

EVALUATION OF THE ALCOHOL AND OTHER DRUGS PEAK BODIES' ROLES IN BUILDING CAPACITY

IN THE NON-GOVERNMENT ALCOHOL AND OTHER DRUGS SECTOR

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CONTENTS

ACKNOWLEDGEMENTS			
IN BRIEF...	ii		
RECOMMENDATIONS	vi		
INTRODUCTION, EVALUATION STRATEGY AND METHODS	1		
PROJECT BACKGROUND AND CONTEXT	1		
KEY CONCEPTS: CAPACITY, CAPABILITY AND CAPACITY BUILDING	2		
EVALUATION STRATEGY	2		
EVALUATION MODEL	3		
EVALUATION METHODS	4		
QUESTION 1: IN WHAT WAYS HAVE THE NGO AOD PEAK BODIES ENGAGED IN SECTOR CAPACITY BUILDING ACTIVITIES FOCUSING ON AOD TREATMENT AND RELATED SUPPORTIVE ACTIVITIES?	5		
THE ACTIVITIES REPORTED UPON	5		
SMSDGF-SUPPORTED ACTIVITIES	5		
CAPACITY BUILDING THE PRIMARY, OR A SECONDARY, GOAL OF THE ACTIVITIES	5		
FOCUSING ON AOD/MENTAL HEALTH COMORBIDITIES	6		
THE KEY CAPACITY BUILDING STRATEGIES USED	6		
THE LEVELS AT WHICH THE ACTIVITIES ARE FOCUSED	7		
STRATEGIES AND LEVELS OF FOCUS	8		
THE OUTPUTS OF THE CAPACITY BUILDING ACTIVITIES	9		
CONCLUSIONS REGARDING QUESTION 1, THE PEAKS' CAPACITY BUILDING ACTIVITIES	10		
QUESTION 2: HOW MUCH OF THE PEAKS' EFFORT IS CAPACITY BUILDING RELATED TO AOD TREATMENT AND RELATED SUPPORTIVE ACTIVITIES?	11		
QUESTION 3: HOW SOUND IS THE RATIONALE UNDERPINNING THE PEAKS' CAPACITY BUILDING ACTIVITIES?	13		
THE PROGRAM THEORY	13		
THE THEORY OF CHANGE	13		
THE THEORY OF ACTION	14		
SOUNDNESS OF THE RATIONALE	14		
ASSUMPTIONS	15		
FIDELITY AND EXTENT OF IMPLEMENTATION OF CAPACITY BUILDING ACTIVITIES GIVEN THE AVAILABLE RESOURCES		16	
FOUR CAPACITY BUILDING STRATEGIES		16	
THE LEVELS AT WHICH THE WORK TAKES PLACE		16	
KEY INFORMANTS' VIEWS ON THE SOUNDNESS OF THE RATIONALE		18	
CONCLUSIONS REGARDING THE SOUNDNESS OF THE RATIONALE		18	
QUESTION 4: HOW WELL HAVE THE PEAKS' CAPACITY BUILDING STRATEGIES AND ACTIVITIES BEEN IMPLEMENTED?		19	
QUESTION 5: HOW VALUABLE ARE THE OUTCOMES OF THE CAPACITY BUILDING WORK?		22	
THE OUTCOMES ATTAINED		22	
THE EXTENT TO WHICH CAPACITY BUILDING OUTCOMES HAVE BEEN ACHIEVED		24	
THE VALUE OF THE CAPACITY BUILDING OUTCOMES		25	
SPECIFIC CHANGES CREATED BY THE CAPACITY BUILDING ACTIVITIES		26	
UNINTENDED OUTCOMES, POSITIVE AND NEGATIVE		27	
POSITIVE UNINTENDED CONSEQUENCES		27	
NEGATIVE UNINTENDED CONSEQUENCES		28	
LESSONS LEARNED		28	
CONCLUSIONS REGARDING OUTCOMES		28	
QUESTION 6: TO WHAT EXTENT HAVE THE CAPACITY BUILDING STRATEGIES AND ACTIVITIES DELIVERED VALUE FOR MONEY?		29	
QUESTION 7: WHAT ARE THE IMPLICATIONS OF THE EVALUATION'S FINDINGS FOR THE FUTURE OF THE PEAKS' CAPACITY BUILDING FUNCTIONS?		30	
CONCLUSIONS		32	
APPENDIX 1: THE 143 CAPACITY BUILDING ACTIVITIES DISCUSSED AT EVALUATION QUESTION 1		34	
APPENDIX 2: POSTER PRESENTED AT THE NOVEMBER 2014 APSAD ANNUAL CONFERENCE		38	

IN BRIEF...

This is the report on an external evaluation of the capacity building work undertaken by the Australian state and territory alcohol and other drug (AOD) peak bodies, focusing on the period from July 2012 to March 2015.

Jointly, the state and territory peak bodies, through their national Peaks Capacity Building Network, resolved that the work that they undertake with the aim of building the capacity of the non-government (NGO) AOD sector, including improving capacity in the area of AOD/mental health comorbidity, would be evaluated. A mid-term Progress Report of the evaluation was submitted in February 2014 and this is the Final Report of the evaluation.

The peak bodies¹ are as follows:

- Alcohol Tobacco and other Drugs Association ACT (ATODA)
- Alcohol Tobacco and other Drugs Council (Tasmania: ATDC)
- Association of Alcohol and other Drug Agencies NT (AADANT)
- Network of Alcohol and other Drugs Agencies (NSW: NADA)
- Queensland Network of Alcohol and other Drugs Agencies (QNADA)
- South Australian Network of Drug and Alcohol Services (SANDAS)
- Victorian Alcohol and Drug Association (VAADA)
- Western Australian Network of Alcohol and other Drug Agencies (WANADA).

All but the Association of Alcohol and other Drug Agencies NT (AADANT) have been fully involved in commissioning, overseeing and contributing data and information to the evaluation. The limited involvement of AADANT reflects the fact that the Association is at an early stage in its development.

A short definition of capacity building has been developed for the purposes of this evaluation:

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 evaluation has identified a wide range of activities, undertaken by the seven participating NGO AOD peak bodies, aiming to build the capacity of member organisations and the broader AOD sector to anticipate and respond appropriately to the AOD needs of the Australian community. Commonwealth funding under the Substance Misuse Service Delivery Grants Fund (SMSDGF), and the Improved Services for People with Drug and Alcohol Problems and Mental Illness Initiative (ISI) that preceded it, has been critically important to this work, along with funding from other sources, particularly the state/territory governments and member contributions.

The key findings of the evaluation follow. The body of the report provides the evaluative data upon which they are based. The sequence of the findings do not reflect any priorities within them.

Key finding 1: Sound outcomes from the capacity building work

An analysis of the empirical data elicited through the evaluation, and the program theory underpinning the peaks' capacity building work, leads to the conclusion that the capacity building work has produced, and is continuing to produce, a more effective, efficient and sustainable AOD sector, producing sound outcomes for AOD clients.

Positive capacity building outcomes have been achieved, in the experiences of the national evaluation survey respondents. Specifically, 92% of survey respondents identified as having been achieved to 'a great extent' or 'to some extent' the outcome 'AOD sector workers are better skilled and/or more confident in their roles', 90% identified 'creating a more effective AOD sector' and 80% identified 'AOD services create improved service user outcomes'.

¹ In this report these organisations are generally referred to as NGO AOD peak bodies, as their work focuses mainly on the NGO sector. It is noted, however, that some of the peaks include government organisations, as well as NGOs, among their members.

With respect to the long-term outcomes of the capacity building activities upon which the peaks reported, nine categories were identified most frequently, namely (in descending order of frequency):

- increased awareness of best practices in AOD service delivery
- strengthened networks and collaborations
- increased implementation of best practices in AOD service delivery
- better skilled AOD agency staff
- enhanced dissemination of information and other resources
- improved awareness of and responses to complex needs clients
- improved agency governance
- improved sector planning
- stronger mental health responses.

Key finding 2: The outcomes of the capacity building work are valuable

The outcomes of the peaks' capacity building work are of significant positive value as demonstrated by the fact that a range of positive outcomes have been achieved, those outcomes are valued by those involved, positive changes have been observed as a consequence of the capacity building work, and that there are few, and not serious, unintended negative outcomes.

Survey respondents rated the outcomes as being of very high value, with 90% or more of respondents rating them as 'very valuable' or 'fairly valuable' on each of the following criteria:

- relevance to the needs of the AOD sector
- effectiveness
- efficiency
- degree of impact in such areas as AOD service provision, service user outcomes, AOD workforce development and the broader AOD sector.

In addition, 83% judged the outcomes as being 'very valuable' or 'fairly valuable' on the criterion of sustainability of the impacts

Key finding 3: The capacity building work has produced valued changes

Almost all evaluation informants indicated that improvements in AOD service delivery practice have been produced by the capacity building work. Most also reported that, in their experience, beneficial changes had occurred with respect to service user outcomes, organisational change within AOD agencies, and changes at the AOD system level. Considering that these are the primary goals of the peaks' capacity building activities, this is a positive outcome.

Key finding 4: The capacity building strategies used have met the funding objectives

Capacity building is the primary goal in most of the peaks' work, and the majority of it includes an AOD/mental health comorbidity component.

Most of the capacity building activities were funded under the SMSDGF and, if this funding is not available in the future, it is unlikely that the work will be able to continue at the same level of intensity.

The most prominent capacity building 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.

Particular forms of advocacy engaged in by the peak organisations are key capacity building strategies as they help to create an enabling environment. The peaks advocate on behalf of their members and members' clients with the aim of creating better policy and improved systems, leading to more appropriate levels of funding and infrastructure resources, resulting in member organisations being better equipped to produce sound client outcomes. This aligns with the Ottawa Charter's principle of 'advocacy for health'.²

Some differences exist, between the participating peak bodies, about the relative emphases that they place upon training compared with broader activities such as developing the ability of member organisations to identify and respond to such things as changing needs relating to drugs, drug use and drug-related harm; anticipating and responding to changes in funding priorities and levels of funding for the sector; building governance and other aspects of service organisations' infrastructure; and contributing to state-wide AOD policy work. This is illustrated by the contrast between emphasising conducting one-off short training courses, on the one hand, and institutionalising career pathways for AOD workers, on the other.

Key finding 5: The rationale underpinning the capacity building activities is sound

The rationale is sound, based upon the criteria of the validity of key underpinning assumptions, the fidelity of program implementation, the extent of implementation, and the availability of resources.

The rationale, although sound, has been documented retrospectively (through this evaluation) rather than as part of a strategic planning process preceding detailed program design and implementation. This largely reflects the funding bodies' requirements and processes, and the planning approaches used by the individual peak bodies in the past.

Key finding 6: The priority capacity building strategies have been identified

Respondents to the evaluation survey rated the capacity building strategy 'Developing and promoting relevant information and resources' as being important, but considerably less important than the other three strategies which focus on partnerships, service improvement and facilitating training opportunities. This has implications for the Peaks Capacity Building Network's further strategy development activities.

Key finding 7: The capacity building strategies and activities have been implemented well

The peaks' capacity building activities have been implemented well, particularly considering the level of resources available. Questions remain, however, about the sustainability of program implementation in light of uncertainty about future funding.

Key finding 8: The activities have provided value for money, though sustainability remains a concern

The peaks' capacity building work has delivered good value for money, fully justifying the Commonwealth and state/territory governments' significant investment in this work.

Uncertainty remains, however, about Commonwealth funding past 30 June 2016. A need exists for the Commonwealth to work with the peaks with the aim of ensuring the sustainability of the peaks' capacity building activities and outcomes. This is because capacity building does not have an end point. The need to develop the capacity of workers, organisation and the AOD sector is ongoing, particularly in light of emerging challenges such as 'ice' and the new psychoactive substances, and the need to implement new findings from treatment and prevention research, as well as sharing innovation through practice-based approaches.

2 International Conference on Health Promotion 1986, 'Ottawa Charter for Health Promotion', WHO/HPR/HEP/95.1, First International Conference on Health Promotion, Ottawa, 17-21 November 1986.

Key finding 9: The evaluation has demonstrated the need for ongoing support of the peaks' capacity building work

A particularly strong finding of the evaluation is the widespread support for AOD sector capacity building continuing to be the main activity of the state and territory peak bodies but, as mentioned above, to a significant extent this is dependent upon the continuing availability of

Commonwealth funding or the identification of other funding sources.

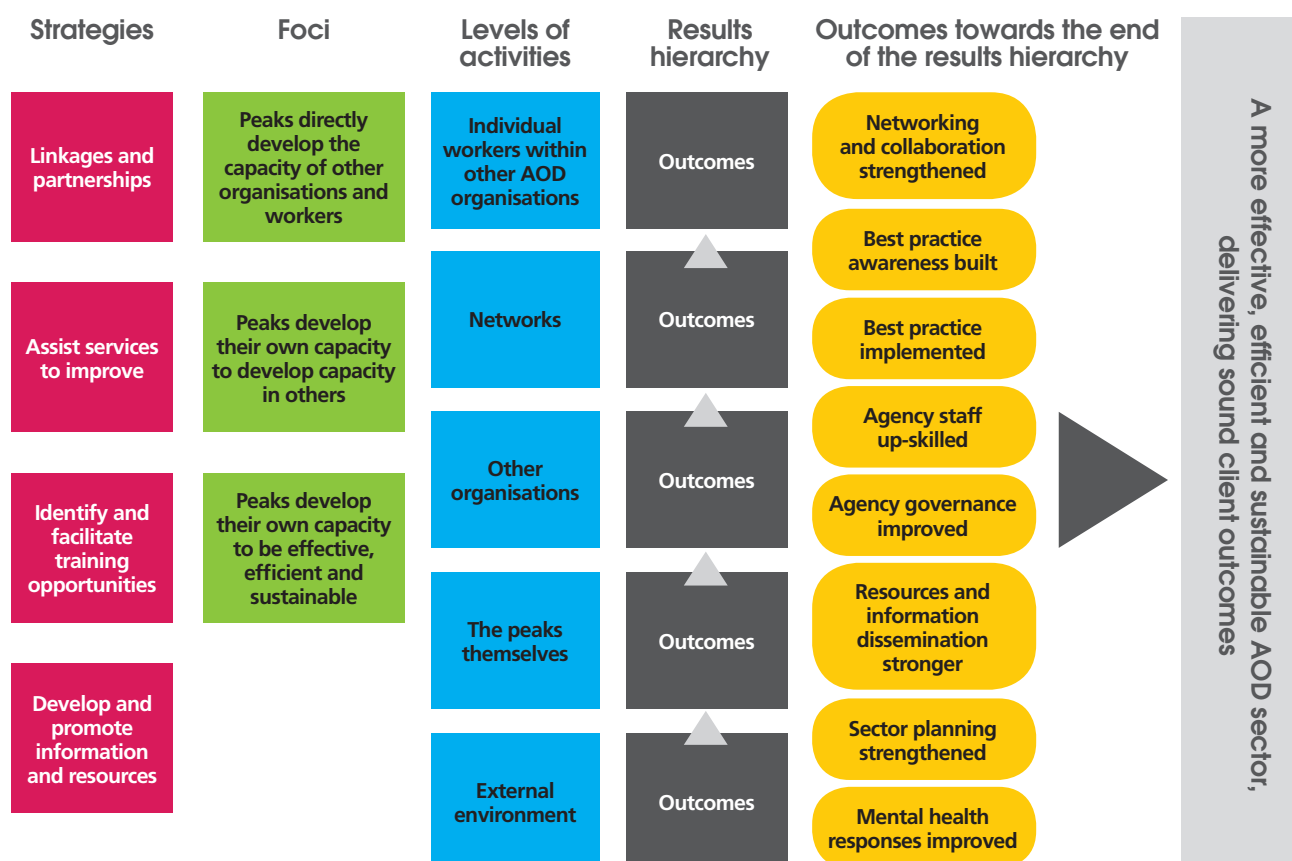
Also relevant to the future of the peaks capacity building work and achievements is the current Commonwealth Government's Review of the Drug and Alcohol Prevention and Treatment Services Sector, and reform processes taking place in some of the states and territories, as these have real potential to change the shape of the Australian AOD sector.

Visualising the program theory and evaluation findings

Figure 1 draws together, in summary form, key elements of the program theory and the evaluation findings about the capacity building strategies implemented, the foci of those activities, the levels at which they are applied, and the types of outcomes demonstrated towards the end of the results hierarchy. The Peaks Capacity Building Network may find it a useful tool in high-level capacity building strategic planning.

FIGURE 1

The program theory and evaluation findings



RECOMMENDATIONS

Recommendation 1

The state and territory NGO AOD peak bodies maintain capacity building as their primary focus, with the aim of building the capacity of AOD workers, agencies and the sector as a whole to deliver sound, valued client outcomes.

Recommendation 2

The Peaks Capacity Building Network brief the Commonwealth and other stakeholders about the success of the SMSDGF funding that the Commonwealth has provided over the last three years to support the peaks' capacity building work. This work has been undertaken in a cost-effective manner and has delivered sound, highly valued outcomes.

Recommendation 3

The Commonwealth continue to support capacity building work across the Australian AOD sector, through the state/territory peak organisations, as a key strategy for service improvement, acknowledging that improved client outcomes are contingent upon strengthened worker, agency and sector capacity.

Recommendation 4

In negotiations with funding bodies, the NGO AOD peak bodies and their individual members draw attention to the potential adverse consequences of funding their capacity building work from the same pool of money as is used to support agencies' service delivery. This is because it places the peaks in direct competition with their members for the limited funds available.

The separate funding streams for the peaks' capacity building work, and for the treatment/harm reduction agencies' service delivery, provided under the ISI/CSSSP, is a model.

Recommendation 5

The peaks give particular attention, in future capacity building work, to assisting member organisations to strengthen their professionalism, improve their governance and better manage data. A related priority is strengthening their members' flexibility so that they can respond with alacrity to changing needs and opportunities.

Recommendation 6

The peaks continue to engage in advocacy and sector representation activities as this is broadly accepted as a sound capacity building strategy. Advocacy that creates an environment that is conducive to expanded and higher quality services for the clients of AOD service agencies should be the focus, implemented in a manner sensitive to context.

Recommendation 7

In further developing their capacity building activities, the individual peaks review the relative emphases placed on training compared with other activities that focus on the sector, and on member services more broadly.

Recommendation 8

The Peaks Capacity Building Network, and individual peak bodies, review the program theory statement developed through this evaluation and build on it as part of their ongoing strategic planning and evaluation work.

This could be done in general terms, taking a national view; at the level of the individual peaks' state/territory programs as a whole; and/or with respect to individual, significant capacity building activities. Figure 1 (the summary visualisation of the program theory and evaluation findings) may be a useful contribution to this initiative.

Recommendation 9

The Peaks Capacity Building Network discuss the implications of the survey responses about which capacity building strategies are considered most important, and take them into account in further strategy development. The strategies in question are 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.

Recommendation 10

The Peaks Capacity Building Network explore opportunities to work more closely together, developing and implementing collaborative, nation-wide capacity building activities as part of a national workforce development focus. Doing so will build upon the infrastructure that has been created within the peak bodies through investments by the Commonwealth and other funders.

INTRODUCTION, EVALUATION STRATEGY AND METHODS

Project background and context

All of Australia's eight states and territories have peak bodies representing the alcohol and other drug (AOD) sector within their respective jurisdictions. Some of the state and territory peaks have among their members (either as full or associate members) governmental AOD organisations, although in the majority of the peak bodies the focus is on the non-government (NGO) sector. The peak bodies are as follows:

- Alcohol Tobacco and other Drugs Association ACT (ATODA)
- Alcohol Tobacco and other Drugs Council (Tasmania: ATDC)
- Association of Alcohol and other Drug Agencies NT (AADANT)
- Network of Alcohol and other Drugs Agencies (NSW: NADA)
- Queensland Network of Alcohol and other Drugs Agencies (QNADA)
- South Australian Network of Drug and Alcohol Services (SANDAS)
- Victorian Alcohol and Drug Association (VAADA)
- Western Australian Network of Alcohol and other Drug Agencies (WANADA).

All but AADANT have been fully involved in commissioning, oversighting and contributing data and information to the evaluation. The limited involvement of AADANT reflects the early stage of development of the Association.

Some of the state and territory peaks have been operating for decades whereas others, particularly those in Tasmania, the ACT and the Northern Territory, have been established more recently. Having a peak body in each state and territory has allowed them to work together to an increasing degree. While all have their individual constitutions, strategies, challenges and opportunities, one thing they have in common is a commitment to building the capacity of the NGO AOD agencies within their respective jurisdictions to deliver evidence-informed, cost-effective, high quality AOD treatment and related supportive services.

Each of the participating state and territory peaks has been funded by the Commonwealth Government Department of Health, under the Substance Misuse Service Delivery Grants Fund (SMSDGF), to increase the capacity of the NGO AOD sector to provide high quality treatment and related services. The funding for capacity building activities commenced earlier, however, under the Improved Services for People with Drug and Alcohol Problems and Mental Illness Initiative (ISI) – Cross Sectoral Support and Strategic

Partnerships (CSSSP) project which was part of the COAG mental health package. The SMSDGF capacity building funds have covered the three year period from July 2012 to June 2015, with a subsequent extension to 30 June 2016. The peak bodies have a number of other sources of support for capacity building activities, including membership fees, state and territory government grants, and donations. This fact, combined with the broad scope of the peak organisations' capacity building activities, means that the evaluation focuses on both the activities directly funded under the SMSDGF and on related activities funded from other sources.

Jointly, the state and territory peak bodies, through their national Peaks Capacity Building Network, resolved that the work that they undertake with the aim of building the capacity of the non-government AOD sector, including improving capacity in the area of AOD/mental health comorbidity, would be subjected to an external evaluation.

A mid-term Progress Report of the evaluation was submitted in February 2014 and this is the Final Report of the evaluation. A poster dealing with

The evaluation covers 7 of the 8 peaks. Their capacity building activities have been largely funded by the Commonwealth Department of Health, state/territory governments and membership fees.

Capacity building defined: 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 Peaks Capacity Building Network and this evaluation received an award for excellence at the November 2014 Annual Conference of the Australasian Professional Society on Alcohol and other Drugs. The poster is reproduced in the Appendix.

Key concepts: capacity, capability and capacity building

'Capacity building' 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).

'Capacity' and 'capability' are related concepts. In the context of capacity building, 'capacity' is a skill, a faculty, a state of competence, attained by an individual or an organisation. In contrast, 'capability' means being able to use one's capacity to achieve the desired outcome. It entails turning one's capacity into practice. So, for example, a psychologist may have the capacity to undertake long-term psychotherapy with drug dependent people (because they have advanced training in that type of intervention) but, because the demand on their services is so great, they only have the capability of providing brief psychological interventions. An implication of this differentiation is that capacity building can usefully focus on both (a) building the capacity of people and organisations to provide quality services and (b) building the capability

of organisations to make the optimal use of the capacity of their staff.

A useful definition of capacity building, developed with particular reference to the public health field, is as follows:³

If capacity is defined as 'the ability to carry out stated objectives', then capacity building is a process that improves the ability of a person, group, organization or system to meet its objectives or to perform better. Capacity building interventions therefore work to improve the input and processes within the health system as a whole (seeking to improve the way it functions); organizations within the health system (to improve the way they function); health personnel (to improve their ability to perform work functions); and clients of the system and their communities (to improve their ability to engage productively with the health system through accessing services and influencing resource management, and improving their own health). Capacity building is further defined by the following five characteristics.

Capacity building in the health sector:

- *Is a dynamic and continuous process*
- *Can occur and be measured on four mutually dependent levels of society: health system, organization, health personnel and individual/community*

- *Should lead to an improvement in performance*
- *Is influenced by the external environment*
- *Contributes to the sustainability of the health system, health-related organizations, and health personnel and individual community behaviour.*

As discussed below, the emphasis in this definition of how capacity building operates at the levels of the health system, individual AOD (treatment) organisations, the staff of those organisations, and the clients/communities that interrelate with them, provides part of the conceptual framework underpinning this evaluation.

A short definition of capacity building has been developed for the purposes of this evaluation:

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.

Evaluation strategy

Purpose of the evaluation

The purpose of the evaluation, as documented in the consultant briefing paper, was as follows:

The aim of this project is to evaluate the role of peak bodies for the NGO AOD sector in building sector organisational capacity, particularly each peak body's ability to support the NGO

3 LaFond, AK, Brown, L & Macintyre, K 2002, 'Mapping capacity in the health sector: a conceptual framework', *The International Journal of Health Planning and Management*, vol. 17, no. 1, p. 10.

This evaluation applies the Utilisation-focused Evaluation model.

AOD treatment services to deliver measurable and sustainable results in treatment outcomes, including improvement of services to people experiencing co-occurring mental illness and substance misuse.

The outcome measures will need to be flexible enough to take into account the varying existing levels of capacity within each state and territory and the diverse range of key activities to be undertaken.

The evaluation is not designed to result in a comparison of each state and territory, but rather assesses the role of peak bodies overall. However, some jurisdictions may request details of the data and information collected in their jurisdiction.

Evaluation questions

Seven evaluation questions have been endorsed by the Peaks Capacity Building Network, as follows:

1. In what ways have the NGO AOD peak bodies engaged in sector capacity building activities focusing on AOD treatment and related supportive activities?
2. How much of the peaks' effort is capacity building related to AOD treatment and related supportive activities?
3. How sound is the rationale underpinning the peaks' capacity building activities?
4. How well have the peaks' capacity building 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 capacity building 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' capacity building functions?

This report presents the findings of the evaluation.

Evaluation model

This evaluation applies the Utilisation-focused Evaluation model. Utilisation-focused Evaluation is 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 increase understanding. Utilization-focused program evaluation is evaluation done for and with specific intended primary users for specific, intended uses.⁴

The Utilisation-focused Evaluation model has been recently assessed as being one of the nine 'Best approaches for twenty-first-century evaluations',⁵ using the international program evaluation standards⁶ as the assessment criteria.

The key users of the findings of the evaluation are the Peaks Capacity Building Network members (representatives of the eight state and territory NGO AOD peak bodies), and the individual peak bodies themselves. Other users with whom the Network may choose to share the evaluation's findings include their members and current and potential funding bodies. High level policy committees, such as those managing the state and territory and national drug strategies, may also be identified as potential users of the evaluation's findings.

The evaluation focuses on both the processes and outcomes of the peak organisations' capacity building activities. It includes identifying any unintended consequences of the initiative (both positive and negative) and attends to both what has been achieved and how this has come about.

An important part of any program evaluation is attending to the assumptions that underpin its development and implementation, and to the contexts within which it operates. Context is particularly important for this national capacity

4 Patton, MQ 2008, *Utilization-focused evaluation*, 4th edn, Sage Publications, Thousand Oaks, p. 39.

5 Stufflebeam, DL & Coryn, CLS 2014, *Evaluation theory, models, and applications*, 2nd edn, Jossey-Bass, San Francisco.

6 Yarbrough, DB, Shulha, LM, Hopson, RK & Caruthers, FA 2011, *The program evaluation standards: a guide for evaluators and evaluation users*, 3rd edn, SAGE Publications, Thousand Oaks, CA.

Evaluation methods included conceptual work about the nature of capacity building in the AOD field, along with the collection and analysis of empirical data on the peaks' capacity building activities, an online survey of the peaks' members and others, and interviews with key informants.

building initiative. The national AOD system is dynamic, having to respond to changing patterns of drug use and drug-related harms, changing availability of financial and human resources, and changing economic and political contexts. All of these have potential to be powerful influences on the implementation and achievements of the peaks' capacity building activities. One authority emphasises that the importance of context should not be underestimated:

Fifty years of evaluation findings point over and over again to the fact that the degree of effectiveness of programs and projects depends to a great extent to the larger system dynamics of which they are a part and which either limit or support their effectiveness.⁷

Evaluation methods

This evaluation project commenced in December 2012. After being briefed about the background and expectations of the evaluation, the evaluator prepared a draft evaluation protocol for consideration by members of the Peaks Capacity Building Network (the Evaluation Reference Group-ERG). The protocol was modified to reflect comments provided by the ERG members and was finalised in March 2013.

At various stages in the evaluation the evaluator visited each of the peak organisations to discuss the evaluation, and its context.

(As noted above, AADANT has expressed its interest in the evaluation but is not actively participating owing to the early stage of development of its activities.) During these visits, the evaluator and the personnel of the state and territory peaks discussed the evaluation in depth. Particular attention was paid to the evaluation strategy and the scope of evaluation data collection to ensure that they were realistic, taking into account the ability of the individual peak bodies to contribute in this way.

In July 2013 a draft template for collecting data on the peaks capacity building activities undertaken during the 2012-13 financial year was distributed. The framework was endorsed the following month and the seven participating peak organisations provided activity data in the agreed-upon format during the August-December 2013 period. A similar process was used covering the 2013-14 year. These data inform much of the evaluation findings presented below.

In the second half of 2014 an evaluation survey was developed to tap the experiences and views of the members of the seven peaks, and people in other organisations who were considered to be knowledgeable enough about the peaks' capacity building activities to contribute useful data. The survey was deployed online and was live during the November-December 2014 period. 106 people

provided usable responses. The seven participating peaks promoted the survey to their members and to others whom they believed knew enough about the capacity building work to be able to provide meaningful survey responses.

This approach to promoting the survey and attracting respondents – a non-probability, purposive sampling strategy⁸ – could produce biased results if respondents who look favourably upon the peaks' work were more likely to find out about the survey and respond to it than were people who took a different view. An analysis of the survey responses demonstrated, however, that a number of the survey participants were somewhat negative in their assessments of the peaks' work, indicating that, if this selection bias occurred, it was present only to a small degree.

In addition, interviews were conducted with eight key informants from five states and the ACT. These were people with close knowledge of the peaks' capacity building activities and their outcomes who were working at senior levels in government agencies and prominent NGOs that interrelated with the peaks.

We now consider the first evaluation question: In what ways have the NGO AOD peak bodies engaged in sector capacity building activities focusing on AOD treatment and related supportive activities?

7 Patton, MQ 2013, 'The future of evaluation in society: top ten trends plus one', in SI Donaldson (ed.), *The future of evaluation in society: a tribute to Michael Scriven*, Information Age Publishing, Charlotte, NC, p. 58.

8 Trochim, WM 2006, *The research methods knowledge base: nonprobability sampling*, Cornell Custom Publishing, Cornell University, <<http://www.socialresearchmethods.net/kb/samprnon.htm>>.

QUESTION 1:

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

In each of the two years of the evaluation, all seven participating peaks identified the ten or so activities that they had undertaken during the year that they rated as being the most important or significant. Of course, this is not exhaustive of all the capacity building activities undertaken by the peaks during that period. The aim of this part of the evaluation is to provide descriptive information about the national capacity building activities, thus operationalising or making concrete capacity building as it is actually undertaken by the peaks. This section focuses on activities, not outcomes. Evaluation question five, below, deals with the latter.

The activities reported upon

In all, 143 activities have been reported upon. They are listed by peak body in Appendix 1. This is an average of 20 per peak, with a range of 15 to 28. The criteria that were suggested for identifying activities that could be classified as 'the most important or significant' during both years were as follows:⁹

- The size of the activity in terms of resources of time, expertise funds, etc. employed
- The significance in terms of creating important changes or having a real potential for doing so in the future
- The number of organisations or people likely to benefit from the activity

- Addressing an urgent challenge that, if it is not dealt with reasonably well, could create adverse outcomes
- Addressing a serious challenge that, if not dealt with reasonably well, could create adverse outcomes
- The degree to which the approach is likely to be successful based on empirical evidence and/or a strong program logic
- The feasibility of implementing the activity and of producing good outcomes, taking into account the available resources
- The likely impacts on equity
- Value for money
- Combinations of the above.

SMSDGF-supported activities

Although the evaluation has a particular focus on capacity building activities that are funded under the Commonwealth Government Department of Health's SMSDGF initiatives, it is clear that the peaks engage in many capacity building activities that are not funded from this source. Furthermore, some activities are funded partly from the SMSDGF and partly from funds obtained from elsewhere. Of the 143 projects reported upon, 62% were identified as being fully funded under the SMSDGF, 17% partially funded this way, and the balance (21%) funded from other sources. This highlights the important

contributions of the SMSDGF to the state and territory peaks' initiatives in building capacity within the AOD sector nationally.

Capacity building the primary, or a secondary, goal of the activities

Many of the activities undertaken by the peaks have multiple goals. For many of them, capacity building was identified as the primary goal. Examples include NADA's Personality Spectrum Disorders Workshop, ATODA's 7th Annual ACT Alcohol, Tobacco and Other Drug Conference, ATDC's Consumer Engagement and Participation initiative and WANADA's development and implementation support for the Standard on Culturally Secure Practice (AOD Sector).

For other activities, capacity building was identified a secondary (albeit important) goal. Examples include QNADA's website redevelopment project, SANDAS' serving as a member of the SA Justice Reinvestment Group, and VAADA's work in promoting and maintaining effective collaboration with the Peaks Capacity Building Network.

Capacity building was identified as being the primary goal in 81% of the activities reported upon. In the remaining 19% of cases, capacity building was reported as being a secondary goal.

9 The development of this list was informed by Vogel, JP, Oxman, AD, Glenton, C, Rosenbaum, S, Lewin, S, Gulmezoglu, AM & Souza, JP 2013, 'Policymakers' and other stakeholders' perceptions of key considerations for health system decisions and the presentation of evidence to inform those considerations: an international survey', *Health Res Policy Syst*, vol. 11, p. 19, <http://www.health-policy-systems.com/content/11/1/19>.

Most of the capacity building activities were fully or partially funded under the SMSDGF, with just 21% entirely funded from other sources.

Capacity building was identified as being the primary goal in 81% of the activities. It was a secondary goal in the other 19% of activities.

Focusing on AOD/mental health comorbidities

Commonwealth government funding to the state and territory peak bodies in recent years has included a focus on AOD/mental health comorbidity. For this reason, the evaluation identified the extent to which the activities, selected as being the most important or significant conducted by the seven peaks during 2013-14,¹⁰ included some focus in this domain. As shown in Table 1, below, two-thirds of the activities were partially focused on AOD/mental health comorbidity and an additional 23% fully focused on that area. In other words, 90% of the activities had some AOD/mental health comorbidity component.

Examples of activities fully focused on AOD/mental health comorbidity are WANADA's AOD and Mental Health Cross Sector Forum and VAADA's delivery of trauma master classes. Examples of activities partially focused in this area are QNADA's development of the statewide NGO AOD service map and SANDAS' collaborative work to strengthen the community and health sectors' response to AOD and comorbidity through the SA Alcohol, Tobacco and Other Drug Nursing Statewide Action Group.

This indicates that the investments made by the Commonwealth and the state/territory governments to mainstream action on AOD/mental health comorbidity, within the AOD

TABLE 1

The extent to which the selected 2013-14 activities have an AOD/mental health comorbidity focus (N=70)

FOCUS ON AOD/MENTAL HEALTH COMORBIDITY	NUMBER	PERCENT
Fully	16	23
Partially	47	67
Not at all	7	10

sector nationally, are producing good outcomes in the day-to-day activities of the peaks and their member organisations.

The key capacity building strategies used

The Peaks Capacity Building Network has adopted four main strategies into which their capacity building activities can be classified. They were developed as part of the ISI/ CSSSP project, and also informed by consultations on the ISI facilitated by the National Centre for Education and Training on Addiction.¹¹ These are:

Building sustainable linkages and strategic partnerships (e.g. ATDC's Biennial Comorbidity Symposium, and Drug Action Week projects in most jurisdictions in 2013)

Assisting services to undertake service improvement (e.g. NADA's Applied Suicide Intervention Skills Training (ASIST) Trainers Network and VAADA's promotion and distribution

of the Capacity Building and Change Management manual)

Identifying and facilitating training opportunities (e.g. SANDAS' Gambling and Comorbidity Workshop and ATODA's ACT-specific ATOD training packages)

Developing and promoting information and resources (e.g. QNADA's monthly newsletter 'Focus' and WANADA's development and launch of a Stigma and Discrimination Position Paper).

The most frequently used strategy was building sustainable linkages and strategic partnerships. This was followed by assisting services to undertake service improvement, identifying and facilitating training opportunities, and developing and promoting information and resources. Table 2 has details.

¹⁰ This variable was not included in the dataset for the 2012-13 year.

¹¹ Roche, AM & Pollard, Y 2006, 'Improved services for people with drug and alcohol problems and mental illness: assisting alcohol and other drugs (AOD) non-government organisations to better respond to people with comorbid AOD and mental health issues. A Summary Report to the Australian Government Department of Health and Ageing', National Centre for Education and Training on Addiction, Adelaide.

90% of the activities were fully or partially focused on AOD/mental health comorbidity.

The level at which the activities were most frequently focused was organisations other than the peak bodies themselves. This was closely followed by a focus on individual workers within those organisations.

TABLE 2

The key capacity building strategies employed
(N=143, multiple responses permitted)

STRATEGIES	NUMBER	PERCENT
Building sustainable linkages and strategic partnerships	65	45.5
Assisting services to undertake service improvement	52	36.4
Identifying and facilitating training opportunities	49	34.3
Developing and promoting information and resources	48	33.6

It should be noted that any particular activity could have a focus at a number of different levels concurrently. Overall, the most frequently identified level of focus was 'other organisations'. The other organisations were mainly the peaks' own members plus non-member organisations in the broader AOD, mental health and related sectors. This was followed by a focus on individual workers within other organisations, and networks. The external environment, the peak organisations themselves and individual workers within the peak organisations were less frequently the focus. This spread of foci demonstrates the breadth and depth of the peaks' capacity building activities. Table 3 has details.

The levels at which the activities are focused

Capacity building activities can be classified under three key foci:

- The peak bodies directly developing capacity in other organisations
- The peak bodies developing their own capacity to develop capacity in other organisations
- The peak bodies developing their own capacity to operate effectively and efficiently.
- Individual workers within other organisations (e.g. ATODA's monthly research eBulletin)
- State/territory peak bodies themselves (e.g. NADA's Community Mental Health Drug and Alcohol Research Network Forums)
- Other organisations (e.g. ATDC's comorbidity bus tours)
- Networks (both formal and informal) (e.g. SANDAS' collaboration with SA Health (DASSA) on workforce development and government and NGO comorbidity service issues)
- The external enabling (or impeding) environment (e.g. WANADA's collaborating with all WA universities and the WA Clinical Training Network in implementing the WANADA student placement program).

With regard to their capacity building work, the peaks have placed most emphasis on the first two of the foci listed.

These three foci are operationalised through activities that can be seen at one or more of six levels, namely, focusing upon

Individual workers within the state/territory peak bodies (e.g. QNADA's scholarships to attend the 2013 Complex Needs Conference)

Building sustainable linkages and strategic partnerships was the strategy most frequently used.

When looking at the type of strategy and level of focus together, it is observed that building sustainable linkages and strategic partnerships among organisations other than the peaks themselves was most frequently reported.

TABLE 3

The levels at which the capacity building activities took place
(N=143, multiple responses permitted)

LEVELS	NUMBER	PERCENT
Other organisations	126	88
Individual workers within other organisations	111	78
Networks (both formal and informal)	101	71
The external enabling (or impeding) environment	85	59
Your organisation (i.e. your own state/territory Peak body)	63	44
Individual workers within your state/territory Peak body	58	41

Strategies and levels of focus

Table 4, below, presents data on the 143 capacity building activities that the peaks have identified as being the most important or significant during the 2012-13 and 2013-14 years, combined. It cross-tabulates the four capacity building strategies with the six primary levels of focus. (Please note that these data cover responses not respondents. Multiple responses were permitted so the totals do not sum to 143 which is the number of activities. The marginal totals and percentages do not correspond to the two tables above for the same reason.)

The cells that contain more than 40 responses are highlighted in bold throughout the report. As noted above, the most frequently employed strategy was building sustainable linkages and strategic partnerships, and the most frequently reported level at which this occurred was the organisational level in agencies other than the peaks themselves.

The key elements from Table 4 are as follows:

- The largest combination (58 activities) was linkages/partnerships focussing on organisations external to the peak bodies themselves.
- This was followed in frequency by linkages/partnerships focusing on networks (52 activities).

- Also particularly prominent, in descending order, were
 - the strategy of service improvement focusing on other organisations, and linkages/partnerships focusing on the external environment (both 47 activities)
 - linkages/partnerships focusing on workers in other organisations (45 activities)
 - training activities focusing on other organisations (43 activities) and on workers in other organisations (42 activities)
 - providing information and other resources to organisations external to the peak bodies (42 activities).
- The strategy/level combinations that were least frequently used were training activities among the peak bodies' own staff (19), service improvement and the provision of information/resources focusing on workers in the peak bodies themselves, and training activities focused on the peak organisations themselves (all 23).

The key messages emerging from this rather detailed analysis of the activities that the peaks themselves rate as being their most important or significant over the two years are as follows:

- the peaks are using a wide range of capacity building strategies with building sustainable linkages and strategic partnerships being most prominent

TABLE 4

THE CAPACITY BUILDING STRATEGIES EMPLOYED AND THE LEVELS FOCUSED UPON
(N=143)

LEVEL OF FOCUS	CAPACITY BUILDING STRATEGY					ROW PERCENT
	LINKAGES/ PARTNERSHIPS	SERVICE IMPROVEMENT	TRAINING	INFO./ RESOURCES	TOTAL	
Other orgs	58	47	43	42	190	22
Workers in other orgs	45	39	42	39	165	19
Networks	52	37	39	33	161	19
External environment	47	36	30	27	140	16
Peak org.	38	25	23	24	110	13
Workers in own org.	28	23	19	23	93	11
Total	268	207	196	188	859	100
Column percent	31	24	23	22	100	

- they are focusing their capacity building work at a number of different levels, particularly undertaking activities that focus on their member and other organisations, and on networks.

The outputs of the capacity building activities

To conclude this presentation of the capacity building activities undertaken over the two years to 30 June 2014, it is instructive to review the outputs, that the participating peaks reported, of the 143 selected activities. (Evaluation question 5, below, discussed the outcomes. Here we consider outputs only.) In all, 222 outputs were reported and they

have been coded to the categories shown in Table 5, below. (A particular output could be coded to more than one category, with the result that the total number of outputs shown is greater than the total number of activities reported upon.)

The six categories of outputs that were reported most frequently composed two-thirds (68%) of the total. Those outputs are, in descending order of frequency, in the areas of sector planning (including strengthening referral pathways); training activities; the development and dissemination of resources relating to AOD treatment and screening, including an emphasis on mental health

The most frequently reported outputs (not outcomes) of the capacity building activities were

- *sector planning*
- *training activities*
- *resources relating to AOD treatment and screening*
- *networks & collaborations*
- *resources to strengthen AOD agency governance and*
- *participation in conferences, forums, etc.*

Capacity building is the primary goal in most of the activities, most of the activities fully or partially include an AOD/mental health comorbidity focus, multiple strategies are used, and the activities take place at diverse levels, focusing predominately at the organisational level among member organisations and related agencies.

comorbidity; strengthening networks and collaborations; producing and disseminating resources to strengthen AOD agency governance; and participation in conferences, forums, etc.

Other outputs, whilst important, were mentioned less frequently.

Conclusions regarding Question 1, the peaks' capacity building activities

The evaluation question dealt with in this section is 'In what ways have the NGO AOD peak bodies engaged in sector capacity building activities focusing on AOD treatment and related supportive activities?'. Unlike the other evaluation questions, the responses to this are largely descriptive, rather than evaluative. Based on an analysis of the activities selected by the seven participating peak bodies as being the most significant or important over the two years, we can conclude that capacity building is the primary goal in most of the activities (it is a secondary goal in the remainder), most of the activities fully or partially include an AOD/mental health comorbidity focus, multiple strategies are used, and the activities take place at diverse levels, focusing predominately at the organisational level among member organisations and related agencies.

The next section explores a broader question about how much of the peaks' overall efforts and resource allocations go to capacity building relating to AOD treatment and related supportive activities.

TABLE 5

The outputs of the selected capacity building activities
(number, multiple codes applied)

OUTPUT CATEGORY	NUMBER
Sector planning, incl. referrals pathways	38
Training activities undertaken	34
Treatment/screening/comorbidity resources produced & disseminated	24
Networking/collaborating	23
Agency governance resources produced & disseminated	18
Conference/forum participation	15
Policy/position papers developed	14
Peaks: sharing of resources	9
Peaks: awareness of other peaks activities and their resources	8
Newsletters produced & disseminated	8
Quality Improvement undertaken	7
University collaboration, incl. student placements	5
Websites upgraded	5
Service directories produced & disseminated	4
Stigma and discrimination awareness built	3
Data/information systems developed	2
Training calendars produced & disseminated	2
Community awareness built	1
Evaluation reports developed & disseminated	1
Funding submissions drafted & submitted	1

QUESTION 2:

How much of the peaks' effort is capacity building related to AOD treatment and related supportive activities?

Having described the ways in which the peaks engage in capacity building work we turn now to consider how much of their overall activities is devoted to capacity building related to AOD treatment and related supportive activities. This reflects the fact that they all engage in some activities that are not appropriately characterised as capacity building. Identifying the proportion of their work that focuses on capacity building is a central part of the evaluation considering the widespread acceptance of the importance of capacity building in the sector nationally.

The data demonstrate that, overall, capacity building is the dominant activity of the state and territory peaks around the nation, with their other activities absorbing just one-third of the peaks' staff and financial resources nationally.

More specifically, during the period July 2012 to June 2014, some two-thirds (65%) of the efforts of the seven participating peaks, as shown through the allocation of personnel and financial resources, went to capacity building activities. As per the terms of reference of the evaluation, comparisons of data relating to the individual peaks are not presented. It is noted, however, that

- the estimated proportions of the organisations' staff resources that were used for capacity building activities ranged from 41% to 83%, with a mean of 65% and median of 70%
- the estimated proportions of the organisations' financial resources that were used for capacity building activities ranged from 41% to 83%, with a mean of 65% and median of 66%.
- One of the peak bodies pointed out that the effectiveness of the staff resources funded under the SMSDGF is enhanced through activities that are not directly quantifiable in terms of staff time. This includes the 'Goodwill and in-kind contributions of high-level expertise we can garner which may not otherwise be forthcoming. Access to the intellectual knowledge capital of the total collective of the AOD and related peaks – a synergy effect – e.g. the "swap meet" of capacity building activities that occurs as a result of individual peak funding'.

These data were provided by the peaks themselves, along with supporting evidence. Some key features of these resource allocations included the following:

- Staff resources supported under the SMSDGF were used for both direct, instrumental capacity building activities such as brokering training courses, and for essential infrastructure activities such as staff supervision and back-office support.
- All the peaks have a number of other functions in addition to capacity building; these are funded from other sources. Examples include representation and some forms of advocacy.
- All the peak bodies employ some staff all of whose work is capacity building.

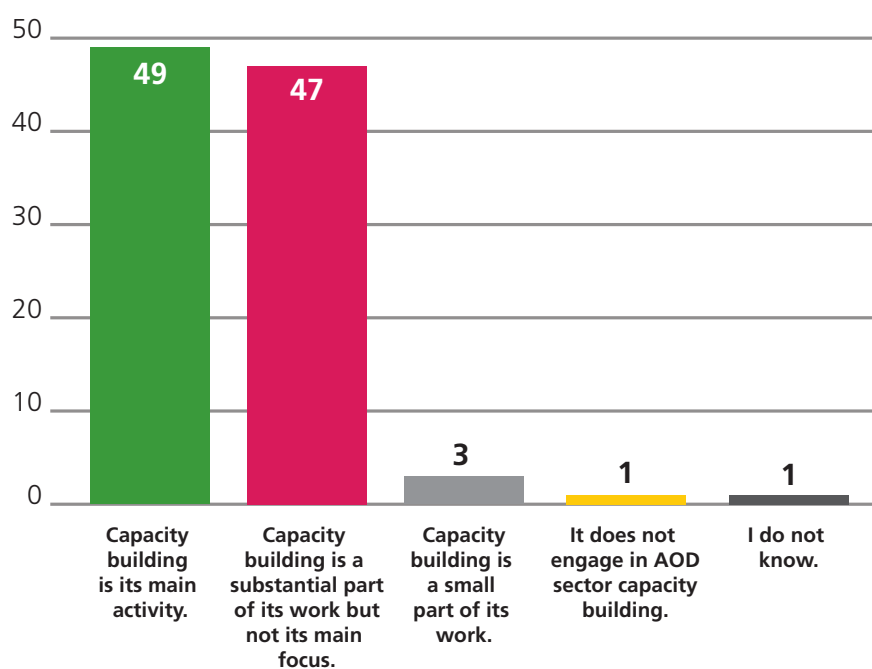
The key informant interviews corroborated the self-reported data on resource allocations provided by the peaks, with most interviewees indicating that well over half, or most of the peaks' activities, focused on sector capacity building.

Data provided by the survey respondents provide more details. When asked 'To what extent does that peak body engage in activities that aim to build the capacity of the AOD sector within its state/territory?' almost half indicated that capacity building is their peak's main activity or it is a substantial part of its work, with very few respondents indicating otherwise. Figure 2 has details.

Capacity building is the dominant activity of the state and territory peaks, absorbing some two-thirds of their financial and personnel resources.

FIGURE 2

Extent to which capacity building is the peak's main activity
(percent, N=105)



Having seen the extensive depth and breadth of capacity building activities undertaken by the peaks, and observed that capacity building composes the bulk of their work, we turn now to explore how sound is the rationale underpinning their capacity building activities.

QUESTION 3:

How sound is the rationale underpinning the peaks' capacity building activities?

This section deals with the central question about the soundness of the rationale underpinning the peaks' capacity building work. It commences with a presentation of the program theory after which the soundness of the rationale is evaluated.

Importantly, the peak bodies' roles in driving AOD sector capacity building activities to improve services for consumers has evolved over the years, in different ways in different jurisdictions, through the work of the individual peaks. This has been funded from various sources, with the Commonwealth's role becoming particularly important in recent years with the roll-out of the ISI and SMSDGF.

The overall assessment of the evaluation is that the rationale is sound, although the program theory has been largely developed retrospectively rather than as part of the early strategic planning process. The evaluative information supporting this conclusion follows.

The program theory

Too often, in the human services generally, programs are designed and implemented without explicit thought being given to their underpinning program theory. In other words, planners too often fail to explicitly identify the mechanisms by which program inputs and activities are expected to create valued outputs and outcomes.

A function of this evaluation is to make explicit the program theory underlying the capacity building work of the state and territory NGO AOD peak bodies, with an emphasis on treatment capacity building. Program theory has been defined as

*...an explicit theory or model of how an intervention, such as a project, a program, a strategy, an initiative, or a policy, contributes to a chain of intermediate results and finally to the intended or observed outcomes. A program theory ideally has two components: a theory of change and a theory of action. The theory of change is about the central processes or drivers by which change comes about... The theory of action explains how programs or other interventions are constructed to activate these theories of change.*¹²

Documenting the program theory is one of the tasks of this evaluation. It is important because the primary sources of program failure (obverse: program success) are generally taken to be (1) faulty program theory, (2) the difficulty of transferring program theory into programs that have high efficacy, and (3) inadequate fidelity of program implementation in the real world.¹³

One way of developing a statement of program theory is to ask 'What are the active ingredients that make this program work?'

Following one-on-one discussions with the seven peaks, the evaluator drafted a preliminary statement of the program theory. This was subsequently discussed with the individual peaks and the Peaks Capacity Building Network collectively, and modified based on their feedback and on data collected, through the evaluation, on their capacity building activities conducted across the nation during the period covered by the evaluation.

The statement of the program theory that underpins the national and state/territory capacity building activities, now agreed upon by the Peaks Capacity Building Network, is as follows:

The theory of change

The state/territory NGO AOD peak bodies, in consultation and collaboration with member organisations and other stakeholders, conduct or facilitate the conducting of a range of activities that assist member organisations to better attain their goals of providing high-quality treatment and related services to clients and, through

12 Funnell, SC & Rogers, PJ 2011, *Purposeful program theory: effective use of theories of change and logic models*, Jossey-Bass, San Francisco, CA, p. xix.

13 Adapted from Wholey, JS, Hatry, HP & Newcomer, KE (eds) 2004, *Handbook of practical program evaluation*, 2nd edn, Jossey-Bass, San Francisco.

The overall assessment of the evaluation is that the rationale is sound, albeit largely having been documented retrospectively rather than as part of early strategic planning processes.

doing so, to attain positive treatment outcomes. These capacity building activities and outcomes are seen at the levels of the broad system within which the AOD sector is embedded, individual AOD organisations, AOD organisations' staff performance, and the interactions of clients and the community with the organisations and the broader AOD sector. A key to success is the engagement of the peak bodies with their members. This engagement is both formal (through contracts) and organic, with the latter seen as genuine bonds that reflect shared values and commitments. The peak bodies have observably different roles from those of their members and other organisations, and operate in such a manner as to add value to the work of their members.

The theory of action

The state/territory peak bodies work with member organisations and other stakeholders to identify areas within which increased capacity needs to be built to produce better client outcomes in a cost-effective manner. The peak bodies develop strategies, and harness and deploy funding and other resources, to assist member organisations to meet the needs identified. The priorities of funding bodies are often powerful influences on the peak bodies' priority-setting. The capacity building strategies include, but are not limited to:

- Building sustainable linkages and strategic partnerships
- Assisting services to undertake service improvement

- Identifying and facilitating training opportunities
- Developing and promoting relevant information and resources.

The capacity building activities have three foci:

- The peak bodies developing their own capacity to operate effectively and efficiently
- The peak bodies developing their own capacity to develop capacity in other organisations
- The peak bodies directly developing capacity in other organisations.

These three foci are operationalised through activities that can be seen at one or more of these six levels:

- Individual workers within the state/territory peak bodies
- Individual workers within other organisations
- State/territory peak bodies themselves
- Other organisations
- Networks (both formal and informal)
- The external enabling (or impeding) environment.

When the capacity building strategies are implemented well, the operation of the sector as a whole is more effective; individual member organisations have improved governance and operational capacity; individual workers within member organisations are more highly skilled

and motivated to provide screening, assessment, treatment and referral interventions to clients; and clients and the community contribute more effectively to member organisations' operations. Furthermore, member organisations are more effective in lobbying and advocacy work that aims to improve AOD policy and resource allocation both nationally and within their individual state/territories and regions, although such advocacy, even when effective, provides no guarantee of continued funding of the peak body itself.

This statement of the theory of change and the theory of action helps to make explicit the assumptions underpinning the peaks' capacity building activities. It demonstrates how the resources are turned into activities, activities into outputs, outputs into immediate outcomes and immediate outcomes into longer term outcomes and impacts. It helps crystallise thinking about the importance of context, and guides data collection along the outcomes hierarchy.

Soundness of the rationale

The overall assessment of the evaluation is that the rationale underpinning the peaks' capacity building activities is sound. This conclusion is based on a definition of plausibility (how plausible is the underlying rationale?): 'The existence of necessary and sufficient conditions for a program to succeed'.¹⁴

14 Wholey, JS, Hatry, HP & Newcomer, KE (eds) 2004, *Handbook of practical program evaluation*, 2nd edn, Jossey-Bass, San Francisco, p. 202.

The soundness of the rationale is evidenced by four factors:

- the validity of key underpinning assumptions
- the fidelity of program implementation
- the extent of implementation
- the availability of resources.

Each of these is discussed in turn.

Assumptions

Four categories of assumptions underpinning the capacity building work are identified in the evaluation literature: diagnostic assumptions, prescriptive assumptions, transformational assumptions and external assumptions.¹⁵

Diagnostic assumptions:

'...stakeholders' expectations or beliefs of the major and minor causes of core problems'.

In this context, the 'core problem' that has been identified, nationally, is a need for continuing quality improvement in the operation of AOD organisations, including the attainment of a sufficient quantity of, and appropriate quality of, positive client outcomes. At both the organisational and workforce level agencies need to improve their capacity and capability so as to continue to meet needs.

These assumptions about the needs and the causes of contemporary challenges are sound.

Prescriptive assumptions:

'...relate to the intervention or strategy devised for the problem or to reach a stated objective, which represents stakeholders' beliefs of what could be the best ways to address the problem or need'.

All of the peak bodies have mechanisms in place for undertaking needs assessment and identifying a range of options available to improve the capacity of member organisations and, where appropriate, other organisations in the AOD and/or related sectors. All now have a body of knowledge and skills derived from their experience in designing and implementing capacity building activities that meet the needs of organisations within their individual jurisdictions. Partly through the work of the Peaks Capacity Building Network they have been active in sharing knowledge and experiences, providing a sound basis to their beliefs about what are the best ways to build capacity across the sector.

Transformational assumptions:

'...relate to how the immediate results of a strategy, program or intervention (outputs) are expected to lead to long term desired changes'.

This is always a difficult challenge for people designing programs that are relatively small but that address problems that are large and/or serious. The program theory statement makes explicit the underpinning assumptions about the relationship between the capacity

building activities, their products, their immediate outcomes and the attainment of longer and deeper goals.

Because capacity building activities have been undertaken in a number of the peaks over some years, and many of the activities have been subject to evaluations that have produced significant findings about their processes and outcomes, it is fair to conclude that the transformational assumptions underpinning the current capacity building activities are relatively sound.

External assumptions:

Assumptions about the 'preconditions for program success that are beyond the control of program stakeholders'.

These are assumptions about the context within which capacity building activities take place. Core assumptions are that the needs for quality NGO AOD services will continue well into the future but that the nature of the needs will change over time, with a concomitant need for services to be able to adapt. A clear trend exists for the up-skilling of the AOD workforce. It is probable that we are entering an era of greater financial restraint in parts of the AOD sector, meaning that organisations will need to continue to improve their capability to deliver quality services with potentially less resources in the future.

15 The source of the quotations in this section is American Evaluation Association 2013, 'Working with assumptions in program evaluation', AEA365: A Tip-a-Day by and for Evaluators, <http://aea365.org/blog/apollo-m-nkwake-on-working-with-assumptions-in-program-evaluation>. Further details are available in Nkwake, AM 2013, *Working with assumptions in international development program evaluation*, Springer, New York.

Survey participants rated the first three capacity building strategies as more important than the fourth.

These assumptions about factors that are beyond the control of the peaks' capacity building programs are sound and provide significant rationale for undertaking and, indeed expanding, NGO AOD capacity building activities.

Fidelity and extent of implementation of capacity building activities given the available resources

A criterion for assessing the soundness of the program theory – the rationale underpinning the capacity building activities – is the degree to which the activities are implemented as intended and have a significant enough reach to produce valued outcomes.

The activity data discussed under evaluation question one, above, indicates a high degree of fidelity of implementation of the capacity building projects (i.e. the programs have been implemented as intended, using strategies and modalities that have been demonstrated to be effective). Furthermore, the amount of capacity development work undertaken by the peaks within the limited amount of funds available is impressive. As discussed below, the evaluation has ascertained that the capacity building activities deliver good value for money.

Four capacity building strategies

The Peaks Capacity Building Network has identified four high-level strategies which they believe, when implemented well, will deliver sound capacity building outcomes. As noted, above, in describing the theory of action, those strategies are as follows:

- Building sustainable linkages and strategic partnerships
- Assisting services to undertake service improvement
- Identifying and facilitating training opportunities
- Developing and promoting relevant information and resources.¹⁶

Survey respondents were asked to identify the relative importance of these four strategies. The first and second listed, 'Building sustainable linkages and strategic partnerships' and 'Assisting services to undertake service improvements', were rated as the most important, closely followed by 'Identifying and facilitating training opportunities'. The strategy 'Developing and promoting relevant information and resources' was rated important, but not as important as the other three. This is particularly interesting considering the extensive efforts expended by a number of the state and territory peaks in developing and promoting information and resources. Table 6 has details.

It is recommended that the Peaks Capacity Building Network discuss the implications of these survey responses and take them into account in further capacity building strategy development. Ensuring that less attention is placed on developing and promoting information and resources than is placed on the other strategies is one approach. On the other hand, it may become apparent that developing those resources is a necessary, but not sufficient, component of some of the other strategies, particularly the second: assisting services to undertake service improvements.

The levels at which the work takes place

The theory of action spells out a number of levels at which the capacity building activities are understood to take place. The validity of this was assessed through asking survey respondents 'In your experience, at which of the following level or levels do the peaks' capacity building activities take place. (Please mark all that apply.)'. The most frequently identified levels, selected by 86% and 84% of respondents respectively, were 1) individual workers within AOD organisations other than the peak bodies themselves and 2) networks, both formal and informal. As will be noted from Table 7, below, the level of 'Other organisations in the AOD sector and/or related sectors' was also frequently identified. The least frequently identified level was 'The external enabling (or impeding) environment'.

¹⁶ Note: In May 2014, as part of a detailed discussion between the evaluator and the members of the Peaks Capacity Building Network at which we explored the program theory underpinning Network members' capacity building work, a fifth strategy was identified, namely *advocacy on behalf of members for AOD system change, improved policy and agenda setting, with the aim of achieving improved AOD infrastructure and funding*. Although advocacy as a strategy is dealt with in a number of places in this report, in accordance with the agreed-upon evaluation protocol it has not been added to this list of four key strategies.

In thinking about the levels at which the capacity building activities take place, survey participants most frequently identified 1) focusing on workers in AOD organisations other than the peaks themselves, and 2) networking.

TABLE 6

The relative importance of four capacity building strategies on a scale of 1 to 4, where 1 represents the most important and 4 the least important (number of responses)

STRATEGY	1 MOST IMPORTANT	2	3	4 LEAST IMPORTANT	N.
Building sustainable linkages and strategic partnerships	51	30	15	10	106
Assisting services to undertake service improvement	49	31	13	12	105
Identifying and facilitating training opportunities	44	32	23	6	105
Developing and promoting relevant information and resources	36	19	21	30	106

TABLE 7

The levels at which the capacity building activities take place (multiple responses permitted, 104 responses)

LEVEL	NUMBER	PERCENT
Individual workers within other AOD organisations	89	85.6
Networks (both formal and informal)	87	83.7
Other organisations in the AOD and/or related sectors	74	71.2
The state/territory peak body itself; the organisational level	67	64.4
Individual workers within the state/territory peak body	60	57.7
The external enabling (or impeding) environment	35	33.7

These findings are consistent with the program theory and the assumptions underlying the capacity building work, and accord with the prioritisation given by survey respondents to the capacity building strategies discussed above. Focusing on workers in AOD organisations other than the peaks themselves, and operating through and building networks, have been identified by the peaks as key ways of achieving their capacity building outcomes.

Most of the key informants assessed the rationale underpinning the capacity building activities as being sound.

Key informants' views on the soundness of the rationale

Some key informants pointed out that, in their understanding, most of the peaks did not commence their capacity building work with sophisticated strategy development based upon a statement of program theory and detailed program logic statements. It is noted that funding bodies generally do not call for this to be documented in grant applications, though they usually ask for the expected outcomes to be specified. Key informants suggested that, to a large extent, the successful activities and outcomes of the peaks reflect experiential learning, rather than ex ante program theory development and strategic thinking. Nonetheless, most of the key informants assessed the rationale underpinning the capacity building activities that have been implemented, and are currently being implemented, as sound.

A number pointed to the fact that the peaks with which they are most familiar very closely engage with their members and the broader AOD sector within their state/territory, and have clearly articulated strategies for obtaining feedback from members and others. These approaches help them to know about the needs and expectations of their members, ensuring that the capacity building activities are well grounded. This is another way of saying that the rationale for the activities is sound,

insofar as they meet the felt needs of member organisations.

Some key informants commented on the challenges confronting the smaller NGOs in the context of sector reforms including approaches to funding that incorporate contestability. An implication of this is that the peaks' capacity building strategies need to be increasingly responsive to the diversity of the sector. This implies some complexification of the program theory to reflect the complexity of the environment.

Conclusions regarding the soundness of the rationale

This section commenced by documenting the program theory (the theory of change and the theory of action) that underpins the peaks capacity building work. That statement has been developed through the evaluation and did not exist earlier. This means that much of the strategy development work over the years, relating to capacity building among the peaks' member organisations, has been based on experiential learning rather than ex ante program theory construction.

Nonetheless, on the basis of a range of indicators, the evaluation concludes that the rationale underpinning the design and implementation of the capacity building activities is broadly sound. This is confirmed through tapping the views of both key informants and

survey participants. They confirmed that the key capacity building strategies employed by the peaks are sound, as are the levels at which the activities take place.

The Peaks Capacity Building Network may care to discuss the utility of further documenting the program theory underpinning their work. This could be done in fairly general terms as in this section, taking a national view; at the level of the individual peaks' state/territory programs as a whole; and/or with respect to individual, significant capacity building activities.

While it is important to have a strong rationale underpinning the strategies and activities employed to improve sector capacity, that is not sufficient. Quality, and fidelity in implementing the strategies and activities, are also crucial. Implementation is dealt with in the next section.

QUESTION 4:

How well have the peaks' capacity building strategies and activities been implemented?

The previous section revealed that the rationale for the peaks capacity building activities, including the underlying assumptions, is sound. That alone, however, does not tell us about their quality, value and importance. In this section we consider how well those strategies and activities were implemented during the 2012-2014 period.

Research in the discipline of implementation sciences draws attention to the stages of implementation: exploration and adoption, program installation, initial implementation, full operation, innovation and sustainability.¹⁷ This section's evaluation of implementation covers all of those stages.

'Implementation' has been defined, in the context of implementation theory, as 'a specified set of activities designed to put into practice an activity or program of known dimensions'.¹⁸ It stresses the differences between implementation processes and outcomes, and effectiveness processes and outcomes. The former asks 'Are they implementing the program as intended?' while the latter notes that, if the answer to the first question is 'yes', we ask 'What kinds of outcomes is the program that has been implemented producing?'. Essential implementation outcomes have been identified as

1. changes in professional behaviour
2. changes in organisational structures and cultures, both formal and informal, and
3. changes in relationships to consumers, other stakeholders and systems partners.¹⁹

We noted above that the stages of implementation are, in temporal sequence: exploration and adoption, program installation, initial implementation, full operation, innovation and sustainability. The state and territory AOD sector peak bodies are at various stages of maturity, as are the particular capacity building programs that they are implementing. With regard to those capacity building strategies and activities:

- All have successfully completed the *exploration and adoption* phase, as evidenced by the successful negotiations between them and funding bodies, particularly the Commonwealth under the ISI and SMSDGF, culminating in the signing of contracts that set out the capacity building activities and intended objectives that are agreed upon.
- All have successfully completed the *program installation* phase, as evidenced by their agreed-upon capacity building programs. These are the things that need to be successfully completed before the capacity building programs

are actually rolled out, including confirming the funding streams, having suitably qualified staff in place, clarity about what the program will look like, along with its governance and monitoring, etc.

- *Initial implementation* of the capacity building activities has occurred across the country over recent years. Although it was beyond the scope of this evaluation to investigate the details of the challenges that individual peaks met in rolling out capacity building activities, and how they dealt with those challenges, the fact that the programs have been in place for some years, in many cases, indicates that the initial implementation tasks are been done reasonably well.
- Five of the seven peaks participating in this evaluation have been operating for many years, with two (ATDC and ATODA) having been developed more recently. This means that the capacity building work in most of the peaks is well into the *full operation* phase of implementation. This is evidenced by the range of monitoring and evaluation reports that have been produced over the years, the results of the regular stakeholder feedback surveys, etc.

17 Fixsen, DL, Naoom, SF, Blase, DA, Friedman, RM & Wallace, F 2005, *Implementation research: a synthesis of the literature*, FMHI Publication #231, University of South Florida, Tampa, FL.

18 *Op. cit.*, p. 5.

19 *Op. cit.*, p. 12.

The peaks' capacity building activities have been implemented well, particularly considering the level of resources available.

- *Innovation* is the fifth phase in the implementation process. It sits at this point in the sequence because research into implementation has confirmed that it is risky to innovate before a program is in full operation. This is because it is important to deal with initial implementation challenges and then interrogate the products of monitoring and evaluation systems to determine what changes are required—but this can only be done effectively once the program is mature and in full operation. It is clear that most of the peaks have reached the innovation stage with a number of their capacity building activities, as evidenced by the fact that they seek funding for new and expanded activities as changing needs and opportunities arise.
- The final stage of the implementation process is *sustainability*. The fact that a number of the peaks have been operating, with success, for some decades indicates a significant degree of sustainability for them as organisations. The sustainability of the more recently created peaks, however, has not yet been demonstrated. In addition, as discussed elsewhere in this report, the sustainability of the peaks' capacity building activities of the type that they have been conducting during the period that this evaluation covers, is not self-evident. One of the findings of the evaluation is the importance of the Commonwealth collaborating

with the peaks with the aim of ensuring stability of capacity building program implementation, and maintaining the sound outcomes that have been observed to date.

Based on the evidence elicited through this evaluation, we can conclude that the peaks' capacity building activities have been implemented well, particularly considering the level of resources that they have available for this work.

The evidence for this conclusion comes in part from the survey respondents who were asked to indicate how effectively and efficiently the capacity building activities were implemented within their respective jurisdictions. With regard to effectiveness (the extent to which particular capacity building objectives were attained) 93% indicated that implementation was highly effective ('very valuable') or effective ('fairly valuable').

With regard to efficiency (the extent to which particular capacity building objectives were attained with the minimum resource expenditure) 94% indicated that implementation was highly effective ('very valuable') or effective ('fairly valuable'). Table 8 has details.

The key informants were also asked for their assessment of quality of implementation. Seven of the eight indicated that implementation was very good or excellent, with one pointing to some serious (but not fatal) implementation failures.

These informants pointed to a number of matters that are relevant to the implementation of the capacity building activities, including the following:

- In some jurisdictions program implementation has been difficult because of external pressures, particularly changing service systems.
- Most of the peaks are closely engaged with their members and, as a consequence, receive rapid and frank feedback which supports quality implementation.
- Internal and external reviews/evaluations are used for ensuring continuous quality improvement.
- Policy workers in public service agencies frequently seek their support in project implementation, demonstrating their confidence in its quality.
- The negative comment, suggesting that implementation was barely adequate, related to the key informant's concerns regarding the scope of activities of their jurisdictions' peak, with too much emphasis being placed on training activities rather than on more systemic capacity building activities, including contribution to state-wide AOD policy work.

TABLE 8**Effectiveness and efficiency of implementation**

('How valuable were the activities and outcomes on the criteria of...') (number)

CRITERION	VERY VALUABLE	FAIRLY VALUABLE	OF LOW VALUE	OF VERY LOW VALUE	DON'T KNOW	TOTAL
Effectiveness (i.e. the extent to which its objectives are attained)	59	39	4	2	1	105
Efficiency (i.e. the extent to which its objectives are attained with the minimum resource expenditure)	55	39	2	4	4	104

Having concluded that, overall, the capacity building activities have been implemented well, we now need to consider the outcomes attained by those activities: what have been the outcomes, and how valuable are they at the levels of the AOD system, organisations, workers and the clients/community? This evaluation question is answered in the next section.

QUESTION 5:

How valuable are the outcomes of the capacity building work?

The previous section revealed that, overall, the quality of implementation of the capacity building activities over the two years under review has been high. It is possible, however, to have activities implemented with a high degree of fidelity and quality, but not produce valued outcomes. Accordingly, in this section we assess just how valuable have been the outcomes of the capacity building activities at the levels of the AOD system, organisations, workers and client/community.

The evidence shows that, overall, the outcomes of the peaks' capacity building work are overwhelmingly considered to be of significant positive value. This was demonstrated through the great extent to which positive outcomes have been achieved; the value of the outcomes as assessed by both survey respondents and key informants; the positive changes that have been observed to flow from those outcomes; the presence of a number of unintended positive outcomes; very few, largely not serious, unintended negative outcomes; and, finally, a range of useful lessons learned through involvement in the capacity building work.

The outcomes attained

Before presenting the data that enable us to assess the value of the outcomes of the capacity building work of the peaks, it is helpful to gain an overview of what those outcomes have been. The responses to the first evaluation question provided details on the

sector capacity building activities. There it was pointed out that each of the seven participating peak bodies identified approximately 20 of their capacity building activities, undertaken during the two years to 30 June 2014, that they considered to be particularly important or significant. They described not only the activities but also the outputs, immediate outcomes and observed or anticipated longer term outcomes.

For the purposes of the current analysis, I have selected the longer term, deeper outcomes from these activities that have been observed as having been attained, rather than simply being expected to occur in the future.

Table 9, below, has details. The most significant observation is that nine categories of outcomes are dominant, namely increased awareness of best practices in AOD service delivery, strengthened networks and collaborations, increased implementation of best practices in AOD service delivery, better skilled AOD agency staff, enhanced dissemination of information and other resources, improved awareness of and responses to complex needs clients, improved agency governance improved sector planning and stronger mental health responses. Between them, these nine categories of outcomes composed three-quarters (76%) of all the reported outcomes during the two years.

The outcomes of the peaks capacity building work are considered to be of significant positive value as demonstrated by

- *positive outcomes have been achieved*
- *the outcomes are valuable*
- *positive changes observed*
- *some unintended positive outcomes were observed, but there were few, largely not serious, unintended negative outcomes*
- *a range of useful lessons were learned.*

The 3rd to 6th columns in Table 9 disaggregate the number of outcomes in each category by the particular capacity building strategy employed to produce them. The largest number was produced by the strategy that we have characterised as building sustainable linkages and strategic partnerships ('Linkages' in Table 9).

Having identified the most significant and important outcomes produced by the peaks capacity building activities during the 2013-14 year, we now turn to the evaluative data that help us answer the question 'How valuable are the outcomes at the levels of the system, organisation, worker and client/community?'

Most of the observed outcomes were in the areas of increased awareness & implementation of best practices in AOD service delivery, strengthened networks and collaborations, better skilled AOD agency staff, enhanced dissemination of resources and other information, and improved agency governance.

TABLE 9

Longer term outcomes observed from the activities by capacity building strategy
(number, multiple codes applied)

OUTCOMES ACHIEVED	CAPACITY BUILDING STRATEGY					SUM
	ALL STRATEGIES	LINKAGES	SERVICE IMPROVEMENT	TRAINING	RESOURCES/ INFO	
Best practice awareness	45	17	19	16	17	114
Networking/collaboration strengthened	43	25	13	11	15	107
Best practice implementation	38	13	18	12	15	96
Agency staff up-skilled	37	11	15	18	16	97
Resources & info. dissemination enhanced	25	10	8	5	11	59
Better awareness & responses to complex needs	24	11	5	10	11	61
Agency governance improved	23	4	14	6	8	55
Sector planning improved	20	13	5	3	4	45
Mental health responses stronger	18	8	4	9	9	48
Community awareness of AOD enhanced	8	5	1	2	4	20
Improved referrals systems	8	5	2	1	1	17
Knowledge of member services improved	7	5	1	2	1	16
Improved worker satisfaction	7	1	3	3	--	14
Improved responses to Indigenous needs	6	4	2	1	2	15
Quality Improvement/standards enhanced	6	--	5	1	3	15
More engagement in capacity building	6	2	3	2	3	16
Peaks function more effectively	6	6	1	1	1	15
Stigma and discrimination strategies implemented	6	3	2	--	2	13
Policy work strengthened	6	3	1	--	2	12
Better use of data	5	--	3	2	3	13
Building the evidence base	5	3	3	1	1	13
Build collaborations with research organisations	5	3	2	3	1	14
Stronger advocacy	4	3	1	--	1	9
Consumer participation strategies implemented	1	1	--	--	--	2
Better responses to new psychoactive substances	1	1	1	1	1	5
Improved women's services	1	--	1	1	1	4
Sum	361	157	133	111	133	--

A range of important outcomes has been produced.

The extent to which capacity building outcomes have been achieved

Survey respondents were presented with a short list of possible outcomes of their state/territory peaks capacity building activities, and asked to indicate the extent to which any of the listed outcomes had been achieved (so far as they knew). Of the seven categories of possible outcomes presented, most respondents indicated that three of them had been achieved to a great extent or to some extent. Specifically, 92% identified 'AOD sector workers are better skilled and/or more confident in their roles', 90% identified 'creating a more effective AOD sector' and 80% identified 'AOD services create improved service user outcomes'. Over 60% identified each of the other listed potential outcomes as being achieved to either 'a great extent' or 'to some extent'. Details are in Table 10.

TABLE 10

Extent to which outcomes have been achieved
(number)

OUTCOMES	TO A GREAT EXTENT	TO SOME EXTENT	TO ONLY A VERY SMALL EXTENT	NOT AT ALL	DON'T KNOW	N.
AOD sector workers are better skilled and and/or more confident in their roles	40	57	5	0	3	105
Creating a more effective AOD sector	53	41	6	2	2	104
AOD services create improved service user outcomes	30	54	11	4	6	105
AOD services are delivered more effectively and/or efficiently	21	59	14	4	6	104
Creating positive impacts on the external environment	31	45	18	1	9	104
The clients and community members participate more effectively in the organisations from which they receive AOD services	23	52	20	3	6	104
The member organisations of the peak body have attained better governance and operations	26	45	11	1	20	103

The outcomes realised are rated as being very valuable.

The value of the capacity building outcomes

While it is important to achieve a range of outcomes, it is also important to identify just how valuable those outcomes are from the point of view of the peaks' members and external observers. Accordingly, survey respondents were asked to assess how valuable were the outcomes that they had identified. They were presented with the five criteria listed in the first column of Table 11, below. Overall, the outcomes were rated as being of very high value, with 90% or more of respondents rating them as 'very valuable' or 'fairly valuable' on each of the following criteria: relevance to the needs of the AOD sector; effectiveness; efficiency; and degree of impact in such areas as AOD service provision, service user outcomes, AOD workforce development and the broader AOD sector. In addition, 83% judged the outcomes as being very or fairly valuable on the criterion of sustainability of the impacts. Table 11, below, has details.

TABLE 11

How valuable are the outcomes achieved?
(number)

CRITERIA	VERY VALUABLE	FAIRLY VALUABLE	OF LOW VALUE	OF VERY LOW VALUE	DON'T KNOW	N.
Relevance to the needs of the AOD sector	78	22	4	1	0	105
Effectiveness	59	39	4	2	1	105
Efficiency	55	39	2	4	4	104
Degree of impact	58	37	4	3	3	105
Sustainability of the impacts	40	46	4	3	11	104

The eight key informants were also asked their judgement about how valuable have been the outcomes. All but one indicated that the outcomes were of very high value. For example

- Over the years the outcomes have been incredibly valuable, especially the Improved Services Initiative which has helped develop a cohesive, highly skilled sector with clarity over how to build mental health capacity.
- Very high value outcomes which are demonstrated through documentation and other means. Further evidence is that people in public sector agencies seek out the peak for its staffs' support and advice.
- Very valuable contributions to policy work, always included in government advisory and governance structures.
- At the worker level very valuable in enhancing their responses more effectively and adroitly. Member organisations get more valuable outcomes than do non-member NGO/private sector organisations, particularly regarding service quality, communication of the evidence base, etc.

The capacity building activities have created a range of positive changes, at various levels.

Overall, 94% of survey respondents indicated that beneficial changes (improvements) had occurred with respect to AOD service delivery practice.

The key informant who rated the outcomes as being of not particularly high value indicated this is because the scope of the work, hence the scope of the outcomes, is too limited, though has high potential. In referring to scope they meant the activities chosen by the peak to be its primary focus were too narrowly focused, rather than that the level of resourcing of activities was insufficient.

Specific changes created by the capacity building activities

An early part of this section reported upon the extent to which the capacity building activities are understood to have created valued outcomes and, overall, survey respondents indicated that positive outcomes have been achieved to a very high extent. It is useful to drill down further to identify the specific changes at the various levels that people understand to have occurred as a consequence of those capacity building activities.

Overall, 94% of survey respondents indicated that beneficial changes (improvements) had occurred with respect to AOD service delivery practice. Furthermore, 87% reported that, in their experience, beneficial changes had also occurred with respect to service user outcomes, organisational change within AOD agencies, and changes at the AOD system level. Considering that these are the primary goals of the peaks' capacity building activities, this is a positive outcome. Table 12 has details.

TABLE 12

Specific changes created by the capacity building activities
(number)

CHANGES	SIGNIFICANT BENEFICIAL CHANGES	SOME BENEFICIAL CHANGES	NO BENEFICIAL CHANGES	N.
Improvements in AOD service delivery practice	49	50	6	105
Improvements in service user outcomes	33	56	13	102
Improved organisational change in AOD agencies	33	56	13	102
Improved AOD system changes	30	61	14	105
Other changes (positive or negative)	15	38	16	69

Survey respondents were invited to provide more information about the types of changes that they had observed. 54 provided details, most of them pointing to more than one change created by the capacity building work. All but one of the changes mentioned were positive. (The single negative change reported was that the peak body competes with other agencies in the state for the limited government funding available. This reflects the funding arrangements for the SMSDGF. Separate funding for the peaks and the treatment/harm reduction agencies was provided under the CSSSP.)

The responses are categorised in Table 13, below. The most frequently mentioned change was improvements in service delivery. As one would expect, this is consistent with the corresponding multiple-choice question the responses to which are given in Table 12, above. In order of number of mentions, this was followed by the building or strengthening of collaborations and consortia, and improved service systems. The other categories had far fewer mentions.

The unintended outcomes of the capacity building work are almost entirely positive.

TABLE 13

Examples of the specific changes created by the capacity building activities (number coded from open-ended responses provided by 54 respondents)

TYPE OF CHANGE OBSERVED	NUMBER
Service delivery improved	19
Collaborations/consortiums built &/or strengthened	14
Service systems improved	14
Networking strengthened	7
Higher qualifications attained	7
Client outcomes improved	5
Resource availability increased	5
Mental health comorbidity collaborations and service delivery strengthened	5
Advocacy improved	4
Client outcomes data utilisation improved	3
Governance of agencies strengthened	3
Consumer engagement and consumer led initiatives built	2
Information dissemination improved	2
Quality assurance/accreditation expanded	2
Aboriginal peoples voices increasingly heard	2
Community engagement strengthened	1
Grants management improved	1
Women's needs better attended to	1

Unintended outcomes, positive and negative

In exploring outcomes, it is important to identify both the hoped-for outcomes and any unintended outcomes. The latter can be either positive or negative. Survey respondents were invited to describe any such unintended consequences.

Positive unintended consequences

A range of positive unintended consequences were identified by 27 – one quarter – of respondents. By far the most frequently identified was the building of networks and strengthening collaboration – though most of the peaks would consider these to be intended, rather than unintended, outcomes.

Fewer respondents (four) identified service improvements and the provision of support to service agencies as unintended positive consequences; three emphasised advocacy work; two referred to improved external relationships especially with governments, and contributions to policy work; promoting organisational standards and a higher focus on the AOD sector; and one identified the support of and involvement of people who use drugs and their organisations, and outreach to the general public, informing them about AOD issues.

As mentioned above, in response to evaluation question five about the value of the capacity building work, the staff of each of the peaks selected around 20 of the most significant or important capacity building activities, and documented them describing the activities,

Various lessons have been learned through involvement in the capacity building work, particularly around networking/ collaboration and the importance of sharing information and other resources.

outputs, immediate outcomes and longer term outcomes, both observed and anticipated. An unintended positive outcome of this activity, as reported by some of the staff who undertook that work, was that it helped them to build their skills at program logic design and outcome analysis.²⁰ These are generic skills valuable in any context where strategic planning and policy/ program evaluation are important.

Negative unintended consequences

Only 7 of the 105 respondents identified what they considered to be negative unintended consequences of the capacity building work. Two indicated that this was the case with respect to the peaks competing with other organisations in the sector for the limited available funding. Two drew attention to differing perspectives between their peak body and agencies within their state/ territory, one referred to duplication of activities, one stated that the Minimum Qualification Strategy is a waste of time and money, and one expressed discontent with 'Too many useless meetings'.

Lessons learned

A potential outcome of the peaks' capacity building activities is that people who have been involved in them, or who have observed those activities if they were not directly involved, have learned some broader lessons from those experiences.

When asked about this, 61% of respondents stated that they had learned such lessons, 12% said they had not and 27% said that they were unsure.

The most frequently reported lessons learned were concerned with networking (14 reports), the power of collaboration (12), and the importance of sharing information and resources (11). Others mentioned (less frequently) included

- the importance of advocacy
- creating learning opportunities
- managing change
- the challenges of collaboration
- how to improve service provision
- the positive roles of the peaks, including that they can deliver valued outcomes
- the importance of a sector focus
- better understanding changes occurring in the AOD sector as a whole
- that engagement with the peak can help people develop skills and learn new tools for their work
- that strong leadership exists within the sector
- the importance of networking with the mental health sector.
- No negative learning experiences were reported.

Conclusions regarding outcomes

The evidence presented in this section leads to the conclusion that the peaks' capacity building strategies and activities have created a significant range of outcomes that are both positive and highly valued by both the participants in those activities and others who have observed them, although they have not been directly involved. Although a pleasing result, if the capacity building work has a high opportunity cost in settings in which very limited funds are available for the sector, there would be reason for concern. Accordingly, in the next section we explore the extent to which this work has provided value for money.

20 This is known, in evaluation theory terms, as 'process use' of evaluation: Cousins, JB (ed.) 2007, *Process use in theory, research, and practice*, New Directions for Evaluation, no. 116, Jossey-Bass, San Francisco, Calif.

QUESTION 6:

To what extent have the capacity building strategies and activities delivered value for money?

The previous section revealed that the outcomes of the peaks' capacity building work are judged, overall, to be highly valuable. In this section we explore the extent to which those capacity building strategies and activities have represented good use of the available resources to achieve valued outcomes, i.e. constitute good value for money.

Although it did not fall within the scope of the evaluation to identify the total amount of money expended by the peaks on capacity building activity, the evaluation has identified, above, that nationally approximately 65% of the peaks' total expenditures went to capacity building activities.

When asked about value for money, survey respondents indicated that the outcomes achieved represent a good return on investment, with 90% stating that they have delivered high or fair value for money. Only 4% considered them to have delivered poor value for money. Table 14, right, has details.

Of the eight key informants, six indicated that the peaks provide high or excellent value for money, and one was not able to assess this. One key informant indicated that, although their state's peak failed to deliver high value for money, they were encouraged by the fact that this evaluation is taking place, believing that its findings may assist the peak to improve its cost effectiveness/value for money.

TABLE 14
Value for money

VALUE	N.	PERCENT
High value for money	69	65
Fair value for money	27	25
Poor value for money	4	4
Don't know	6	6
Total	106	100

Having observed that, generally speaking, the peaks have delivered a significant range and depth of useful outcomes and, in doing so, have delivered good value for money, we now consider the implication of the evaluation's findings for the future of their capacity building functions.

The peaks' capacity building work has delivered good value for money.

QUESTION 7:

What are the implications of the evaluation's findings for the future of the peaks' capacity building functions?

The overarching findings of this evaluation, documented above, are that capacity building has been implemented by the peaks, in recent years, in many different ways and at number of different levels. Some 65% of the peaks' activity and financial expenditures goes to capacity building, the rationale underpinning that part of their work is sound, implementation has been good, producing valued outcomes, and those outcomes constitute sound value for money. Given those findings, what are their implications for the future of the peaks' capacity building functions?

Survey respondents were asked to indicate what priority AOD sector capacity building should be for their respective state/territories peak bodies over the next few years. Almost all respondents – 91% – indicated that capacity building should definitely be a high priority, with only 2% indicating that it should be a low priority. Table 15 has details.

The key informants discussed what they see as the likely future of the peaks' capacity building activities, including the extent to which they are sustainable. A range of views was expressed, including the following

- It would be a huge loss if the state peak disappeared as it is 'the glue that keeps the sector together'. It helps to maintain the balance of power in the sector, creating a fair and equal playing field.
- Commonwealth Government funding has been crucial to the capacity building work. It is unclear how this work could continue were those funds to no longer be available.
- The state will continue to fund the peak despite the unknowns about Commonwealth funding. Expectations on the peak will continue to grow and will become increasingly difficult for the organisation to manage.
- The focus in the future should be on strengthening the members' own capacity to operate effectively, responding to changing needs, without relying too much on external funding sources.

TABLE 15

The priority that sector capacity building should be for the state & territory peak bodies over the next few years

PRIORITY	N.	PERCENT
Capacity building should definitely be a high priority	96	91
Capacity building should be a priority, but not a particularly high priority	7	7
Capacity building should be a low priority, other things are more important	2	2
Don't know	1	1
Total	106	100

Sector capacity building should continue to be the peaks' main activity. It would be helpful for the peaks and the Commonwealth to collaborate to identify strategies for strengthening the sustainability of the peaks' capacity building work.

- The focus in the future should be on increasing professionalism, improving governance and better data management.
- Strategic planning is needed to reduce reliance on government funding, perhaps through involving the private treatment sector and setting membership fees at levels that adequately reflect the services that members receive. Membership fees should be at least at the levels charged by professional associations.
- The increasing move towards contestability in funding will probably result in fewer small AOD organisations and more large ones. A consequence of this will be the need for the peaks to better engage with the large (including national) NGOs.
- Some of the peaks need to become more sophisticated, especially by becoming a better conduit of information to support government policy development activities. They should focus more on the broader policy context within which they operate, rather than narrowly on members' immediate needs.

Sector capacity building should continue to be the peaks' main activity. It would be helpful for the peaks and the Commonwealth to collaborate to identify strategies for strengthening the sustainability of the peaks' capacity building work.

CONCLUSIONS

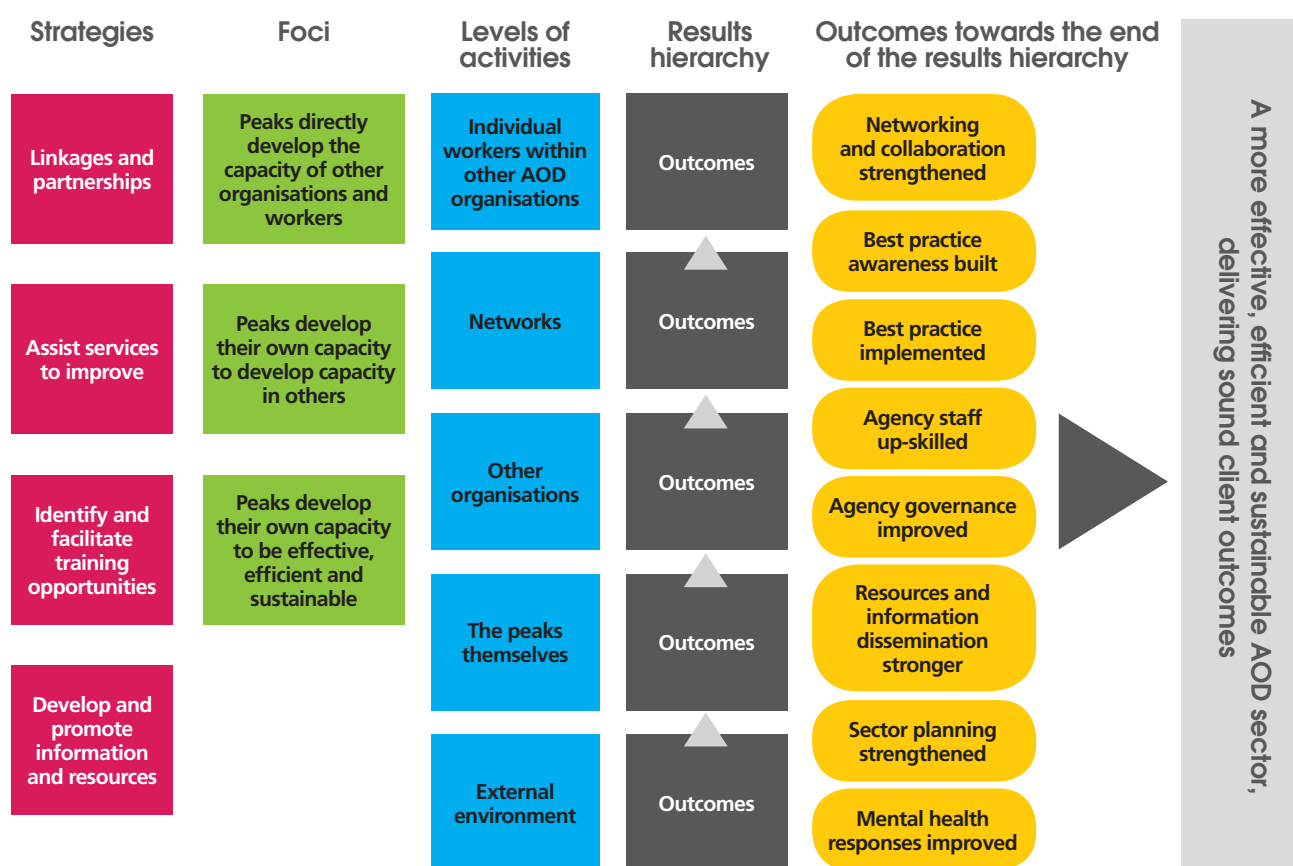
The evaluation has identified a wide range of activities, undertaken by the seven participating NGO AOD peak bodies, aiming to build the capacity of member organisations and the broader AOD sector to anticipate and respond appropriately to the AOD needs of the Australian community. Some of the peaks have been doing this over many years whereas others have been more recently developed. Commonwealth funding under the SMSDGF, and the AOD/mental health comorbidity Improved Services Initiative that preceded it, has been critically important to this work, along with funding from other sources, particularly the state/territory governments and member contributions.

Evaluation question three discussed the program theory that underlies the capacity building work. That part of the evaluation concluded that the underpinning rationale and assumptions are sound. Figure 1, below, draws together in summary form key elements of the program theory and the evaluation findings about the capacity building strategies implemented, the foci of those activities and the levels at which they are applied, and the types of outcomes demonstrated towards the end of the results hierarchy.

It is recommended that the Peaks Capacity Building Network use this framework in their ongoing strategic planning for building the capacity of the Australian AOD NGO sector to create improved client outcomes.

FIGURE 1*

The program theory and evaluation findings



* Note: This is labelled 'Figure 1' as it is the same visualisation as Figure 1 in the 'In brief' section of this report.

APPENDIX 1:

the 143 capacity building activities discussed at evaluation question 1

These are the capacity building activities that were identified by each of the peak bodies as being the most important or significant among those that they have conducted during the two years to 30 June 2014.

PEAK BODY

ATDC (Tas.)

- 2014 ATDC Conference: Visions and Values: Setting the Scene for the Future
- ATDC/UTAS Research Symposium
- Biennial Comorbidity Symposium
- Communication Activities
- Comorbidity Bus Tours
- Comorbidity Workplace Exchange Project (CWEP)
- Consumer Engagement and Participation
- Consumer Engagement Training
- Drug Action Week
- Drug Law Reform Roundtable
- Information Sessions
- Involvement in Subject Matter Expert Reference Group
- Peaks Capacity Building Network
- Regional ATDC member meetings
- Tasmanian Suicide Prevention Community Network (including annual form)

ATODA (ACT)

- 6th Annual ACT Alcohol, Tobacco and Other Drug Conference
- Aboriginal and Torres Strait Islander Alcohol, Tobacco and Other Drug Worker Workshop
- ACT Alcohol, Tobacco and Other Drug Minimum Qualification Strategy
- ACT Alcohol, Tobacco and Other Drug Services Directory
- ACT eASSIST Stage 1 Pilot
- ACT Specific ATOD Training packages
- ACT Training and Professional Development Calendar
- ATODA Website (www.atoda.org.au)
- Canberra Collaboration ATOD Research Networking Workshop
- Comorbidity Bus Tour
- Free NRT for ATOD, mental health and youth workers
- Identifying Quality Improvement Activities for Inclusion in Specialist ACT ATOD services contracts with ACT Health
- Partnership with the mental health and youth peak bodies in the ACT
- Peaks Capacity Building Network
- Pilot of Post-Graduate Level Training Opportunities (part of the ACT ATOD Qualification Strategy)

- Progressing a comprehensive response to blood-borne virus prevention, management and treatment, with a specific focus on hepatitis, in specialist ACT ATOD treatment and support services
- Public Forum and Roundtable Meeting – Professor Beau Kilmer
- Reconciliation Working Group
- Screening for substance use and related issues by specialist alcohol, tobacco and other drug treatment and support services in the ACT: Discussion paper
- Smoking Care Training
- The monthly Research eBulletin
- Workplace Tobacco Management Policies (Template and Support)

NADA (NSW)

- ACHS EQuIP5 Resource Tool
- Applied Suicide Intervention Skills Training - Trainers Network
- Benchmarking Guide
- Capacity Building Communication
- Case Notes training for Managers and frontline workers
- Community (re)Integration Forum
- Community Mental Health Drug and Alcohol Research Network Forums
- Client Outcome Management System (COMS) Training and Support
- Direct member support
- Member networks
 - Women's AOD Services Network
 - Youth AOD Services Network
 - Regional Networks
- NADA Conference 2014: Diversity driving innovation
- NADA Policy Toolkit
- New and Emerging Psychoactive Substances Forum and discussion paper
- Outcomes & mental health capability forum
- Partnership and stakeholder relations to support capacity building
- Peaks Capacity Building Network
- Personality Spectrum Disorders Workshop
- Practice Enhancement Program: Working with Complex Needs
- Trauma Informed Care and Practice series of events
- Women's Service Development Program
- Working with Diversity in Alcohol and Other Drug Settings resource

QNADA (Qld)

- ADCA Policy Council
- Advice to government
- Advising the Queensland Centre for Mental Health Research (QCMHR) AOD service Mapping Project
- Analysis for Sector on the State Government Blueprint for better healthcare in Queensland
- Assistance to members to identify and apply appropriate accreditation framework
- Development of state-wide NGO AOD Service map
- Guide to Contract Reporting
- Informing and influencing the establishment of the Qld Mental Health Commission
- Joint Members forum with the Queensland Alliance for Mental Health
- Medicare Locals (MLs) and Hospital and Health Services (HHSs) – membership and participation in planning activities
- Members Forum, August 2012
- Membership of the Queensland Department of Health AOD Services Improvement Group
- Peaks Capacity Building Network
- Position Paper on Dual Diagnosis
- QNADA Focus (monthly newsletter)
- QNADA Sponsored Addiction Treatment and Relapse Prevention Workshop

- QNADA Sponsored Working Trauma Workshop
- QNADA Sponsored Working With Challenging Behaviours Workshop
- QNADA website redevelopment
- Scholarships to attend the Complex Needs Conference – April 2013
- State Request for Offer Process Sector Guidance

SANDAS (SA)

- Advancing QI in funded organisations through direct onsite support, help desk functions, consultation on approaches and barriers and access to products that help improve systems.
- Alcohol Causes Cancer
- AOD National Peaks Network
- AOD Quality Framework Project
- Being Comorbid in Victoria – Capacity Building Network Forum
- Cert IV AOD for Regional SA
- Collaboration with SA Health (DASSA) on Workforce Development and Government and NGO Comorbidity service issues
- Comorbidity Action in the North (CAN) Project – as one of the Chief Investigators of this ARC Linkage Grant funded 3 year projects.
- Comorbidity Consumer Voices Project
- Comorbidity Network Group Project - Effective Coordination of Services across the AOD and MH sectors
- Cultural and Linguistic Diversity (CALD) Reference Group
- Culturally Secure Practice and AOD & Mental Health Commission - The WA Experience
- Developing Outcome Measures
- EO Network; Peaks Policy Network; Peaks Capacity Building Network (PCBN)
- Gambling and Comorbidity Workshop involving providers form the AOD. MH and Gambling services sectors, both government and non-government.
- National AOD Prevention & Treatment Service – Sector Review
- SANDAS Conference 2014
- SANDAS Organisational Review
- SAYADS Network (South Australian Youth Alcohol and Drugs Services)
- Sector capacity-building training
- Sector Communications E-Bulletin, The Connector News Letter and SANDAS Website
- Sitting Member of Child and Adolescent Mental Health (CAHMS) State Reference Group
- Sitting Member of the SA Justice Reinvestment Group
- South Australian Alcohol, Tobacco and Other Drug Nursing Statewide Action Group (SAG)
- Southern Family AOD and Mental Health Community of Practice
- Subject Matter Expert Group
- VET sector training – Supporting the development of a Comorbidity Diploma and the design of an existing worker Cert IV AOD with MH including evaluation

VAADA (Vic.)

- Amalgamation with, and incorporation of the comorbidity.org.au website into the mainstream vaada.org.au website
- Coordination of SMSDGF network meetings - ongoing
- Delivery of personality disorders workshops - 21 May and 5 June 2013
- Delivery of trauma 'master classes'
- Development of Aboriginal AOD, MH and Trauma prompt cards
- Development of related TIC training program - Level 3
- Development of related Trauma Informed Care (TIC) training program – May-June 2013
- Development of Trauma Informed Care prompt cards
- Dissemination of alcohol and other drugs (AOD) and mental health (MH) prompt cards and provision of related training state-wide - ongoing
- Implementation of level 1 trauma informed care training program
- ISI (SMSDGF)/VDDI conference organisation – 7-8 August 2012
- Managers and Workers Forum
- Participation in capacity building networks - ongoing
- Participation in the Coalition for Aboriginal Health Equality Victoria
- Presentation to Alcohol, Tobacco and other Drugs Council of Tasmania (ATDC) Conference
- Promote and maintain effective collaboration with PCBN - ongoing

- Promotion and distribution of Capacity Building and Change Management manual
- SMSDGF Network agency visits
- SMSDGF Network Meetings - Change management and the AOD sector reform
- Trauma informed care sector survey – March-April 2013
- VAADA conference 2013 'Broadening the Focus' – 14-15 February 2013

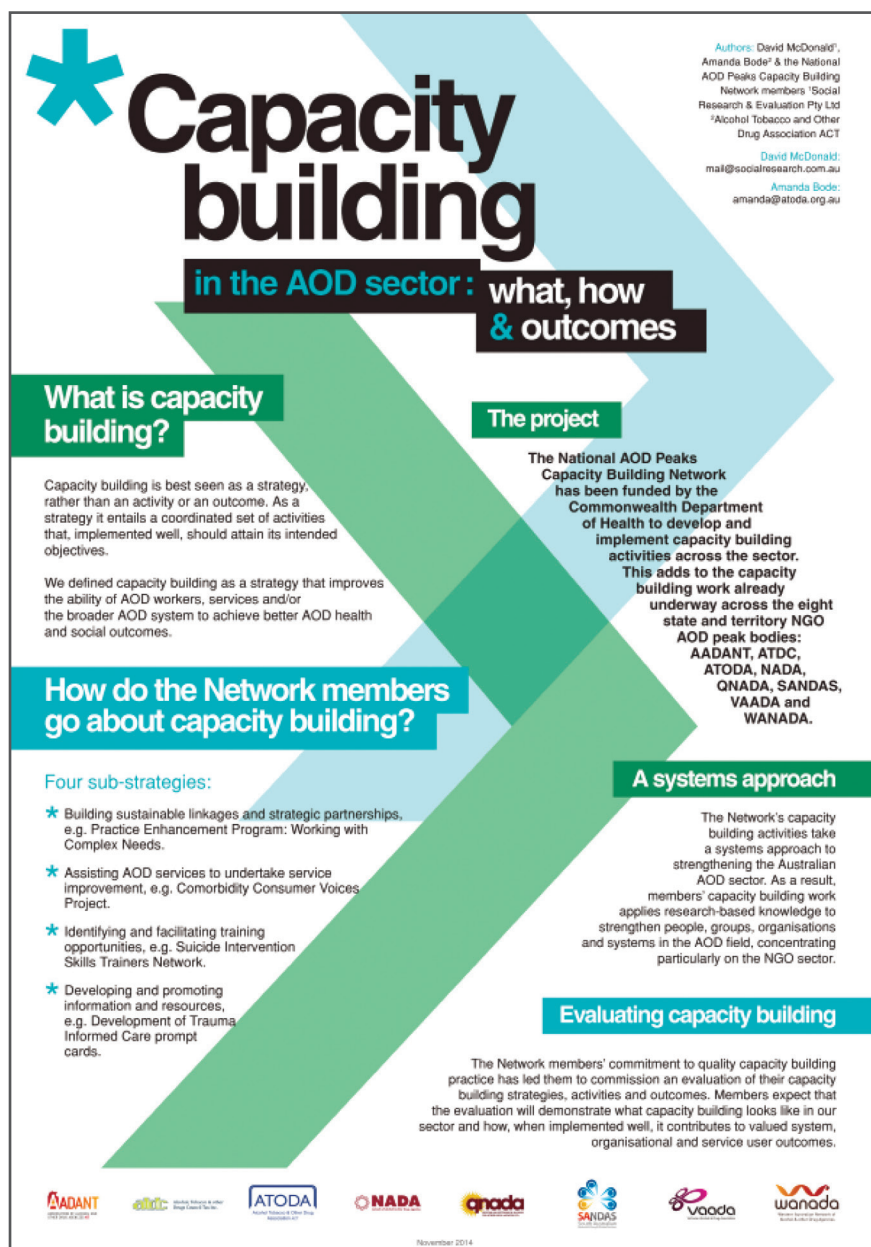
WANADA (WA)

- A Better Fine - A Zimbabwean perspective on AOD and Mental Health
- AOD and Mental Health Cross Sector Forum
- Collaborating with all WA Universities (UWA, ECU, Notre Dame, Curtin and Murdoch) and the WA Clinical Training Network in implementing the WANADA student placement program
- Communication with key stakeholders (weekly newsletter FYI, partnership with DAO on Drugspeak a quarterly newsletter, regular Managers Updates to AOD service managers and CEO's)
- Development and implementation support of the Standard on Culturally Secure Practice (AOD Sector), an Interpretive Guide and the AOD Knowledgebase and links with the Dual Diagnosis Capability in Addictions Treatment (DDCAT)
- Development and launch of a Stigma and Discrimination Position Paper.
- Development of Standard on Culturally Secure Practice website
- Host and administer an AOD service directory and secured funding to develop the 'Green Book' to be a joint service directory of WA AOD and MH services.
- Key Strategic Meetings
- National AOD Prevention and Treatment service sector review
- Participation in the National Complex Needs Alliance
- Peaks Capacity Building Network (PCBN)
- Research and strategies to support capacity building.
- Stigma and Discrimination research
- The collective administration and support for member agencies of the following programs:
 - collective insurance including specialist policy inclusion
 - Employee Assistance Program
 - Interpreter Access Program
 - Childcare Access Program
- These programs are provided to members at subsidised rates or are free to member organisations. The programs are funded through member contributions and/or core funding provided by the Drug and Alcohol Office.

APPENDIX 2:

poster presented at the November 2014 APSAD Annual Conference

This poster was presented at the November 2014 Annual Conference of the Australasian Professional Society on Alcohol and other Drugs. It was authored by David McDonald and the eight member organisations of the Peaks Capacity Building Network. It received the Runner-up Poster Prize (Senior Researcher) award.



For more information about the AOD Peak Bodies:

Alcohol Tobacco and other Drugs Association ACT (ATODA)

www.atoda.org.au

Alcohol Tobacco and other Drugs Council (Tasmania: ATDC)

www.atdc.org.au

Association of Alcohol and other Drug Agencies NT (AADANT)

www.aadant.org.au

Network of Alcohol and other Drugs Agencies (NSW: NADA)

www.nada.org.au

Queensland Network of Alcohol and other Drugs Agencies (QNADA)

www.qnada.org.au

South Australian Network of Drug and Alcohol Services (SANDAS)

www.sandas.org.au

Victorian Alcohol and Drug Association (VAADA)

www.vaada.org.au

Western Australian Network of Alcohol and other Drug Agencies (WANADA)

www.wanada.org.au

