ATCA
AUSTRALASIAN THERAPEUTIC COMMUNITIES ASSOCIATION

ATCA E-NEWS ALERT

August 2011

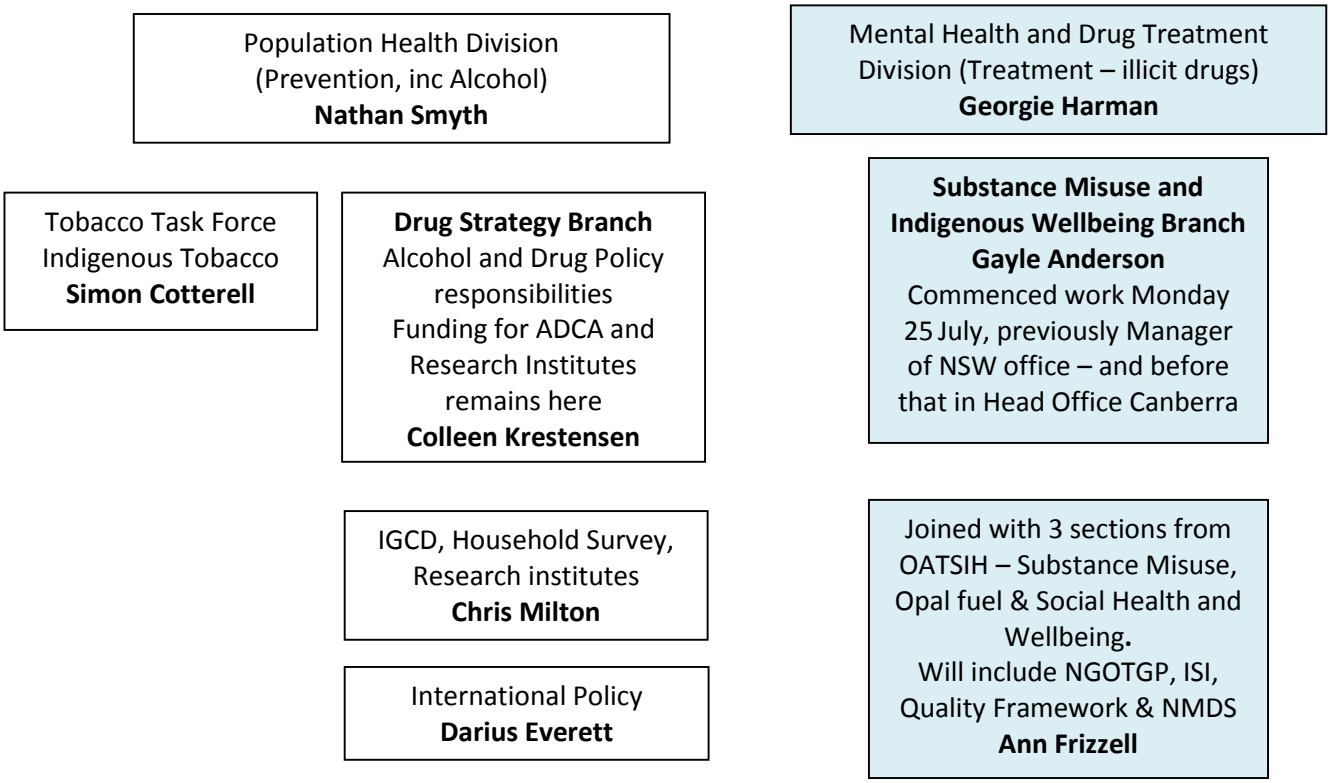
DoHA restructure

All members will have received recent information about the restructure within the Drug Strategy Branch, together with news of the development of a quality framework and outputs-and outcomes-based funding model which it is intended will be applied to future funding arrangements for the NGOTGP and Improved Services Initiative. KMPG has been engaged to undertake this project.

The ATCA is remaining as close to this process as possible, and Lynne was able to meet very recently with DoHA officials. The ATCA has also been one of a relatively small number of stakeholders invited to a Stakeholder Forum on 9 August in Melbourne arranged by the Intergovernmental Committee on Drugs to inform the discussion of the IGCD's annual strategic workshop.

The most important aspects of the DoHA restructure are outlined below, and provided in a graphic form, which hopefully provides a clearer picture of what will be happening. Lynne was able to meet with Ann Frizzell and Dean Biddle who provided a thorough briefing on the changes to this point.

The most important thing to note is that the Drug Strategy Branch has essentially moved into a new Division and is now under Population Health, and is headed up by Colleen Kristensen, who has a long history with Mental Health.



As the above diagram shows, Simon Cotterell is heading up a Tobacco Task Force, which is in fact time limited and will include work on plain packaging, health warnings, whole of population control and COAG Indigenous measures.

Also sitting in the Drug Strategy Branch is the IGCD, the Research Institutes and Household Survey under Chris Milton and International Policy under Darius Everett.

Other functions of drug treatment – and notably those that affect the ATCA and our members – have moved under a new Division - Mental Health and Drug Treatment Division, which is headed up by Georgie Harman. Sitting in this new Division is the new Substance Misuse and Indigenous Wellbeing Branch, which is headed up by Gayle Anderson. Gayle commenced work on Monday 25 July, and was previously Manager of NSW office – and before that in Head Office Canberra.

There are some very important changes here – there are three sections from OATSIH that have moved into the new Branch. These are: Substance Misuse, Opal fuel, and Social Health and Wellbeing. Clearly the next few weeks and months will bring a number of physical changes to DoHA as people move from one section to another. Most importantly, there are significant changes to the way in which funding will be distributed – and this will also tie back into the work which will be undertaken by KPMG.

The current 159 different Health programs have now been collapsed into 18 funds. Under Substance Misuse and Indigenous Wellbeing Branch there is one fund – which will be known as the **Substance Misuse Service Delivery Grants fund** – which will include ISI, NGOTGP, as well as a number of programs that have come over from OATSIH. Currently (without the NGOTGP money at this point) there is $559 mill in this fund, but this includes the funding which has been brought over from the OATSIH programs. There is work underway to have the NGOTGP synchronised with the ISI, and this money will then come into the fund.

The Quality Framework initiative will also sit within the Substance Misuse and Indigenous Wellbeing Branch, and therefore the oversight of the KPMG work will be within this area, rather than the Drug Strategy Branch.

Major difference is a streamlining of funding. From here on, we apply to a fund, rather than to an individual program within the fund. NGOs are not precluded though from applying to other funds. Under Population Health, there will be a fund called Substance Misuse, Prevention and Service Improvement fund. This will include prevention initiatives, including education. NGOs funded through Treatment (Mental Health and Drug Treatment Division) can also apply to this fund – or to any of the other Health funds operated across the Health Department.

The other significant change is an attempt to streamline contracts, and therefore there will be only one contract with DoHA. Any additional funding, including that from other funds will be included as Schedules – so **one contract, one lot of reporting, one contact person.**

This is a huge shift in DoHA thinking and change in business.

As you know, funding arrangements for the NGOTGP and COAG Mental Health Improved Services (ISI) funding were recently extended to 30 June 2012. Consultations with AOD treatment services and national and state and territory peaks will play an important role in the development of the KPMG project, and many of you will have received a letter in relation to the consultation process.

It is anticipated that the development phase of the project will be undertaken between August and early September 2011, and as part of this phase a number of services across each state and territory will be identified for consultation with KPMG.

If you have received a letter, we urge you to provide input into the consultation. If you haven't contact Sandra Downie at sandra.downie@health.gov.au to register your interest and to seek ways in which you can input into the process.

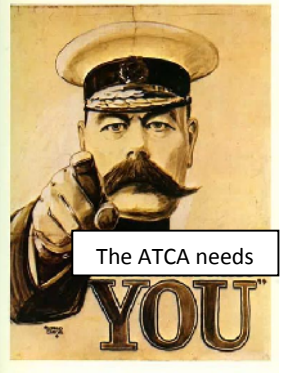
The ATCA will continue to update you and to support your concerns in any discussion with DoHA, with KPMG and through the Stakeholder Forum in Melbourne, which will be attended by Board Directors Garth Popple and James Pitts.

National initiatives

It is also important for all members to remain aware of the changes at national, state and local level – and this includes the development of Medicare Locals and other Health Reforms.

Nineteen communities around Australia will lead primary health care reform, becoming the first Medicare Locals from 1 July 2011. These will be locally-run organisations which, it is anticipated, will better connect the vast array of primary health care services and improve local service delivery.

While it is not clear yet how Health funding will eventually be provided at a local level, it is important to become involved with the Medicare Local in your area, and if possible see if you are able to gain a position as part of the Board – AOD services need to be represented and while there is a broad aim to develop community-based and inclusive Boards, each Medicare Local will have its own profile.



TCs are very good at quietly achieving – but right now we need to be aware strategically of the opportunities in the local and national environment.