's Safety Commissioner
- Gertrude St local businesses
- Dr Alan Gijbbers, Australasian Chapter of Addiction Medicine
- Ms Margaret Goding, Director of Health Service Demand and Mental Health, St Vincent's Health
- Professor Margaret Hamilton, ex Director of Turning Point
- Ms Virginia Hart, Drug Strategy Branch, Population Health Division, Department of Health and Ageing
- Ms Jenny Johnston, COATS Alcohol and Drug Assessment Program
- Mr Demos Krouskos, North Richmond Community Health Centre
- Dr Nick Lintzeris Sydney South West Area Health Service, NSW Health (ex Turning Point Centre)
- Dr Martyn Lloyd-Jones, Acting Chair of Victorian Committee, Australasian Chapter of Addiction Medicine
- Professor Patrick McGorry, Executive Director of the Orygen Youth Service
- Dr Benny Monheit, Southern Metropolitan Addiction Consultancy Clinic
- Dr Peter Muhleisen, ex Senior Pharmacist at Turning Point
- Mr Geoff Munro, Director of Community Alcohol Action Network
- Mr David Murray, Youth Substance Abuse Service
- National Drug and Alcohol Research Centre
- Ms Carol Nikakis, CEO of Windana Drug and Alcohol Recovery
- Dr David Nolte, David Nolte Pharmacy
- Associate Professor Simon Lenton, Deputy Director and Project Leader Area: Illicit Drug Use, National Drug Research Institute
- Amira Rahmanovic, Multicultural Centre for Women's Health
- Donna Ribton-Turner, Manager of Withdrawal Services UnitingCare, Moreland Hall
- Associate Professor Alison Ritter, National Drug and Alcohol Research Centre (ex Turning Point)

- Professor Ann Roche, Professor and Director of the National Centre for Education and Training on Addiction (NCETA)
- Mr Simon Ruth, Peninsula Drug & Alcohol Program, Frankston Community Health Centre
- Mr John Ryan, CEO of Anex
- Ms Jacqui Shaw, Manager, DePaul House at St. Vincent's Health
- Mr Paul Smith, Director, Drugs Policy & Services Branch, Mental Health & Drugs Division, Victorian Department of Human Services
- Professor Bruce Singh, Deputy Dean of the Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne
- Ms Sylvia Alberti, Victorian Department of Human Services (ex Turning Point Centre)
- Mr Geoff Soma, Director of the Western Regional Alcohol and Drug Centre (WRAD)
- Mr Bill Stronach, Chief Executive of the Australian Drug Foundation
- Mr Brian Vandenberg, Senior Program Advisor in Tobacco and Alcohol Program, Vic Health
- Mr Neos Zavrou, Director of the Odyssey Institute of Studies, Odyssey House

Submissions received

- Dr Peter Muhleisen
- Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne, by Professor Bruce Singh
- Turning Point Alcohol & Drug Centre, Executive Group Submission
- Victorian Addiction medicine Interhospital Liason Association (VAILA), by Dr Alan Gijbbers
- Victorian Committee of the Chapter of Addiction Medicine, Royal Australasian College of Physicians, by Dr Martyn Lloyd-Jones
- St Vincent's Hospital

Appendix B – Advantages and Disadvantages of structural options

Option 1

Status Quo, continuing as an NGO with the Board appointed by the Minister, and renegotiate relationships with key partners

<u>Advantages</u>	<u>Disadvantages</u>
<ul style="list-style-type: none"> - No exposure to the risks of structural change. Will quarantine successes such as the Training and Development arm and telephone-based services - Focuses on strengthening links with existing partners - Protects the integrity of TPC as a complex organisational entity, with three distinct but related businesses 	<ul style="list-style-type: none"> - TPC has not gained substantial benefits to date from its partnerships with St Vincent’s and Melbourne University – may not change that pattern - External partners may not recognise TPC’s renewal without tangible structural reform - Possible difficulty in attracting new staff without a more visible new beginning - Possible difficulty in renewing internal culture of TPC for same reason - Present Board is not highly engaged in the AOD community and is considered by many to be too close to Government - Board has limited AOD expertise - Unlikely to sustain a competitive in-house research capacity

Option 2

Continuing as an independent NGO but reconstituted with a more representative Board (and possibly membership structure) and renegotiated relationships with key partners

<u>Advantages</u>	<u>Disadvantages</u>
<ul style="list-style-type: none">- Board restructure would strengthen links with community partners in non-government sector- Possibly stronger basis to renew partnerships with both St Vincent's and Melbourne University- Protects the integrity of TPC as a complex organisational entity, with three distinct but related businesses- Still relatively little exposure to the risks of structural change.- Will quarantine successes such as the Training and Development arm and telephone-based services	<ul style="list-style-type: none">- Not going to create the critical mass that is likely necessary to sustain a competitive in-house research capacity- Might create basis and imperative to renew relationship with St Vincent's Hospital but not likely to create clinical leadership relationships that would arise from Option 3.- Would have to manage the change process with Government and with multiple players in NGO sector to ensure new constitutional structure was well balanced

Option 3

Becoming a Division of a major teaching hospital, with guaranteed autonomy, budget integrity and an advisory Board

<u>Advantages</u>	<u>Disadvantages</u>
<ul style="list-style-type: none">- Could provide substantial support to rebuilding of clinical services, including:- Opportunities for recruiting and sustaining specialist clinical staff by sharing clinical appointments and rotations- Would strengthen clinical training and provide career progression opportunities for clinical staff- Liaison with other clinical departments, eg Psychiatry, G-I, Infectious Disease- Sharing clinical infrastructure (e.g. clinical governance resources)- Sharing corporate services support with a bigger agency- Provides a relationship with the university that the teaching hospital is linked to and other research alliances / institutes (while Option 4 does not necessarily provide a relationship with a hospital)- Improved chance of sustaining a competitive in-house research capacity	<ul style="list-style-type: none">- Need to be very certain of the “guarantees” to ensure viability of TPC organisational structure and operating model- Urgent priority on addressing vulnerability in clinical services, especially specialist medicine, may cause fear of an “over medicalisation” of TPC- Hospitals often not as strong at community and partner engagement, which remains important- Hospitals not usually welcoming places for drug users – TPC clients name this fear

Option 4

Becoming part of a university or research institute, with guaranteed autonomy, budget integrity and an advisory Board

<u>Advantages</u>	<u>Disadvantages</u>
<ul style="list-style-type: none">- Strong opportunities for research arm- Opportunities for recruiting research staff- Career progression opportunities for research and training staff- Sharing infrastructure with a bigger agency- Sharing corporate services support with a bigger agency	<ul style="list-style-type: none">- Need to be very certain of the “guarantees” to ensure viability of TPC organisational structure and operating model- Additional risks in not prioritising strengthening of core clinical services arm- Also likely to be negative in improving community and service user engagement