NADA
network of alcohol & other drugs agencies

The newsletter of the Network of Alcohol and Drug Agencies

Issue 2: June 2013

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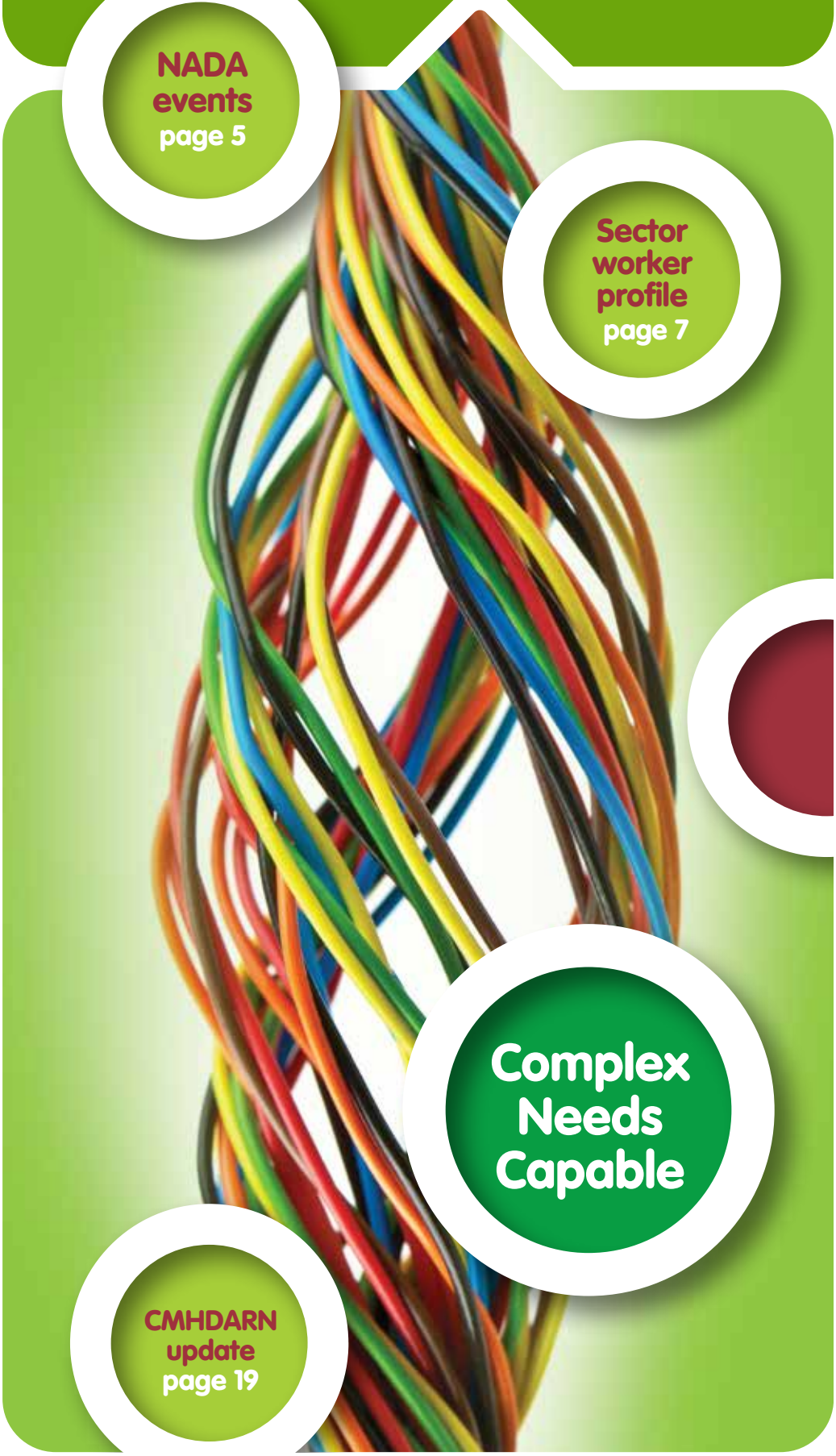


Complex Needs Capable

This edition we ask a number of guest writers to respond to the theme:

> ***Non government drug and alcohol organisations – a complex needs capable sector.***

Read responses from:

Michael Moore
CEO, PHAA

Prof Anne Roche
Director, NCETA

Other projects from:

WHOS
The Lyndon Community
Karralika

A Complex Needs Capable Sector

Social Inclusion and Complex Needs

Michael Moore CEO, Public Health Association of Australia

Real people with real problems were the focus of the Public Health Association of Australian (PHAA) Social Inclusion and Complex Needs Conference held in Canberra in mid-April. Working with the Alcohol and Other Drugs Council of Australia (ADCA) and the Australian Red Cross the PHAA, aimed at considering the evidence and identifying effective pathways.

People don't live their lives within portfolios – and people with complex needs require help to negotiate their way through the maze of government and non-government services to access meaningful help. 'Complex Needs' is not necessarily a widely used term in the broader community, but it's really not a difficult concept to grasp. 'Complex Needs' is simply about people struggling to overcome more than one challenge in their lives simultaneously.

For instance: people with a mental illness who have turned to alcohol and other drugs as a coping mechanism; people with a cognitive impairment or intellectual disability whose problematic behaviour has brought them into contact with the police and criminal justice system; victims of prior abuse – or ex-defence personnel – who struggle to overcome post-traumatic stress and transition back into the mainstream community. There might also be an oral health issue or a physical disability such as deafness, sight impairment or a chronic condition such as diabetes. Apart from dealing with the specific issues, any and all of these people often also need help to find jobs and support themselves and their families – homelessness can be a key concern.

The conference declaration highlighted the recognition that as funding bodies and service providers, we need to work together to help create pathways that connect the services that people with complex needs require. It was agreed that a start has been made.

However, there is more to be done if we are to assist some of the most vulnerable people in our community make meaningful changes to improve their lives.

The Social Inclusion and Complex Needs Conference was the first Australian conference to showcase successful programs and a range of different approaches in addressing complex needs and social determinants of health. There was a clear aim on behalf of the PHAA and its partner organisations ADCA and the Red Cross to identify what works and how to manage the required change.

It has long been acknowledged that people with complex needs often fall through the cracks in service delivery – between national and jurisdictional service delivery, between government and non-government services, and between services delivered by different portfolio agencies. However, recognising that structural issues create discrepancies, the conference sought to identify and showcase successful collaborative efforts in service delivery, with a view to informing whole-of-government approaches to policy and program development.

The conference provided a unique opportunity to hear the most recent research and practitioner wisdom with a view to breaking down structural and systemic barriers to achieving better health and social outcomes for people with complex needs. With noted national experts from both government and non-government sectors showcasing their work, the conference shed new light and considered current evidence about issues. It did not shy away from the real challenges in seeking to achieve better outcomes for people with complex needs in the Australian community.

Another attribute of the conference was the diversity of attendees. Speakers and attendees represented a broad range of perspectives on everything from alcohol and other drugs, mental health, homelessness, the justice system, chronic disease, physical disability, Aboriginal and Torres Strait Islander health, victims of prior abuse, right through to refugee and veterans affairs. Attendees included consumers, front-line workers, policy makers, program managers, researchers, police as well as people working in the criminal justice system and beyond. This conference was the first of its kind to unite such a diverse group seeking to forge new linkages in developing comprehensive approaches to addressing complex needs.

The Conference Declaration along with an outline of the conference program including audio and PowerPoint slides from plenary sessions are available on the PHAA website at: ***www.phaa.net.au***.

The Social Inclusion and Complex Needs Conference is a step forward. Most importantly, however, is the recognition that it is already past time to develop and progress a comprehensive and meaningful agenda for change in addressing complex needs.

PHAA National Social Inclusion and Complex Needs Conference

15 - 16 April 2013 - Hotel Realm, Canberra

A Complex Needs Capable Sector

Systems, issues and responses

Professor Ann M Roche **Director, National Centre for Education and Training on Addiction**

The alcohol and drug field in Australia has never been short of challenges. It is true to say that the field has changed very substantially over the past couple of decades. No longer do we just focus on a client's single drug of concern. It is now well recognised that, for most clients, poly drug use is the norm. In recent years, there has also been increasing emphasis placed on the co-occurrence of an alcohol and drug problem in conjunction with a mental health issue. Grappling with co-morbidity has meant many changes to governance structures, service delivery models as well as the skill sets required of workers and the expectations placed on them.

More recently, the alcohol and drug field has evolved even further. We now attempt to deal not only with co-morbidity but with a much wider array of complex needs that clients may experience. Into the future we will be dealing with multiple morbidities. This might entail mental health issues, physical health problems (note here the exponential increase in hepatitis C for example) or disabilities (people with disabilities now represent a larger proportion of the population than ever previously as people survive adverse events more than before). In addition, there is growing recognition of the pivotal importance of addressing housing, education, employment and other factors that might contribute to social vulnerability and exclusion and undermine progress in dealing with alcohol and drug problems.

Client demographics are also changing. The adage that most clients will 'grow out of their drug use problems' is no longer applicable. Unexpectedly, we now see baby boomer clients in retirement facilities who have maintained their drug use, or their pharmacotherapy, well into their later decades. Not that long ago this was not on our radar at all.

Conversely, there is also growing pressure and expectation on all parts of the health and human services sectors to address the needs of children much more effectively and proactively than we have done to date. Both children and families feature more centrally than they have done for some time in our thinking, planning and responses. Plus the particular and unique needs of groups such Indigenous Australians, prisoners and returned service personnel are increasingly prominent.

Fold into this mix the widening array of problematic substances, including pharmaceuticals, synthetic drugs and performance enhancing products, and the challenges we are facing become even more starkly evident.

Some might suggest that we are on a potential collision course. Services into the future will need to deal with entirely different clients with different needs and concerns from those that their services were initially established to address.

Ideological differences have always been part of the landscape of the alcohol and drug field. Although many of the fundamental areas of difference and friction seemed to have been resolved in recent years: Nonetheless, there remains controversy. This takes various forms but includes some treatment modalities (eg naltrexone implants as but one example), outcome goals (as evidenced in the new recovery discourse), or even fundamental aetiology (the medicalised brain disease vs a broader public health perspective). While these controversies prevail it is encumbent upon workers to have a good grasp of these issues and to be able to engage in meaningful debate and arrive at informed positions that then shape and inform their own practice and professional behaviours.

All the above have important implications for the best ways to configure services, as well as the most appropriate way to foster the required professional development for workers. These are complex issues that require senior leadership and direction, as well as input from workers at the coal face. More than ever, it also necessitates intersectoral involvement and collaboration.

In terms of the workforce challenges entailed, this will require a struggle for talent as the demand for health and human services workers will out strip the demand for workers in other sectors by several fold. At a time when the alcohol and drug sector needs increasingly skilled and specialised workers, a wider agenda is propelling the development of a generic workforce that can function across multiple domains. The risk here is that we are left with less technically skilled and knowledgeable workers than we had decades ago, at a time when the roles and requirements are more complex and sophisticated than they have ever been.

So, while we are experiencing some of the most important developments encountered by the alcohol and drug field, and as we stand on the precipice of a significant paradigm shift, it is imperative that we not lose sight of the field's central unifying principle - and that is our ability to provide effective harm reduction and ameliorate suffering experienced from alcohol or drug use.

NCETA

Australia's National Research Centre on AOD Workforce Development

CEO report

A Complex Needs Capable Sector

Larry Pierce

Larry Pierce

I think there is no doubt that the specialist non government drug and alcohol sector in NSW has moved to become a complex capable sector, however there are limits to which individual drug and alcohol organisations and the wider sector can actually achieve becoming fully "complex capable." The first thing that has driven the sector to having to diversify and extend its range of interventions and services is the fact that for the last decade the range and complexity of needs the clients bring with them to drug treatment services has grown considerably. The second issue has been growing recognition by service providers that drug and alcohol clients have mental health and other complex health issues and that this is the business of drug treatment.

This had led to acceptance by the sector that good drug treatment is about handling the complex needs of clients within the context of addressing the primary drug health problem they have. It doesn't mean becoming quasi mental health specialists as well as disability experts – it means becoming capable of identifying these main issues in the design and delivery of a comprehensive treatment program to clients. It means having better trained and skilled staff, better case planning and management, better and direct linkages to supportive external and internally provided specialist services. Finally, it means opening and getting rid of the no/wrong doors to service delivery in drug treatment land.

But there are problems that confront our sector in continuing to meet the complex needs of our clients. They are in relation to the way we are funded and the way that the external governmental environment behaves. In terms of funding, it is only relatively recently that health department funders at both state and commonwealth level have recognised the need for drug treatment funding that targets the delivery of complex case management, the development and maintenance of external partnerships and service linkages, and the needs for longer term care coordination of clients to support the effects of initial or primary drug treatment.

Generally, funding for drug treatment has been about the purchasing of specific treatments (e.g residential rehabilitation beds or detoxification services) and the rest has been left up to the agency to work out. This is clearly not good enough to support service sustainability or complex service support provision.

In terms of the way relevant government agencies work, there is still very much a "silo" approach to funding a range of services like drug treatment, mental health, primary health, housing and disability. There have been improvements in the way these government agencies interact and much effort put into "whole of government" approaches to complex human service problems, but we think much more needs to happen in terms of better funding linkages between these agencies and better coordination of whole of government funding approaches.

This is because no one program can "fix" an individual with a drug problem or a community affected by drugs and alcohol. There are multiple factors that determine drug dependency across multiple areas of need and whole of government approaches need to join the policy and funding programs of government agencies responsible for corrections, housing, health and child and family services to name a few key ones.

NADA will continue to work with the Ministry of Health and other key government departments on the need to align their funding programs so that consideration of funding streams from these agencies into the drug and alcohol program can be realised in the life of this and the next state government.

"In terms of the way relevant government agencies work, there is still very much a "silo" approach to funding a range of services like drug treatment, mental health, primary health, housing and disability."

NADA events

NADA Community (re)Integration Forum

9.30am – 4pm, 3 July 2013
Parkroyal Darling Harbour, Sydney

We know that people connected to the community have better health and social outcomes. So what are organisations doing for clients, what do individuals actually want, and how do we measure success? This NADA forum will explore how services are connecting people to housing, employment, education, family and social networks.
For more information.

http://www.nada.org.au/eventdetails?event=54

Save the date

NADA AGM and Forum

18 November 2013
Parkroyal Darling Harbour, Sydney
For more information contact Craig.
craig@nada.org.au

Do you have something you would like included in the next NADA Advocate?

NADA encourages members and stakeholders to contribute to the NADA Advocate. You could promote new services and projects, innovative partnerships, awards and achievements, research activity or upcoming events. Email final content to Craig. craig@nada.org.au

The next issue's content deadline is 30 August 2013 for distribution mid-September.

NADA events

CMHDARN Webinar: Incorporating Research Findings Into Service Delivery – An Introduction to Implementation Science

10am-11am, Friday 5 July 2013

CMHDARN Reflective Practice Webinars aim to promote your understanding, knowledge and analytical skills about recent research.
http://www.cmhdarnresearchnetwork.com.au/research-network-activities/

Trauma Informed Care and Practice (for staff)

9am-5pm, 5 August 2013

The full-day training introduces the concept and application of trauma informed care and practice and involves participants actively considering how trauma-informed principles can be applied in their service, with particular reference to their own practice and role/s.
http://www.nada.org.au/eventdetails?event=61

Trauma Informed Care and Practice (for managers)

9am-1pm, 6 August 2013

The half-day training is tailored to the needs of managerial staff who seek to implement trauma-informed principles across and within the service culture of their organisation.
http://www.nada.org.au/eventdetails?event=62

Other events

2013 Australian Winter School

17-19 July 2013 Novotel Brisbane, QLD
http://winterschool.info

14th International Mental Health Conference

5-7 August 2013 Outrigger Surfers Paradise QLD
http://www.anzmh.asn.au/conference

Healing the Scars: Respecting gender, family and culture in the delivery of drug and alcohol programs to rural and remote Aboriginal communities and its members

20-21 August 2013, Batemans Bay NSW
Email: *http://www.healingthescars@lyndoncommunity.org.au*

International Conference for the Recovery from Childhood Trauma and Mental Illness

14-15 October 2013, Mercure Koonindah Waters Resort
http://www.astmanagement.com.au/heal4life

Narrative and Strengths Based Approaches to Health and Welfare

7-8 November 2013, Prince Henry Conference Centre, Little Bay, Sydney
http://www.sydneynarrative.com

APSAD Conference

24-27 November 2013, Brisbane Convention Centre, QLD
http://www.apsadconference.com.au

National Indigenous Health Conference: Many pathways, one outcome

25-27 November 2013, Cairns, QLD
http://www.indigenoushealth.net

Welcome new NADA members

Aboriginal Medical Service Western Sydney

Substance Misuse Program

AMS Western Sydney is an Aboriginal Community Controlled Medical Service run by local Aboriginal people for Aboriginal people. The AMS Western Sydney vision is to provide the highest standard of client care whilst incorporating a holistic approach toward diagnosis and management of illness.

The Substance Misuse Program delivers opioid substitution treatment where it is recognised that substance misuse is a dimension of health that can be successfully managed in a whole of person approach as part of standard primary health care.

The team consists of a clinical nurse specialist and a Substance Misuse Aboriginal Health Worker alongside permanent GPs who have all completed extra training in delivery of OST. This team provides management of physical, social, emotional and substance use issues in line with the organisation's aim of providing holistic care to all patients.

Contact **(02) 9832 1356** for more information on services available.

Hunterlink Recovery Services

Newcastle and Hunter region

www.hunterlink.org.au

Hunterlink Recovery Services provides support services to individuals, families, communities and workplaces in the Newcastle and Hunter region of NSW.

Three primary programs are offered:

- **EASE** – Designed to assist employees and/or their families, this program is implemented in conjunction with employers.
- **STAR** – A 'total abstinence' based services for people suffering from addiction and related mental health concerns, this program provides transitional accommodation, education, case management and addiction counselling.
- **CASE** – Community access education and counselling for addiction and related mental health concerns.

Phone **(02) 4929 6625** for further information.

NADA member profile

Dianella Cottage

www.dianellacottage.org

"Holding the hope"

Dianella Cottage is a harm minimisation service based in Katoomba, Blue Mountains providing programs and support for women with coexisting drug, alcohol and mental health issues. The service welcomes women at all stages of addressing their drug use, and includes women on pharmacotherapies and women impacted by the criminal justice, child protection and mental health systems.

The team at Dianella Cottage believe:

- Behind drug & alcohol dependence is a woman with a story
- Women are powerful; they just don't always believe it
- Change is possible; sometimes we need to be given the opportunity and support to make it happen
- A strong relationship with ourselves is at the heart of health and well-being
- The most important relationships we have are with ourselves, our Spirit, our family and friends, our community, our environment
- Recovery from drugs and alcohol and mental health issues is possible
- Recovery means different things to each one of us
- Recovery is an individual experience

Services provided by Dianella Cottage are:

Wise Woman's Day Program Supportive environment day program exploring issues, patterns and work on developing practical tools to manage our lives. In this collective environment we draw on women's wisdom and resources and be empowered to make decisions about where drugs and alcohol fit in your life.

New Directions Transition Program Seven week program for women embracing change.

CHOICES: Psycho-education Program Program for women transitioning from prison.

Activities Program Health based activities which support recovery.

Friends of Dianella Project Community engagement projects to support the sustainability of the service.

Consultants of Experience Project Consumer driven activities to raise community awareness and reduce stigma.

Strength-based collaborative counselling and supported referral

To find out more about accessing programs; we look forward to chatting with you further, so feel free to contact us for more information on (02) 4782 3887.

A day in the life of...

Sector worker profile

Paul Hardy

Senior Transitional Drug and Alcohol Worker
Community Restorative Centre

How long have you been working with your organisation?

Since October 2012.

How did you get to this place and time in your career?

I started working in community services in the UK where I'm originally from in 1999. I left in 2005 to come to Sydney where my wife is from and we got here after a year travelling in Asia. I worked in Sydney in community services for 3 years and then we left for another long period of travel, this time in Africa. After spending some time in the NT I'm now back in Sydney.

What does an average work day involve for you?

Some office time and some outreach time visiting clients at another service at their home and at corrective centres. My office is in the city and I visit clients in all of the corrective centres around the Sydney metro area. Also a fair percentage of my clients live in western Sydney, so I spend quite a bit of time driving too.

What is the best thing about your job?

Having the flexibility to provide outreach drug and alcohol counselling and support to clients who do not do well accessing mainstream office based services.

What is one thing you would like to see different in the non-government drug and alcohol sector? What needs to change to get there?

Longer term stable funding arrangements to give non government organisations a position of strength and security from which to define more creative reporting and outcome measurements. If this sector is truly to become complex needs capable and successfully work with the clients we are not engaging at the moment, we need to move away from the current short term funder imposed outlook.

If you could be a superhero, what would you want your superpowers to be?

I'd like to be able to turn bullets and bombs into flowers.

www.crcnsw.org.au

Introducing NADA Board member

Dr Julaine Allan, Deputy CEO
Senior Research Fellow, The Lyndon Community

How long have you been with NADA?

I was elected to the NADA board in November 2012 but I have been involved with NADA activities – training, research and sector action – since I started work at the Lyndon Community in 2007.

What experiences do you bring to NADA?

I've worked for nearly 30 years in the community services sector as a youth worker, mental health social worker, family therapist, sexual assault counsellor, TAFE teacher, uni lecturer and researcher. The key thing that ties all that together is a concern for social justice and human rights. I see structural problems like poverty and social exclusion as significant barriers for participation in society and those barriers limit opportunities for many people trying to manage their substance misuse problems. My research interests are around access to healthcare, and economic and social participation for drug and alcohol clients and also in what is good practice. I think practitioners have a lot to teach researchers about what works in practice.

What NADA activities are you working on at the moment?

I'm learning about being on the NADA Board. The big issue for the sector is the future of funding at State and Commonwealth levels, and the challenges that poses for consistent service delivery and staffing. Competitive tendering and outcome measures are things we all have to grapple with and NADA is, and will continue to be, a significant part of how services manage these processes.

What is the most interesting part of your role with NADA?

Being part of policy and funding level discussions is interesting. Governments and their ways of working are a bit of mystery from the outside. Being part of NADA gives me a closer view of how things work and how the D&A sector can benefit.

What else are you currently involved in?

I am an Official Visitor with the NSW Official Visitors program. I visit inpatient wards at Bloomfield Hospital on a monthly basis to make sure that people's human rights are being protected as much as possible in an involuntary setting and to act as an advocate for people - patients, family members and staff – who feel that they don't have a voice in the institution. My colleagues in Orange have started visiting the Involuntary Drug Treatment Unit that opened at Bloomfield last September as a replacement for the Inebriates Act. It is the most significant legislative change I have seen in drug and alcohol treatment in the past few years.

Tell us something you enjoy doing on your days away from work.

I like to travel, take road trips, see new places - maybe I'm getting old. My parents used to take me for Sunday drives when I was a kid, which invariably took longer than planned and involved getting lost and my dad refusing to ask for directions. I'm doing the same thing to my kids – no need to ask for directions with a GPS now though. Will have to get one for my dad.

www.lyndoncommunity.org.au

The Lyndon Community

Cognitive Impairment Project

Dr Julaine Allan Deputy CEO and Senior Research Fellow, The Lyndon Community

The Lyndon Community successfully applied for a Practice Enhancement Project (PEP) grant from NADA in 2011. The focus of the project was cognitive impairment. We wanted to know how many of the people coming through our programs experienced some form of cognitive impairment (CI), how staff responded to their cognition problems and what ways we could improve our practice to retain people in treatment and get better outcomes.

We employed a project worker with the grant funding. Annette Golden, our CI PEP project worker spent 10 months working with us. There were four stages to the project, a literature review, a staff survey to identify skills, knowledge and training needs of workers', screening of clients coming into our residential programs to identify the prevalence of CI and a training program individualised to each of our treatment programs (withdrawal, residential rehabilitation and community outreach) to improve practice. The staff survey was repeated after the training to evaluate changes in staff knowledge and skills.

The literature review found that CI can be a hidden disability which, for example, affects encounters with people in their surroundings, and can lead to difficulties in relations and contacts with society. The effects of CI are not always visible or obvious; it affects intangible processes like thinking and behaviour. Often the person may have no physical impairment, but lacks insight into their own needs and behaviour. Consequently, they do not look like they need help and do not think that they need any help, so often they may not get any help.

The results of the survey and client screening were confronting. We found that staff had no training in dealing with people with CI. This included their formal qualifications across a broad range of disciplines and there was little or no informal support or strategies in place to respond to clients with cognitive problems. We did identify that some of the symptoms of cognitive impairment were thought to be behavioural responses to addiction. These results were coupled with the client screening that found that 52% of clients screened had some form of cognitive impairment, 12% had a severe impairment and 82% of Indigenous clients had some form of cognitive impairment. CI was prevalent in our programs and we didn't know how to deal with it.

Annette developed a training manual (available on our website *www.lyndoncommunity.org.au*) that included a practice plan for each program developed during the training session. The practice plan identified three or four strategies for workers to undertake to change the way they delivered treatment.

> *The project highlighted cognitive impairment is a significant issue for the drug and alcohol treatment sector and finding ways to make our services accessible and effective for clients with CI is important for them and for us.*

We chose to do this using universal design for learning principles. Universal design for learning principles endeavours to make environments, resources and education methods accessible for people with CI. The same environments, resources and products are used for people without CI. This meant we didn't have to screen people or have a separate program for people with cognition problems. From a universal design perspective the psycho-social components of the treatment program would include skills practice before theory, repetition and role play and written material to support spoken material for all participants.

Some of the other changes were simple and practical. Signs using pictures for the phone for example, a white board with the daily schedules on it in a public area that could be checked frequently, name tags for staff and a revamp of the group materials and delivery. The program plans were put in place and the repeated staff survey found an increase in knowledge and skills. The organisation undertook to simplify information on the website to improve readability and accessibility including having some audio only information. Unfortunately since our PEP grant ended and our project worker left there has been limited follow-up of the program plans, impact of changes and monitoring of outcomes for clients. We have new staff coming in without background knowledge of CI or skills training and no specific training in place to get them up to speed.

We still have cognitive impairment on the radar though and are developing a specialist treatment program within the Lyndon rehabilitation program.

The project highlighted cognitive impairment is a significant issue for the drug and alcohol treatment sector and finding ways to make our services accessible and effective for clients with CI is important for them and for us.

Changing the way we do things at Karralika

Responding to complex needs

Dawn Bainbridge, Manager, Community Programs, Karralika

Karralika Programs Inc. has been supporting adults and families in the ACT and surrounding region for over 35 years through residential and community based alcohol and drug programs. With a growing number of clients with both alcohol and other drug issues and coexisting cognitive impairment including acquired brain injury (ABI) and comorbidities, Karralika Programs took the opportunity, with support from the NADA Practice Enhancement Project (PEP) grant in 2011, to take a closer look at our operations, structures and supports available for clients.

Our project sought to develop policy and procedures, implement targeted staff training, review and modify our assessment tools, program delivery, support mechanisms and changes to the treatment environment in order to build organisational capacity to respond to the needs of our clients. We were surprised to find that staff were initially unsure of their capacity to work with clients with ABI conditions but after targeted training and skills development activities and an improved risk screening process staff recognised this work was not significantly different to that which already occurred in our programs and staff confidence in their ability and skills to support clients with complex needs has grown.

Although the project has concluded, we continue to offer residential programs for clients with a range of complex conditions. This year, 37 clients with multiple complexities including specific risk of ABI were admitted to Karralika Therapeutic Community. The majority of risk identified was related to drug use patterns, assaults and motor vehicle accidents. Over 30% have completed treatment in our Karuna 8 week program with over 80% of those continuing through to the next treatment phases of the Therapeutic Community.

Whilst the PEP project focussed specifically on access to treatment for clients with ABI our approach has evolved to a more comprehensive view of complexity and complex needs. Our staff accept that clients with complex needs may require higher levels of support and assistance as well as flexibility in terms of program delivery. The notion of working with clients with a range of complex needs is well embedded into the culture of the organisation and we remain committed to ensuring that we offer the best service possible for all clients entering our programs.

Our organisation-wide approach, supported by access to and/or provision of relevant information, training and resources has assisted us to maintain service delivery at similar levels to that recorded during the PEP project phase.

We continue to focus on service delivery enhancements through ongoing staff training and program development initiatives including Dialectical Behaviour Therapy, Motivational Interviewing, updates on ASIST, and piloting the Suicide Assessment Kit developed by the National Drug and Alcohol Research Centre and the University of New South Wales. We are also in the process of producing an audio visual information package which will describe, from various perspectives, KPI and what to expect from the TC experience. It is envisaged that this will enhance our suite of resources and support and strengthen our work with clients with complex needs.

Our team and our clients have greatly benefited from the support we have received through the PEP project and the ongoing support of NADA and the membership.

KARRALIKA
programs to help you choose a better life

> *...after targeted training and skills development activities, and an improved risk screening process, staff recognised this work was not significantly different to that which already occurred in our programs and staff confidence in their ability and skills to support clients with complex needs has grown.*

WHOS Complex Needs Project

Screening clients for cognitive impairment

Jo Lunn, **Improving Organisational Capacity Project Officer, WHOS**

WHOS was successful in obtaining the Practice Enhancement Program (PEP) funding. The aim of WHOS PEP was to expand the capacity of WHOS to manage complex clients which experience cognitive impairment (such as foetal alcohol syndrome, alcohol related brain damage, head injury, intellectual disability) and/or are involved with the criminal justice system. The project involved a number of activities. However the focus of this article is the development of a brief screening tool to screen for cognitive impairment in the client population attending WHOS for AOD treatment.

It is important to recognise the potential for cognitive impairment to result from long-term substance use. However it is also essential to consider the additional common causes of cognitive impairment and the high level of exposure average clients accessing AOD treatment have to these additional risk factors, in particular acquired brain injury (see table below).

Common causes of cognitive impairment

Developmental	Learning Disorder, Attention Deficit-Hyperactivity Disorder, Autistic Disorder / Asperger's Disorder, Intellectual Disability
Acquired Brain Injury	Traumatic Brain Injury, Stroke, Hypoxic Brain Injury, Alcohol and Other Drug Related Brain Injury
Neurological	Multiple Sclerosis, Huntington's Disease, Parkinson's Disease
Mental Illness	Depression / Anxiety Psychosis / Schizophrenia
Dementia	Alzheimer's Dementia, Vascular Dementia, Fronto-Temporal Dementia

Table taken from Berry (2012) Montreal Cognitive Impairment Manual

WHOS identified the need for a brief screening tool that could identify cognitive impairment in our client group. This screening tool would need to be administered by our current staff (e.g. not necessarily a qualified psychologist) and could not require on-going copyright costs.

WHOS engaged a consultant to review the literature and determine if there was such a screening tool. The consultant identified a number of potential screening tools however the Montreal Cognitive Assessment (MoCA, originally developed to assist GPs to screen for early dementia) showed the most promise. There was already an existing study, which had used the assessment tool in an AOD population.

WHOS partnered with the University of Wollongong and engaged a fourth year psychology student to administer the MoCA to WHOS clients. The MoCA results indicated that 45.9% of participants (n114) were classified as cognitively impaired using the existing MoCA normative data. It is important to note that the MoCA normative data was developed using an elderly population as this screening tool was originally designed to screen for dementia. As normal cognitive decline occurs from thirty-five onwards it can then be assumed that a higher number of clients would have screened positive if age appropriate norms were available. The student who conducted the original MoCA research has been successful in obtaining a scholarship to complete her PhD in this area and the first part of her study is to develop accurate norms for AOD populations.

Further, the initial study found a significant negative correlation between total MoCA score and number of times participants had lost consciousness after a head injury (i.e. the higher the number of times a client reported loss of consciousness, the higher the score on the MoCA which indicates the greater the level of cognitive impairment).

Continues on page 11 >

> *... many of the symptoms of cognitive impairment make it impossible for a client to engage in treatment in the traditional sense and simply be able to follow the rules, particularly residential treatment .... [by] understanding your client's capacity and the area of the brain that may be damaged and modifying learning processes/ treatment tasks accordingly can make a big difference and lead to the client being retained in treatment.*

Continued...

WHOS Complex Needs Project

Screening clients for cognitive impairment

What all of this means is that there is now a way for AOD workers to screen for cognitive impairment in their clients. Although ideal, accessing a clinical neuropsychological assessment completed by a clinical neuropsychologist is generally not feasible (approx. $1500-$3000). The MoCA is accessible and takes approximately 15 minutes to administer and can be administered by a general AOD worker (although they must be trained). If that is too complicated simply asking the client if they have ever lost consciousness is a very useful screening question for potential cognitive impairment.

It is essential to know if your client has cognitive impairment as it has important treatment implications. Depending on the area of the brain that was impacted, will depend upon a client's capacity to recall old information, concentrate, plan, and learn new information. A major issue facing many AOD workers is trying to engage clients that are unmotivated or just simply don't seem to be compliant with treatment. Often these clients are ultimately discharged from treatment.

It is important to note that many of the symptoms of cognitive impairment make it impossible for a client to engage in treatment in the traditional sense and simply be able to follow the rules, particularly residential treatment (as they can't follow rules they don't remember nor can they complete homework they do not understand).

Simply understanding your client's capacity and the area of the brain that may be damaged and modifying learning processes/ treatment tasks accordingly can make a big difference and lead to the client being retained in treatment. The changes for some clients can be as simple as:

- presenting information in diagrams as opposed to text
- encouraging the use of a diary
- explaining to other clients (with the target clients permission) the difficulties they have with remembering things
- using 'to do' lists.

For further information on the project please contact Jo Lunn on (02) 8572 7401

WHOS
helping people help themselves

Training in ABI for drug and alcohol services

The arbias training program

Tom Spencer, Training Coordinator

arbias Ltd is a not for profit organisation specialising in Alcohol and Other Drug Related Acquired Brain Injury. Originating in Victoria with its head office situated in Brunswick, arbias also provides specialist assessment case management and intervention services state-wide in NSW with an office base in Bass Hill.

arbias Ltd provides a number of direct specialist support services including assessment (both neuropsychological and neurobehavioural), case management (intake and response), community integration programs, individualised flexible support services and accommodation support. In addition to these direct support services, arbias Ltd has an established training unit which provides specialised tailored training to organisations and individuals in Acquired Brain Injury (ABI). arbias has a suite of ten training modules ranging from introductory foundation modules to more advanced training for experienced AOD clinicians and practitioners.

During 2011-2012, arbias NSW in a partnership with Ageing, Disability and Home Care (ADHC), delivered 32 ABI Awareness Training sessions throughout NSW training in excess of 600 participants. During this same period, four AOD agencies (in Lismore, Armidale, Newcastle and Canberra) obtained NADA WFD training grants to undertake training in the administration of the ABI Screening Tool and Triple Co-morbidity Training (arbias' Modules 7 & 8).

A primary aim of the arbias ABI Screening Checklist component of the training for these AOD organisations was to assist workers to identify whether an individual is at risk of having an ABI. It was evident through the feedback from the training sessions, that many service providers were unaware of the true impact of ABI and how this reduces an individual's ability to access, engage and benefit from drug and alcohol treatment programs and services.

Through the arbias training, service providers reported that they now felt more confident to not only support these individuals but to adapt their policies and procedures to ensure that they are not excluding these individuals from their programs. Also during 2012, the NSW arbias team developed a new module titled "Supporting Clients with Cognitive and Behavioural Impairments following Acquired Brain Injury". This two day package is available to individuals and agencies and is designed as an interactive and practical training session for the wider sector. arbias has a number of new and exciting training options being developed during 2013.

The focus of our training unit during this year is the development of an ABI training module for Indigenous communities. Consultation and the development of a partnership with the James Cook University in Northern Queensland are in the early stages for joint development and delivery of this training module. Further information regarding the development of this module will be provided during the coming months. Organisations considering applying for the next round of NADA WFD training grants should strongly consider the benefits of the arbias suite of ABI training modules for their drug and alcohol workers.

If you interested in the above training or in having training tailored to the individual needs of your organisation then contact our Training Coordinator: Thomas Spencer: 03 8388 1206 or email ***tspencer@arbias.com.au***.
You can also view our training options at ***www.arbias.org.au***

Translating Research into practice

Complex needs and the criminal justice system

Professor Eileen Baldry School of Social Sciences, UNSW

International and national evidence points to an increasing and widespread over-representation of disadvantaged people with mental and cognitive impairments and problematic alcohol and drug use across the criminal justice system, both as victims and offenders: in police work, the courts, and juvenile and adult prisoner populations. There has been very little research examining the many and compounding problems this group of people experiences, how institutional and agency practices interact with each other and individual life experiences, the lifecourse institutional pathways of these individuals or how they become locked into the criminal justice system instead of being supported through human and social services.

The findings emerging from two ARC Linkage projects on persons with mental and cognitive disability in the criminal justice system[1] are highlighting the way compounding and negative cumulative effects of having multiple disabilities and disadvantages (often referred to as 'complex needs') funnel many into the criminal justice system early and repeatedly. They are also highlighting the very poor recognition of these persons' disability support and service needs especially when they are children and adolescents and the very limited service response to them. Indigenous Australians are not only grossly over-represented at all points of criminal justice systems across Australia but are further over-represented amongst those with complex needs.

Analysis of the linked and merged criminal justice and human service data for 2,731 people in the ARC projects' dataset indicate that persons with complex diagnoses and disadvantages, with problematic alcohol or other drug use being a common feature in their lives, make up 70% of the cohort. They are significantly more likely to have: been in out of home care as a child, experienced earlier police encounters, higher juvenile justice involvement, and to have had more offences, convictions and imprisonments than persons with a single diagnosis and those with no diagnosis. Persons with cognitive impairment in combination with other disorders and impairment have the highest rates of criminal justice involvement both as victims and offenders.

> *Evidence from the research indicates there is almost no understanding of cognitive impairment (intellectual disability, borderline intellectual disability, acquired brain injury and fetal alcohol spectrum disorders) and even less of the implications for service and support when they are combined with other disorders, disability and disadvantage.*

Their offences though are almost all in the lowest 10% of seriousness and they are over-represented in the remand population. This group has experienced very poor school education, juvenile detention and orders, and low disability service recognition and support. They rely heavily on social housing but have a high tenancy failure rate due largely to being re-incarcerated and the recurrence of mental disorders. Only one quarter of those with intellectual disability and virtually none of those with borderline intellectual functioning have been clients of the state disability service. Of those who are clients, 79% became clients only after going to prison. Those becoming clients after going to prison fare better than previously, especially in regard to stable supported housing, indicating that appropriate holistic disability and other support services make a significant difference in these individuals' lives.

Many agency staff, from police to alcohol and drug workers, struggle to understand the effects of these disorders and impairment in combination and to respond helpfully. Evidence from the research indicates there is almost no understanding of cognitive impairment (intellectual disability, borderline intellectual disability, acquired brain injury and fetal alcohol spectrum disorders) and even less of the implications for service and support when they are combined with other disorders, disability and disadvantage.

The MHDCD research is helping to develop a framework for understanding these multiple interlocking compounding experiences and factors that span disability, health and social issues.

Continues on page 14 >

DisabilityCare

How relevant is it for me and my clients?

Rachel Merton Chief Executive Officer and **Bev Taylor** Training and Development Manager

Brain Injury Association NSW

DisabilityCare – the National Disability Insurance Scheme – is coming, and there is no doubt it will change the whole landscape in which we work. A record number of people with a disability, including many people with psychiatric conditions, will have their own funding packages and their own individualised plans and goals.

They will make their own choices about which service provider to use, and which services they would like to buy. They will represent a new and empowered group of people who will knock on your door and request your services. They will have funding to pay, and they will have an expectation that they will have choice and control in their experience with you. How will you respond?

In other words, despite the name (and we won't dwell on its lack of appropriateness here!), DisabilityCare will have a ripple effect well beyond the disability service sector. Its focus on each person's whole of life will directly affect organisations like yours outside the disability sector.

Disability service providers will no longer be block funded, and will rely on attracting people to their service to buy what they provide. Competition, standards, promotion, reputation – all will become part of day to day work. Disability service providers will, by necessity, have to become more flexible to clients' needs, and will need to be genuinely 'person-centred' in their approach.

'Person-centredness' is a term now widely used in disability settings, and underpins the approach of DisabilityCare.

Like the term suggests, it's about the person with disability being at the centre of all decisions about their life; it goes well beyond service provision: into broader lived experience, quality of life, choices, dreams and long term ambitions.

The vision is that this will, over time, see an end to the days of the silo-ed approach. Specialised services will still be needed, but far more collaboration across systems will be essential. A condition or diagnosis will not be a pre-requisite. Eligibility and assessment will be based on how a person's ability to live a quality of life is impacted upon by their lack of function or ability in some areas of their lives, and service response will have to be broader and collaborative. Response will be about what they can do to maximise their quality of life, and how you can work with them to support them to do this.

A challenge for the drug and alcohol sector is to reconcile this approach with the tried and tested models for drug and alcohol treatment. Short term goals may be associated with reducing or stopping drug/alcohol use, but the importance of what this can lead to in somebody's life will need to come to the fore, more than ever before. Longer term goals like employment, education, social participation, travel, etc, should guide and drive someone's shorter term goals of reducing or ceasing drug and/or alcohol abuse.

> *A challenge for the drug and alcohol sector is to reconcile this approach with the tried and tested models for drug and alcohol treatment.*

But how does this work in practice? We all know the constraints and barriers, particularly when working with someone with a very complex range of experiences that may include a long history of substance abuse, disability, mental illness, periods of homelessness, challenging behaviours, and/or repeated interactions with the criminal justice system.

Add to this when acquired brain injury (ABI) is in the mix, which may present for you additional challenges that may include impaired executive functions that need to be in place to commit and follow a drug or alcohol rehabilitation plan, ie. the ability to:

- Be proactive,
- Plan and organise, and make judgements and decisions,
- Problem-solve,
- Learn from their own mistakes, and
- See the consequences of behaviour.

The barriers and complexities may seem overwhelming, but focusing on that individual and their longer term goals and hopes can help to guide you, together with the person, to an agreed plan and approach. For many people with an ABI, establishing a commitment to change can be a treatment goal in itself, and can be facilitated through a focus on what this may mean for that person in their future life.

Where can I get help?

There are some support agencies around, BIA NSW runs an information line and advocacy service, and training in working with people with an ABI, including a module on setting person-centred goals.

Contact BIA NSW on:
Phone: 02 9868 5261
Freecall: 1800 802 840
Email: mail@biansw.org.au
Website: www.biansw.org.au

Continued...

Translating Research into practice

Complex needs and the criminal justice system

An important element in working with and supporting a person with complex needs is the recognition that it is not simply a matter of compiling a checklist of needs. It may be helpful to think of a three dimensional matrix of factors, elements and circumstances that interact simultaneously and across time. The interactions have a compounding effect in that the effect is not just the sum of the individual parts but each aspect adds to and increases the potency of each of the other effects. The result of these interlocking and compounding elements is that the total is more than the sum of its parts. There is both a breadth and depth of needs as each increases the other.

For example it is very likely that a person from a cultural and linguistically diverse (CALD) or Indigenous background who has experienced trauma as a young person, is living in out of home care or precarious housing and has cognitive impairment will experience these factors in a heightened negative manner and develop further impairment as a result of these interactions. Rather than the common current experience of this group, which is to be referred from one service to another because none can or are willing to work with the whole person and all their impairments, disorders and disadvantages, a holistic approach in which the person's needs drive the support and services provided is proving the most beneficial.

[1] LP0669246 'People with mental health disorders and cognitive disability in the criminal justice system in NSW' (Cls Baldry, Butler, Webster, Dowse, Indig) and LP100200096 'Indigenous Australians with Mental Health Disorders and Cognitive Disabilities in the Criminal Justice System' (Cls Baldry, Dowse, Trollor, Dodson) http://www.mhdcd.unsw.edu.au/

Responding to the social determinants of health

Access to housing, employment, education and connection to family and social networks should not be a matter of complexity, but a basic human right to live a health and happy life. We know that connection with community can produce better health and social outcomes, reduce problematic substance use, and assist in relapse prevention.

In an upcoming forum hosted by NADA we ask *what does a contributing life for drug users and those in recovery look like, and how should we be supporting them?*

With the release of the National Mental Health Commission report card '*A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention*', Professor Ian Webster will reflect on what this means for those with substance use issues. Associate Professor David Best will speak to the role of social networks, the implications for practice and how we measure success. A diverse range of service providers will talk about their practices in connecting consumers into the community.

NADA invites you to attend this free forum to explore the health and social needs of individuals affected by problematic substance use.

The forum details are:

Community (re)Integration Forum

Date: Wednesday 3 July 2013
Time: 9.30am-3.30pm
Venue: Parkroyal Darling Harbour, 150 Day Street ,Sydney

The forum will be opened by the Hon Kevin Humphries, Minister for Mental Health, Healthy Lifestyles, and Western NSW. Welcome to country will be provided by Michael West, Cultural Representative of the Metropolitan Local Aboriginal Land Council. Michael is a member of the Stolen Generations, Co-Chair of National Sorry Day Committee and Director of NSW Indigenous Chamber of Commerce.

The format of the forum will be a combination of presentations, panel discussions, snapshots of current practice and opportunity for audience participation. As well as providing consumer perspectives.

Contact **robert@nada.org.au** or visit **http://www.nada.org.au/media/40248/nada_ci_forum_flyer___rego.pdf** for more information and to register.

Regional, rural and remote NADA members may be eligible for a travel subsidy to attend. Contact Robert for more information.

This forum is supported by the Commonwealth Department of Health and Ageing under the Substance Misuse Service Delivery Grant Fund.

Complex Needs Capable

A practice resource for drug and alcohol services

Complex Needs Capable: A practice resource for drug and alcohol services has been developed by NADA for the Practice Enhancement Program (funded by the NSW Ministry of Health).

This program aimed to build capacity within the drug and alcohol non government sector in responding to clients with complex needs such as acquired brain injury, intellectual disability, foetal alcohol spectrum disorder and contact with the criminal justice system.

The resource includes practice tips for workers and services in working with people with complex needs. It links theory to practice, provides information on what workers need to know about particular complex need issues, discusses screening and assessment and appropriate tools for service use. The resource contains useful links to support services and a comprehensive list of resources. A CD linking the reader directly to further information, service templates, useful websites and additional resources is also included.

This resource is currently in production and will be available from NADA in July 2013. The website, Complex Needs Capable, will be available in the following months.

The NADA Working with Complex Needs Resource Advisory Group included the following key stakeholders:

- Ageing Disability and Home Care, Family and Community Services
- Brain Injury Association NSW
- Community Restorative Centre NSW
- Corrective Services NSW
- Drug and Alcohol Multicultural Education Centre
- Intellectual Disability Rights Service, Criminal Justice Support Network
- Karralika Programs Inc.
- Mental Health Drug and Alcohol Office, NSW Ministry of Health
- NSW Council of Intellectual Disability
- Russell Family Fetal Alcohol Disorders Association
- University of Technology Sydney

All NADA member services will receive a copy of the resource free of charge and limited copies are available for non-member services. For more information contact *Ciara@nada.org.au*

Strategic Plan

For mental health in NSW

The Mental Health Commission of NSW is developing a draft Strategic Plan for Mental Health in NSW, that will also address drug and alcohol issues and is seeking feedback and ideas from the non government drug and alcohol sector.

The Plan's recommendations will extend beyond the health portfolio and address other portfolios such as housing, education, employment, law enforcement and justice because these have a major influence on the lives of people with comorbid mental health and drug and alcohol problems.

As a first step, people from a range of NGOs were asked for input to help shape our approach to the plan. From this feedback, there were strong calls for the draft Strategic Plan to be developed by and with the people who can lead reform; whether by virtue of their lived experience of mental illness, formal organisational roles, their practical leadership within programs related to mental health and drug and alcohol, through their professional interests. We would like your support to engage broadly with people who may be able to contribute their ideas and thinking, whether as part of your organisation or your wider networks.

People who register will have the opportunity to nominate particular areas of interest and say how they would like to participate via the different options available, including via online forums, face-to-face or community meetings later in the year.

Visit the Mental Health Commission of NSW website to register and have your say.

www.nswmentalhealthcommission.com.au

Mental Health Commission of New South Wales

National Police Check FAQs

NADA has developed an FAQ document surrounding the management of criminal record checks and how they impact policies, procedures and operations within the NGO drug and alcohol sector. The document includes information on recruitment processes, organisational responsibilities and the relevant anti-discrimination laws in relation to hiring employees with a criminal record.

To view the document visit:

http://www.nada.org.au/resources/nadapublications/resourcestoolkits/

or contact Mahlia for more information *mahlia@nada.org.au*

Quality Improvement Resource Tool

For Non Government Drug and Alcohol Organisations - Version 2

NADA is pleased to announce completion of Version 2 of the Quality Improvement Resource Tool for Non Government Drug and Alcohol Organisations.

NADA and the Australian Council on Healthcare Standards (ACHS) have partnered to develop a specific resource to support non government drug and alcohol organisations understand and apply ACHS' EQuIP5 Standards. This QI Resource Tool provides explanations for EQuIP5's Standards, Criterion and Elements; and suggests evidence that may assist in developing organisation's quality improvement program and attaining accreditation. It also provides an introduction to the quality improvement development process.

An electronic copy of the resource has been posted on a NADA flash drive to all NADA members engaged with the ACHS EQuIP5 Program. If you are a NADA member engaged with ACHS and you did not receive a copy of the resource, contact *mahlia@nada.org.au*.

The resource is also available for download in our publications section of the NADA website:

http://www.nada.org.au/resources/nadapublications/resourcestoolkits/

This QI Resource Tool has been some time in the making, and NADA thanks those NADA member staff that provided feedback and suggestions for this second version.

NADA is keen to receive any feedback on the resource's content, usefulness or areas for improvement. Feedback can be provided to *feedback@nada.org.au* or contact Tanya Merinda, Director Planning and Strategy at *tanya@nada.org.au* or phone (02) 8113 1312.

"We thank you and your staff for this superb resource. We are well aware of the time, effort and expertise that goes into the creation of such a document..."

Kay Elson,
CEO, Haymarket Foundation.

NADA Resource Reminder

From Individuals to Families: Single Session Family Consultations A practical example from an alcohol and other drugs service.

In June 2012 NADA launched a new DVD resource that was developed in partnership with The Bouverie Centre. From *Individuals to Families* demonstrates the single session approach as an intervention to improve health and social outcome for both clients and their families. It provides an insight into the clinical and organisational processes required to implement and sustain the approach in services.

The DVD features interviews with 3 NADA members who have implemented the single session, from the perspective of residential and an out client services. They discuss both the benefits and challenges that have seen in conducting family meetings in their services.

The DVD can be used to:

- gain an understanding of the resources and supports required to assist workers to implement family work
- reflect on how to engage family members in the work of individual clients
- discuss sections as part of an implementation strategy
- learn about the skills and processes involved in setting up and facilitating useful family meetings
- be used by teams to discuss as part of professional development.

Though the DVD has been developed for NADA members and highlights an example in a drug and alcohol service setting it will also be useful to most health and community service organisations. Services are invited to adapt the practices reflected in the DVD to fit in with their own practice values and service processes.

The DVD was distributed to all NADA members in June 2012 and is also available through The Bouverie Centre. Please contact *robert@nada.org.au* if you would like to find out more information.

Working with families and support networks

The single session intervention is only one of many approaches to engage families and support networks. For more information contact www.fds.org.au to discuss the Bridging the Divide project on 1300 884 186, or download the *NADA Family and Carer Toolkit: Tools for Change: A new way or working with families and carers.*

http://www.nada.org.au/resources/nadapublications/resourcestoolkits/familycarertoolkit/

Dr Rod McQueen recognised in National Drug and Alcohol Awards

Congratulations to Dr Rod MacQueen from The Lyndon Community who was inducted onto the Honour Roll at the 2013 National Drug and Alcohol Awards (NDAA) at Parliament House in Canberra this month. The Awards acknowledged that Rod has worked tirelessly for his drug and alcohol 'punters' for over 30 years – from his many years as a general practitioner and methadone prescriber in rural New South Wales to the last decade working in Aboriginal drug and alcohol across Western NSW as the Addiction Medicine Specialist. Dr MacQueen not only selflessly gives his time to his clients and communities, but also to countless students, health workers and doctors that have been privileged to cross paths with him. He has been a trail blazer in rural and remote addictions.

National Drug & Alcohol Awards

Meet Your Neighbour

MHCC invites NADA members to host a Meet Your Neighbour network event

The Mental Health Coordinating Council (MHCC) invites community organisations with an interest in mental health to get connected through a *Meet Your Neighbour* event.

MHCC holds *Meet Your Neighbour* events around NSW to encourage organisations to meet, learn more about each other and find ways to work better together. What better way to get to know your neighbouring services than to have them visit you, see where you are and meet your team?

We all know that the mental health and AOD sectors need to work better together to provide the best services for people with co-existing mental health conditions and alcohol and other drugs issues. Experience has shown that through *Meet Your Neighbour*, referral pathways have been established and consumers and carers have been better matched to programs and services in their area.

How it works

An organisation volunteers to be the host. MHCC works with the host to send out the invitations, manage responses and facilitate the event. The host provides a meeting space and a light morning tea. The get-togethers are about 2 hours, with plenty of time for networking.

Would your organisation be willing to host an event?

For more information visit: *www.mhcc.org.au*
or contact Stephanie Maraz
P: 9555 8388 (x104) or
E: *Stephanie@mhcc.org.au*

mhcc
mental health coordinating council

Research Grants Program

2013/14 NSW Health Drug and Alcohol Research Grants Program

Expressions of interest are now open

The Research Grants Program supports innovation in drug and alcohol research in NSW, and provides 12 month funding for small research projects under the following categories:

Category 1:

Experienced Researchers (applicants with 5 or more years of research experience).

Applicants in this category can apply for an amount between $25,000 to $75,000.

Category 2:

Early Career Researchers (applicants with less than 5 years of research experience).

Applicants in this category can apply for an amount up to $25,000.

Application Guidelines and an Application form can be obtained from: *mhdaoresearch@doh.health.nsw.gov.au*.

Applications must be received by:
COB Friday 28 June 2013.

NSW GOVERNMENT | Health

Community Mental Health Drug and Alcohol Research Network update

Relationship development with university staff

The CMHDARN project is a collaborative project seeking to enhance research skills and understanding across the community managed drug and alcohol and mental health sectors, with the longer term objective being to enhance capacity and increase the level of engagement by community managed organisations in research activity. As discussed in past issues of the NADA Advocate, the CMHDARN activities focus on many different aspects of capacity building.

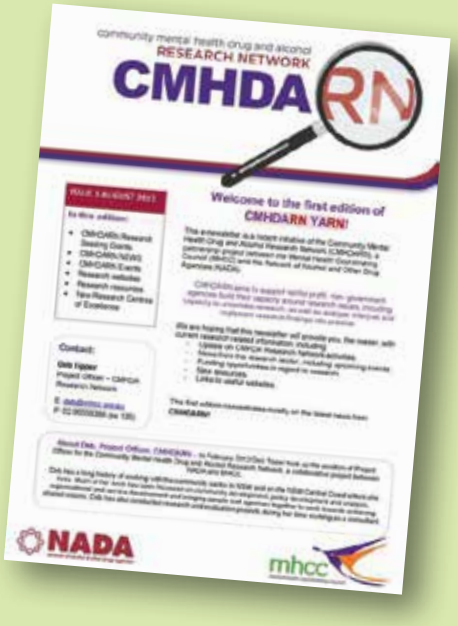
These include:

- Research Seeding Grants
- Research Forums
- Reflective Practice forums
- CMHDARN Website
- Mentoring
- CMHDARN - Yarn, an e-newsletter

A consistent thread through these activities is an aim to develop and enhance relationships between staff of community managed organisations (CMOs) and academic research staff of universities, which in turns increases shared understanding about issues, processes and strengths. It is hoped through these improved relationships better skills exchange will be facilitated and there will be an increase in collaborative research work. To that end, an examination of the people from universities engaged in CMHDARN activities paints an interesting picture. In the last two years (2011-2013) the active involvement of people from universities has been broad.

The nature of this involvement includes:

- **Presentations to, and workshop facilitation of, CMHDARN research forums and workshops** (12 presenters from 5 universities). The feedback in relation to these presenters has been extremely positive, with participants indicating the contribution of academic researchers has added to their enhanced understanding of the particular issues.
- **Attendance at CMHDARN organised events** (around twenty from eight universities): this provides opportunities for networking between the CMO sector and university staff, supporting relationship building.
- **Membership of CMHDARN project reference group:** with its recent expansion, there are now four members from four universities supporting this group. This provides opportunities for CMHDARN to draw on the broad experiential base of different disciplines, foci and university centres of excellence to support the professional development of CMHDARN members in the drug and alcohol and mental health community managed sectors.
- **CMHDARN Research Seeding Grants:** each of the sixteen recipient CMOs is required to develop a relationship with an academic research partner. These relationships lead to increased understanding and skills and knowledge exchange between those involved, and the creation of the potential for additional future partnerships.



Reflections of several university staff who have been involved in CMDHARN activities to date has been to note how critical the shared relationship between them and CMO staff is and to encourage workers to view it as an equal relationship for knowledge, experience and skill exchanges. It is through these relationships and enhanced insights that the research undertaken by university staff in collaboration with CMO staff will ultimately have more relevance to practice and lead to higher quality outcomes for consumers.

For more information on CMHDARN and to become a member check out the CMHDARN website.

www.cmhdaresearchnetwork.com.au

NADA snapshot

Policy and submissions

- NADA provided comment on the NSW Ministry of Health's Research Hubs Strategic Policy Paper. Contact *robert@nada.org.au* for more information.
- NADA provided comment on the review of the Public Health Association of Australia Illicit Drug Problem Policy. Contact *robert@nada.org.au* for more information.
- NADA provided comment on the review of the NSW Ministry of Health draft Consumer Participation Guidelines and policy framework. Contact *robert@nada.org.au* for more information.
- Following NADA's written submission to the NSW Parliamentary Bill on Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence), Larry and Tanya presented evidence to the Committee. We emphasized the need for improved planning and coordination of the NSW drug and alcohol program, and recognition of the contribution to health and social outcomes made by drug and alcohol services, including the non government sector's unique role.

  Contact *larry@nada.org.au* or *tanya@nada.org.au* for more information.
- NADA made a submission in response to the Draft Code of Best Practice for Engagement with the Not-for-profit Sector developed by the Office of the Not-for-Profit Sector Department of Prime Minister and Cabinet. Contact *tanya@nada.org.au* for more information.

Advocacy and representation

- NADA met with the NSW Mental Health Commission's, Mr John Feneley, to discuss the place of drug and alcohol and how it relates to the Mental Health Commission's role. The meeting was a great opportunity to identify strategies for better partnerships between the mental health and drug and alcohol sectors.
- NADA has continued to represent the needs of NSW Health funded drug and alcohol NGOs at the NGO Advisory Committee, asking for clarity on decision processes related to the recent Grants Management Improvement Program (GMIP). NADA, along with other peaks and representative organisations, ask that the NSW Health Ministry work in partnership with the NGO sector so that a improved programs are developed and provided for communities and client.

Sector development activity

- In addition to a number of NADA resources being finalised recently
  - QI Resource Tool
    http://www.nada.org.au/media/41192/nada_achs_equip5_resourcetool_april2013.pdf
  - National Police Check FAQ
    http://www.nada.org.au/resources/nadapublications/resourcestoolkits
- The NADA *Mapping the Non Government Drug and Alcohol Sector* Project is powering along. *http://www.nada.org.au/sectordevelopment/mapping-the-nsw-ngo-sector*
- The Organisation Survey and the Individual Staff Survey has been distributed to in-scope organisations with a closing date of 21 June 2013.

  Contact *tanya@nada.org.au* for project or survey queries.

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