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Evaluating the capacity building roles of the state and territory peak bodies in the Australian alcohol and other drug sector

David McDonald
The Australian National University, Australia; Social Research & Evaluation Pty Ltd, Australia

Robert Stirling
Network of Alcohol and Other Drugs Agencies, Australia

Abstract

The Australian alcohol and other drugs (AOD) sector has a diverse range of actors, including the nongovernment (NGO) service providers. Representing these services in each of Australian states and territories are AOD sector peak bodies. Their national network commissioned an evaluation of their capacity building (CB) activities and outcomes. The network and the evaluator developed a working definition of CB: *Capacity building is a strategy that improves the ability of AOD workers, services and/or the broader AOD system to achieve better AOD health and social outcomes*. The utilisation-focused evaluation (UFE) model was adopted for this project. The evaluation found that sound outcomes have been produced by the peaks' CB work, and that includes valued changes in the service delivery work of the NGO sector. The CB strategies that are particularly important for attaining the desired outcomes were identified. The CB strategies and activities have been implemented well, and have delivered value for money, though sustainability remains a concern. The evaluation concluded that the peak bodies are ideally placed to deliver CB initiatives. The evaluation's recommendations have been implemented, and process utilisation of the evaluation has been observed among its participants.

Corresponding author:
David McDonald, Social Research & Evaluation Pty Ltd, 1004 Norton Road, Wamboin, NSW 2620, Australia.
Email: david.mcdonald@socialresearch.com.au

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Introduction

The Australian alcohol and other drugs (AOD) sector has a diverse range of players seeking to reduce alcohol and drugs related harms, including government and nongovernment (NGO, or not-for-profit) service providers. There are currently approximately 488 NGO services providing a range of in-patient and out-patient treatment and harm reduction approaches in community settings across Australia. These services deliver about 140,000 episodes of care annually (Australian Institute of Health and Welfare, 2018). Representing these services in each of Australia's eight states and territories are peak bodies representing the AOD sector within their respective jurisdictions. Although most of the state and territory peaks focus solely on representing the NGO sector, some include government providers either as members or as associate members.

The Industry Commission (1995) defined a peak body as 'a representative organisation that provides information dissemination services, membership support, coordination, advocacy and representation, and research and policy development services for its members and other interested parties' (p. 181). In addition to the definition, the literature that discusses Australian peak bodies in the health and community services sector describes core roles and responsibilities that include sector consultation and coordination, promoting and facilitating partnerships and sector capacity building (Capacity Building [CB]; Hamilton & Barwick, 1993; Melville & Perkins, 2003; Strickland, Goodes, & 3P Consultancy, 2008).

The Productivity Commission Research Report (Productivity Commission, 2010) that looked at the contribution of the not-for-profit (NFP) sector highlighted the role of peak bodies in supporting sector development, and provided recommendations to government to collaborate with peak bodies in providing support to services, improving knowledge and building skills and capacity 'with a priority for those not-for-profit organisations engaged in delivery of government funded services' (p. 237).

In a parallel process to funding service-level CB, the Australian Government provided funds to the aforementioned peak bodies to conduct state- and territory-wide sector CB activity. This initiative saw the formation of the Peaks Capacity Building Network (PCBN), representing each Australian state and territory. The network adopted four main strategies to undertake CB activities that can be classified as building sustainable linkages and strategic partnerships, assisting services to undertake service improvement, identifying and facilitating training opportunities, and developing and promoting information and resources (NSW Health, 2001; Roche & Pollard, 2006).

This evaluation aimed to ascertain the effectiveness of AOD peak bodies in building the capacity of NGO AOD treatment services across Australia, utilising the abovementioned strategies. Although literature exists on the effectiveness of CB in public health generally (e.g., Grudniewicz et al., 2014), this is the first study, to our knowledge, that

has evaluated the effectiveness of peak bodies in building the capacity of AOD services to improve service responses.

Part of the context for the evaluation was Kotvojs (2017) observations about the lack of success in CB (in the international development sector), and the dearth of evaluations of CB:

> Adoption of an effective capacity development approach is seen as critical to reducing poverty through international development assistance activities . . . As a result, global annual investment in capacity development now exceeds US$30 billion . . . Despite this, donors have consistently identified that capacity development has generally failed . . . Evaluations have contributed little to addressing this as capacity development is rarely evaluated . . . and those evaluations conducted are usually of poor quality . . . Consequently, improving the quality of evaluations of capacity development will provide information that enables initiatives to advance capacity development. (p. 14)

Program theory, evaluation model and methods

The evaluation (McDonald, 2015) was commissioned by the PCBN, funded by the Australian Government Department of Health under its Substance Misuse Service Delivery Grants Fund (SMSDGF), and managed by the NSW Network of Alcohol & other Drug Agencies (NADA) on behalf of the PCBN. It was an independent, external evaluation. It commenced in late 2012 with the evaluator developing a draft evaluation protocol, the contents of which were finalised in March 2013 collaboratively with the members of the PCBN.

From the outset, it was necessary to reach agreement, among the evaluation's main stakeholders, as to *the meaning of CB*. This reflects the diversity of definitions found in the literature and used in the field (Kotvojs, 2015). 'Capacity building' (also called 'capacity development' [op cit] is a complex construct. It implies both a set of processes (e.g., organisational development) and the attainment of valued outcomes (e.g., improved drug treatment services).

A short definition of CB was developed for the purposes of this evaluation, based on a fuller one proposed by public health scholars (LaFond, Brown, & Macintyre, 2002):

> Capacity building is a strategy that improves the ability of AOD workers, services and/or the broader AOD system to achieve better AOD health and social outcomes. (p. 10)

This definition draws attention to CB operating at diverse levels, including the health system, individual AOD (treatment) organisations, the staff of those organisations and the clients/communities that interrelate with them. It provides part of the conceptual framework underpinning this evaluation.

The utilisation-focused evaluation (UFE) model was adopted for this project. It has been defined as follows:

> Program evaluation is the systematic collection of information about the activities, characteristics, and results of programs to make judgements about the program, improve or further develop program effectiveness, inform decisions about future programming, and/or

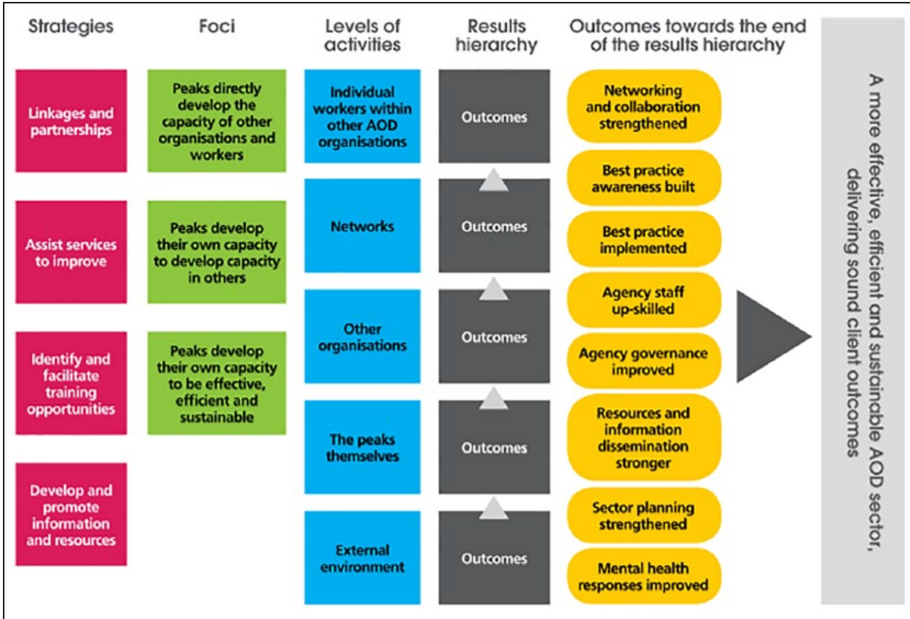

Figure 1. The program theory and top-line evaluation findings.

> increase understanding. Utilization-focused program evaluation is evaluation done for and with specific intended primary users for specific, intended uses. (Patton, 2008, p. 39)

This model has been recently assessed as being one of the nine 'Best approaches for twenty-first-century evaluations' (Stufflebeam & Coryn, 2014), using the international program evaluation standards as the assessment criteria (Yarbrough, Shulha, Hopson, & Caruthers, 2011). Towards the end of this article, we discuss how the processes and findings of the evaluation have been used within the UFE framework.

The program theory underpinning the peaks' CB strategies and activities was documented as part of the evaluation. It comprises the theory of change and the theory of action (Funnell & Rogers, 2011). Figure 1 is a visualisation of the program theory, which accords with the top-line findings of the evaluation. It highlights the main strategies implemented by the peaks, the areas in which those strategies were focused, the levels at which the CB activities took place, the outputs and immediate outcomes (detailed in the evaluation report, McDonald, 2015, but not in this visualisation), and the outcomes towards the end of the results hierarchy.

Seven evaluation questions were developed collaboratively between the evaluator and the PCBN members:

1. In what ways have the NGO AOD peak bodies engaged in sector CB activities focusing on AOD treatment and related supportive activities?

2. How much of the peaks' effort is CB related to AOD treatment and related supportive activities?
3. How sound is the rationale underpinning the peaks' CB activities?
4. How well have the peaks' CB strategies and activities been implemented?
5. How valuable are the outcomes at the levels of the system, organisation, worker and client/community?
6. To what extent have the CB strategies and activities represented good use of the available resources to achieve valued outcomes (value for money)?
7. What are the implications of the evaluation's findings for the future of the peaks' CB functions?

Three main data sources were used to answer the evaluation questions:

1. *Descriptions of the CB activities of the seven participating peak bodies, and the activities' outputs and outcomes.* Each of the peaks reported on their CB activities using a template developed for the purpose. They reported twice, first on 2012-2013 year activities and then on the 2013-2014 activities. Each was asked to report on the CB activities they had undertaken that they classified as 'the most important or significant' during the year, according to a set of predetermined criteria of importance and significance. In all, 143 CB activities were reported upon, a mean of 20 per peak body.
2. *An online survey of the experiences and perceptions of the members of the peak bodies and people in other organisations who were considered to be knowledgeable enough about their peak's CB activities to be able to contribute valid data.* There were 106 respondents to this survey.
3. *Interviews with eight key informants from five states and the ACT.*

Results

The key findings of the evaluation reflect the evaluation questions, as follows.

1. *Sound outcomes from the CB work*. The overarching conclusion of the evaluation is that the peaks' CB work has produced, and continues to produce, a more effective, efficient and sustainable Australian AOD sector, delivering sound client outcomes.
2. *The outcomes of the CB work are valuable*. A range of positive outcomes have been achieved, those outcomes are valued by the people involved, positive changes have been observed as a consequence of the CB work, and there were few, and not serious, unintended negative outcomes.
3. *The CB work has produced valued changes*. Almost all evaluation informants indicated that improvements in AOD service delivery practice have been produced by the peaks' CB work. These changes have occurred with respect to service user outcomes, organisational change within AOD agencies and changes at the AOD system level.

4. *The CB strategies used have met the funding objectives*. The evaluation identified that CB is the primary goal of most of the peaks' work, and the majority of that work includes an AOD/mental health comorbidity component, in accordance with the objectives set by the funding body, the Australian Government Department of Health. The most prominent CB strategies employed, in descending order of frequency, were building sustainable linkages and strategic partnerships, assisting services to undertake service improvement, identifying and facilitating training opportunities and developing and promoting information and other resources. The focus of this work is predominantly on the organisational level within AOD agencies, followed by focusing on individual workers in those organisations, and on both formal and informal networks.
5. *The rationale underpinning the CB activities is sound*. This conclusion of the evaluation is based upon the criteria of the validity of the key assumptions underpinning the CB work, the fidelity of program implementation, the extent of implementation and the availability of resources needed for program development and implementation.
6. *The CB strategies that are most important for attaining the desired outcomes*. Key stakeholders for the peaks' CB work identified three CB strategies as being most important: developing and maintaining linkages and partnerships, assisting member organisations to improve their service delivery and identifying and facilitating training opportunities for members. Developing and promoting information and resources, a prominent activity of many of the peak bodies, was not rated by stakeholders as being as important as the other three strategies listed.
7. *The CB strategies and activities have been implemented well*. Implementation science draws attention to stages of implementation: exploration and adoption, program installation, initial implementation, full operation and innovation and sustainability (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). The peaks are at differing points along this continuum, and have demonstrated sound implementation strategies.
8. *The CB work has delivered value for money, though sustainability remains a concern*. The sustainability of program implementation and achievements is not guaranteed in the light of ongoing uncertainty about future government funding.
9. *The evaluation has demonstrated the need for ongoing support of the peaks' CB work*. A particularly strong finding of the evaluation (reflecting the views of AOD sector workers and key informants) is the widespread support for CB continuing to be the main thrust of the work of the state and territory peak bodies.

Discussion

Peak bodies function on the basis of mutually respectful relationships with member organisations and are, therefore, ideally placed to deliver CB initiatives. Specifically, the AOD Peaks Network is an effective tool for governance in the AOD sector by:

- Providing frontline, real-time local intelligence to State, Territory and Commonwealth governments on AOD policies, programs and problems,
- Being a valued source of information on government investment, protecting investment in community/NGO AOD services across all jurisdictions by supporting the implementation of evidence-informed practice and workforce development,
- Supporting governments by enabling effective and consistent implementation of reform across all jurisdictions,
- Being a conduit for communication between governments, service providers and consumers in the AOD sector,
- Assisting governments in program planning and decision making,
- Supporting collaboration across the sector, with other sectors, and across jurisdictions and
- Supporting information exchange between jurisdictions to minimise duplication in policy and program development.

The strengths of the evaluation included its novelty—evaluating CB in the Australian AOD sector—and how it was implemented collaboratively between the external evaluator and the peak bodies themselves, maintaining a regular flow of information and feedback between the two parties. The evaluation model applied—Patton's UFE—was well suited to the task because the findings of the evaluation were intended to directly influence the operations of the PCBN members and provide an input to Commonwealth decision making on funding the AOD NGO sector. A weakness of the evaluation was that it was not able to include any comparison group as all of the Australian state and territory AOD peak bodies implemented the CB work at the same time, under the same funding model. In addition, the evaluation did not include consultation with drug treatment and prevention service users, and relied on the input of the peak bodies themselves, and their members. Key stakeholders have confirmed that these weaknesses have not impacted adversely on the utility of the evaluation's findings and outcomes.

The findings further reinforce the value of being a member of a peak body to leverage off government CB activities to increase the skills of their workforce, apply evidence and practice-based approaches and align with government priorities. They also highlight that CB is an ongoing process of continuous quality improvement at the sector level that does not have an endpoint, and thus should continue to be funded alongside service delivery in AOD treatment and redirected to respond to new and emerging drug trends, innovation in service delivery and system changes.

The evaluation findings suggest that government could leverage off the peaks to align CB activities with national policy to reduce alcohol and drug related harms, including strategies to strengthen workforce capacity. As the Australian Government has outsourced much of the provision of AOD services nationally through local commissioning bodies (Primary Health Networks), the role of the peak bodies in supporting sector capacity is important to ensure national consistency of the promotion of evidence-informed approaches to treatment and workforce development.

In utilising the findings from the evaluation, the PCBN reviewed its recommendations, accepted them all and commenced a process of implementation. To date all recommendations have been implemented to some degree. A key use of the evaluation has been to demonstrate the value of peak bodies' roles in building capacity to funders of the PCBN, as well as evidence in further funding applications to undertake CB activities to develop the AOD sector. Importantly, the network has used the outcomes of the evaluation to inform decisions about future CB activities, including using the program theory outlined above to develop an evaluation and monitoring framework to support future collective evaluations.

Although not built into the evaluation itself, an additional outcome was the capacity that has been built among the PCBN itself, supporting the literature on *process use* in evaluation (Amo & Cousins, 2007). Patton (1997) defined process use as 'individual changes in thinking and behaviour, and program or organizational changes in procedures and culture, that occur among those involved in the evaluation as a result of the learning that occurs during the evaluation process' (p. 90). This has been demonstrated in this case through

- improved collaboration and future partnership opportunities between members of the PCBN through the shared experience,
- development of research and evaluation skills, as well increased confidence in undertaking evaluation,
- the review and improvement of data collection mechanisms and
- the utilisation of evaluation findings.

It is clear from this that the application of the UFE model employed here supports the conceptual framework developed by Cousins, Goh, Clark, and Lee (2004), in that the evaluation process built the evaluation capacity, organisational learning capacity and readiness for evaluation of the PCBN.

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ORCID iD

David McDonald https://orcid.org/0000-0001-7667-6144

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Author biographies

David McDonald is an interdisciplinary social scientist with research interests at the intersection of criminal justice and population health, and building evidence-informed public policy. He is the Director of the consultancy Social Research & Evaluation Pty Ltd, a Campus Visitor at the National Centre for Epidemiology and Population Health at The Australian National University, and the research advisor to the Alcohol Tobacco and Other Drug Association, ACT. He is a Charter Member of the Australian Evaluation Society, a member of its Awards and Recognition Working Group, and a member of its Canberra Regional Network.

Robert Stirling is Deputy CEO for the Network of Alcohol and other Drugs Agencies, where he is responsible for sector reform and development, policy and planning, and research. Robert has worked in the AOD sector for over 10 years across the government and non government sectors. He holds qualifications in public health and community management.