Advocate

The eMagazine of the Network of Alcohol and other Drugs Agencies

Issue 2: June 2016

INTEGRATED CARE

- Women's Domestic Violence Court Advocacy Services
- Murdi Paaki Drug & Alcohol Network
- Sydney Medically Supervised Injecting Centre
- The Lyndon Community
- NSW Ministry of Health

NADA
network of alcohol and other drugs agencies

CEO report

Larry Pierce NADA

Welcome to the June Advocate. In this edition we focus on the topic of integrated care as it relates to alcohol and other drugs services. We are doing this because of the high priority NSW Ministry of Health is placing on this model for the improvement of the consumer/client journey through the health system to improve health care and the consumer/client experience.

As described by the Ministry on page 6, integrated care is a service system that "involves the provision of seamless, effective and efficient care that reflects the whole of the persons health needs, from prevention through to the end of life, across both physical and mental health, and in partnership with the individual, their carers and family. It requires greater focus on a person's needs, better communication and connectivity between health care providers in primary care, community and hospital settings, and better access to community-based services close to home."

This sounds all good and well, but I think there is a great disconnect out in service delivery land about exactly what this means and how we operationalise it. Issues like solid workable connections with a range of service providers to meet the complex needs of our clients, how the flow of client information is managed and how client outcomes are measured and collected are a couple of the big issues we face as a specialist service system.

What are the best models for ensuring we achieve an integrated care approach—is it as simple as the multi-disciplinary team approach within an alcohol and other drugs treatment service, or is it about a complex array of service level agreements with multiple health and social services providers? Or both? This edition of the Advocate will highlight a range of approaches from our contributors that will shed light on this question and hopeful contribute to the ongoing discussion about how to achieve an integrated care model within alcohol and other drugs treatment services across the NGO sector.

NADA is committed to ensuring that—in the context of moving the integrated care framework forward—consumers/clients are enabled to fully participate in the design and delivery of their treatment and care programs. They must become active participants in the whole process so integrated care doesn't becomes just another model of care that consumers/clients are the passive recipients. As the Ministry states—*integrated care is a model that is delivered in partnership with the individual, their carers and family.*

We hope these articles are helpful and also raise questions that we, as a sector, collectively need to address over the coming months and years. Please let NADA know your thoughts.

Safer Pathway

Integrated care for domestic violence survivors

Renata Field Director, Women's Domestic Violence Court Advocacy Services NSW Inc.

The Women's Domestic Violence Court Advocacy Services (WDVCAS) have been operating in NSW since 1996, supporting women and children experiencing domestic violence (DV) to navigate the local court system for DV protection orders and other related matters. As of 2014, the services have evolved to support women in a more integrated manner through formalised partnerships with NSW police, local government and non government services in a model called *Safer Pathway*.

In September 2014, *Safer Pathway* was launched in Orange and Waverley as part of the NSW Government's Domestic Violence Reform Framework *It Stops Here*. Four further sites were established in Bankstown, Parramatta, Tweed Heads and Broken Hill in the following year.

Progress is promising. Women and their children receive integrated support from a range of partner organisations in a timely fashion. Unprecedented outcomes are being delivered such as rehousing through the Department of Housing within two days or immediate welfare checks from police that have saved lives.

How does Safer Pathway work?

Under the model, NSW Police complete a common assessment tool, called the Domestic Violence Safety Assessment Tool (DVSAT), with clients who are victims of family and domestic violence (FDV). Victims are assessed as "at threat" or "at serious threat" and immediately referred to a Local Coordination Point (LCP) for support. The vast majority of victims are female victims, who are supported by WDVCAS, while male victims are supported by Victims Services.

LCPs, hosted by WDVCAS services, assess the threat of further violence to clients referred to them and provide case coordination to ensure their safety and support needs are met. WDVCAS workers attempt to contact women within one business day of receiving referrals. Every attempt is made to contact women, gain consent and ensure their immediate needs are met. Privacy laws were changed to allow freedom to share information if the client or her children are assessed to be at risk of harm, allowing action to be taken to prevent further harm even if the client cannot be contacted.

Safety Action Meetings (SAMs) occur fortnightly, coordinated by the relevant LCP and chaired by a local senior police officer. In cases where a woman is assessed as being "at serious threat," her details are forwarded to the SAM for discussion and support. A range of agencies attend the SAMs to provide the client with the most effective support available, including NSW Police, WDVCAS, Centrelink, Department of Housing, NSW Health, crisis accommodation services, AOD services, corrective services, local schools and the Department of Family and Community Services. Government attendees are permanent members and attendance is compulsory. Non government agencies will be invited where it meets the needs of the client, or where the client is receiving service from a particular agency.

Agencies work together at SAMs to ensure FDV victims don't have to repeat their story every time they need help. A safety action plan is developed to provide for the safety of the clients and their families and for their continued support through local services. Fortnightly meetings and thorough minutes with action points ensure accountability from all members of the meeting and offer clients the best safety outcomes. Clients who are "at serious threat" are now being properly identified and prioritised for immediate support.

Safer Pathway represents a ground-breaking shift in the way FDV victims are supported and perpetrators are dealt with in NSW. What NSW Police, WDVCAS and their local service partners are achieving by implementing the *Safer Pathway* reforms is a timely, assessment based, safety-focused integrated response to victims, many of whom fear for their lives and are at serious risk of harm.

Moving forward

The Hon. Pru Goward MP has committed to *Safer Pathway* being rolled out state-wide by 2019. The launch of five further sites which were to be established in March, have unfortunately been delayed by government. *Safer Pathway* is an important initiative to respond in an effective and integrated manner to the increase in FDV cases being reported and to the alarming number of DV-related deaths. Women and children across the state should have access to the positive outcomes and protection from further violence that have been seen in the six launch sites. The NSW Government should fund the *Safer Pathway* model to be rolled out across the state immediately.

Women's Domestic Violence Court Advocacy Service NSW Inc

WDVCAS NSW Inc. and the 28 WDVCASs across NSW are funded by Legal Aid NSW through the Women's Domestic Violence Court Advocacy Program.

Integrated care for co-occurring disorders in New Zealand

Dr. Fraser Todd Senior Clinical Advisor, Matua Raki

There has been considerable effort to improve care for people with co-occurring substance use and mental health problems in New Zealand over the past decades.

Developments in co-occurring disorders have been led by Workforce Development Centres, in particular Matua Raki. This has been supported by the Ministry of Health which published updated clinical guidelines (Te Ariari o te Oranga) and service level guidelines (Integrated Solutions) in 2010.

Implementing integrated care for co-occurring disorders in New Zealand has faced a number of challenges:

- While New Zealand mental health and addiction services are funded by the Ministry of Health, no specific funding for integrated care has been made available.
- There are few other drivers of integrated care for co-occurring disorders apart from committed practitioners and managers.
- There are competing demands on clinicians and services that can appear disconnected from each other—for example, COPMIA, primary-specialist integration and physical health integration (Equally Well). Maintaining momentum for systems change that might take decades is difficult in the face of these competing demands.

As a result there has been a focus on the capability of services to deliver both mental health and addiction care in an integrated way, relying on collaboration across services as a means of integration. Co-occurring disorder champions and managers report good progress in this regard, however many clinical leaders and middle managers are not engaged in integrated care for co-occurring disorders and large pockets of resistance remain.

Co-occurring disorders is one of many areas where integrated care is needed to improve health outcomes. Many attempts to integrate care have focused on integrating two or three issues that are prominent at any given time and usually start at a service or funding level. These often have little impact at a clinical level and become disconnected from treatment for other problems.

Increasingly we are advocating a different model of integrated care. Rather than trying to bring together two or three specific aspects of care at a service level, we start with the needs of the person and their family, providing clinicians with the tools to integrate the multiple different care needs. Clinical services, administrative support, information technology services, funding streams and other support services would then be expected to support clinical integration rather than make collaborative arrangements that suit their own needs, as often currently happens.

The starting point for integrating care at a clinical level is for clinicians to share a common "big picture" vision of their purpose. This then becomes an overarching framework or mental model of how they work. The most suitable model for integration of health care is a model of wellbeing or quality of life, as this allows subordinate models to be included. It has become increasingly apparent in interactions with the mental health and addiction workforce that while many people acknowledge the importance of AOD, mental health, physical health, and recovery principles, they struggle to integrate this into their work. While they are able to articulate the importance of these health dimensions the models of care active in their practice tend to be narrower. For example, many mental health clinicians still practice as if their key purpose is to treat specific mental health disorders. This is often reinforced by how services are funded and function and by the contracted outcome measures and key performance indicators.

When integrating care across systems, a higher level model is needed. For example the justice system sees its purpose as maintaining public safety and ensuring fair application of laws, and the quality of life of the people being dealt with is not seen as its primary concern. Integration between justice and health would therefore need a shared higher order model—such as one of community, or social wellbeing—within which personal wellbeing, and as part of that treatment of disorder, can be incorporated.

Such an approach will require a major transformation in how the health system thinks about what it does and this is likely to take time. Ultimately however, such an approach would lead to more widespread integration of health care rather than attempts to bring together a small number of specific health tasks driven by service needs.

Matua Raki
National Addiction Workforce Development

Learn more about Matua Raki.

Integrated care

A message from NSW Health Integrated Care

Person-centred care

Delivering integrated care involves the provision of seamless, effective and efficient care that reflects the whole of a person's health needs, from prevention through to end of life, across both physical and mental health.

There is considerable research to show person-centred care can improve care quality, health outcomes and consumer experience. Integrated care is person-centred care, developed in partnership with the individual, their carers and family.

Integrated care requires better communication and connectivity between health providers in primary care, community and hospital settings and better access to community-based services closer to home.

It is recognised people using alcohol and other drugs often have multiple and complex needs. There can be a high prevalence of co-occurring mental and physical health conditions as well as social and welfare needs. Coordinating suitable care and ensuring clear referral pathways is essential to effectively meeting these needs.

Transforming healthcare

NSW Health has invested in a range of strategies to help achieve integrated care including: the NSW Integrated Care Strategy, HealthOne NSW, the NSW Chronic Disease Management Program and the Whole of Health Program. NSW Health also continues to invest in health promotion and disease prevention programs.

Delivering truly integrated care is one of the three strategic directions of the NSW State Health Plan: Towards 2021. The Integrated Care Strategy has seen the NSW Government commit $180 million over six years to implement innovative, locally led models of integrated care.

Of this, $50.6m is being invested over four years in three integrated care demonstrators, based in metropolitan western Sydney, the Central Coast region and the rural west of NSW. These demonstrators see local health districts and specialty health networks partner with government and non-government organisations, hospitals, primary care providers and community services.

Each demonstrator is a taking a different approach, responsive to local needs, and knowledge gained will be shared across the state.

The $17.6m Western Sydney Integrated Care Program is supporting GPs and patients to manage chronic conditions —cardiovascular and respiratory disease, diabetes—as well as provide better access to specialist services within the area.

A whole-of-population approach is being taken by the $16.2m Central Coast Integrated Care demonstrator. It is looking at social determinants of health and social services, such as housing and education. People living with complex and chronic conditions, vulnerable older people and vulnerable younger people are the three targeted consumer groups.

Closing the Aboriginal health gap is a key focus of Western NSW Integrated Care. Funding of $16.8m is supporting ten different locally focused demonstrator sites to enable better connections between services and improved delivery of care.

Integrated care initiatives mean NSW is now moving towards

- focusing on organising care to meet the needs of consumers and their carers, rather than organising services around provider structures
- designing better connected models of healthcare that leverage available service providers, especially to meet the needs of rural communities
- improving the flow of information between all healthcare providers
- developing new ways of working across government agencies and with Commonwealth funded programs to deliver better outcomes, and
- providing greater access to community based services to help ensure people receive care closer to home.

Achievements can be measured by

- consumers reporting that they can more easily navigate the health system
- improved experiences with better health outcomes
- reduced waiting times
- more people cared for in the community
- fewer avoidable and less frequent hospital admissions and emergency department attendance, and
- better sharing of clinical information and a reduction in unnecessary duplication of tests and services.

Integrated care

continued

Such transformation in the way healthcare is delivered invites changes to the culture of the health system, workforce skills and capabilities, the way care is paid for and the commitment to and investment in these changes.

By building on the strengths that a range of providers can offer across the system to people needing help, NSW is very well positioned to deliver the right care in the right place at the right time.

For more information about NSW Health Integrated Care please contact Stefanie Williams, A/Executive Director Health and Social Policy Branch.

NSW GOVERNMENT Health

LikeMind

LikeMind is a service for adults with mental health concerns, their families and carers.

With centres in the outer Sydney suburbs of Penrith and Seven Hills, LikeMind brings together existing community and health services in accessible and welcoming spaces that are close to transport, shopping and other facilities.

Mental health, alcohol and drug health, primary care and employment services are offered by a consortium of providers. This nucleus of the integrated services provides shared care practices between GPs, allied health private practitioners and consortium member agencies.

Workforce development and community outcomes through partnerships

Julie Proctor Program Manager, Murdi Paaki Drug & Alcohol Network

The Murdi Paaki Drug & Alcohol Network (MPDAN) is a workforce development strategy aiming to support professionals in the delivery of drug and alcohol services to Aboriginal communities in the Murdi Paaki region of NSW—but it's much more than that.

MPDAN was formed through partnerships between Lyndon and Aboriginal health services across the Murdi Paaki region, with the aim to reduce harm done by alcohol and drugs in Aboriginal populations. MPDAN's hub in Orange focuses on improving access to specialist drug and alcohol knowledge and supporting existing primary health care through worker support, capacity building and community development. MPDAN coordinators are located in the Aboriginal health services that provide frontline clinical services. The hub provides supervision, training, peer support, specialist addiction medicine visits, culturally appropriate resources and practice guidelines to its service partners who work with Aboriginal people. Following are two initiatives in the MPDAN region that demonstrate integrative approaches.

Challenge to Bourke

The challenge issued to Bourke was for the local community to reduce consumption of drugs and alcohol and to confront family and domestic violence. MPDAN Coordinator and Drug & Alcohol Counsellor, Michelle Goodwyn, based at Bourke Aboriginal Health Service (BAHS), brought together a wide range of agencies and businesses to organise a month-long project culminating in a three-day conference in July 2015. The project included loss and grief workshops, people pledging to reduce their drug/alcohol intake and Aboriginal cultural activities.

"The community was disturbed by the cycle of alcohol, drugs and violence—it had to be an all-of-community approach where people could make connections between addressing social issues and better health outcomes," said Michelle.

In partnership with MPDAN hub staff and local organisations, Michelle developed a program of diversional activities. People engaged in culturally-appropriate, meaningful occupation whilst accessing education about alcohol and drugs. Activities included paperbark workshops, men's yarning group, encaustic wax art workshops and weaving workshops.

"The events were mostly well-attended and feedback from community and services has been positive. We're hoping to continue the *Challenge to Bourke* concept into the future," said Michelle.

Darling Local Area Command (LAC) was pleased with the results of the initiative and requested the project be repeated in January 2016.

Coonamble Alcohol & Drug Advisory Group

The Coonamble Alcohol & Drug Advisory Group (CADAG) is an interagency group that has been running monthly meetings for four years. CADAG is facilitated by MPDAN Coordinator and Drug & Alcohol Counsellor, Robert (Bobby) Jones, based at Coonamble Aboriginal Health Service.

The goal is to advance the knowledge and understanding of alcohol and drug issues among professionals and throughout the Coonamble community. Through an education-based model, various topics are discussed in an easy to understand format, allowing for openness and interaction. Each month around fifteen cross-sector participants join together to discuss community drug and alcohol concerns, social issues and pathways to care. The result has been that workers from the wide range of organisations attending, have not only the knowledge to engage their client groups in the area of alcohol and other drugs, but also a sense of being comfortable in doing so, enabling more effective referrals.

"The sessions play an important function in building the capacity of local providers who have little or no knowledge of the subject matter—yet they deal with clients affected by drugs and alcohol regularly."

In June, CADAG members will be attending training the MPDAN hub is rolling out across the region entitled *Engaging Clients: Introducing Drug & Alcohol Screening and Brief Intervention Approaches*.

MPDAN will continue to support grassroots integrative care models into the future. Visit this webpage for more information, or email MPDAN Program Manager Julie Proctor.

Translating research into practice

The CUPID study: Research with couples who inject drugs

Jake Rance, Associate Researcher and **Carla Treloar**, Professor
The Centre for Social Research in Health, UNSW Australia

Sexual relationships frequently incorporate a high degree of intimacy, collaboration and sharing; this is as much the case for partnerships between people who inject drugs as for other partnerships. Perhaps not surprisingly then, epidemiological and survey data show that the majority of sharing of injecting equipment also occurs between sexual partners. Despite this, little research to date has focused on the intimate partnerships of people who inject drugs as key sites of hepatitis C (HCV) prevention or transmission. In an effort to address this gap in knowledge, the Centre for Social Research in Health has been leading a three-year study based on interviews with heterosexual couples who inject drugs and harm reduction workers in Sydney and Melbourne. We particularly wanted to better understand the role of intimate partnerships, as not only crucial sources of care, support and stability, but as influential sources of practice, including those negotiated around injecting drug use.

Main findings

For many couples, trust was the distinguishing feature of shared drug use with their intimate partner. Trust meant more, however, than simply the avoidance of viral danger; it functioned as a form of emotional (as well as risk) management. Nearly all participants described "rules" they had negotiated with their partner around injecting drugs with others. Abiding by these rules was integral to not only ensuring each other's viral safety, but creating and maintaining trust and intimacy within the relationship.

Many of our participants reported doing "everything together." Being continually physically proximate as well as emotionally close facilitated the co-creation of intimate, interpersonal knowledge, including about each other's injecting practices, viral serostatus and medical check-ups. Couples' incorporation of this "biomedical" knowledge within the partnership enabled both the consolidation of mutual trust and collaborative forms of viral-risk management.

Importantly, participants' perceptions of risk were not fixed but fluid and contextual. Couples' sense of risk evolved over the course of their relationship. For some, their vigilance around keeping their equipment separate diminished over time as the relationship became more "serious." However, a growing sense of emotional closeness did not necessarily lead to a "relaxation" of attitudes towards HCV. Some participants reported their injecting practices became "stricter"—after gaining a clearer understanding of genotypes, for example, or beginning HCV treatment.

Participant accounts revealed the extent to which risk management for couples who inject drugs is a complex, and at times, contradictory process, involving the balancing or prioritising of multiple, often competing, risks. They revealed the importance of the intimate partnership as a site of everyday risk management, shaping how viral and other risks are given particular meaning, and influencing how risk-related practices (including sharing) unfold. Sharing with one's partner was invariably described by participants as a "last resort" and, for nearly all participants, something not done with anyone else. Nonetheless, participants invariably prioritised the protective effects of their relationship over the dangers of viral infection. Caring for one's partner, for example, might mean reusing (or sharing) equipment to cope with the immediate demands of drug dependence and withdrawal.

Interviews with harm reduction workers were similar in many respects. Most reported that they had little experience working with couples in harm reduction settings; some felt that couples shared the same HCV prevention needs as individuals. The popular stereotype of couples who inject drugs—as "drug-driven" and "unhealthy"—was also discussed. Workers tended to focus on those relationships that were "in trouble" with issues such as domestic violence. While we acknowledge that this is indeed a reality for some relationships, the love and care that many couples have for each other was rarely mentioned. Failing to work with the strengths found in the intimate partnerships of couples who inject will, we believe, limit the impact of HCV prevention and health promotion programs. We concluded that there are considerable opportunities to assist the harm reduction workers in integrating a more strengths-based approach when working with couples.

Translating research into practice

continued

Selected recommendations for policy and practice

1. Develop and implement workforce capacity-building strategies for the blood-borne virus sector to

- capitalise on the existing strengths of the harm reduction workforce in providing evidence-based and client-centred care
- challenge stereotypes of couples who inject drugs as dysfunctional, non-caring and co-dependent
- acknowledge policy and practice limitations, such as client confidentiality
- develop specific skills and competencies around injecting drug use and hepatitis C prevention for work with couples; and
- include couples who inject drugs in the development of workforce strategies.

2. Develop and implement harm reduction/hepatitis C prevention materials that are tailored to couples who inject drugs that

- challenge existing messages and practices which assume "the individual" is the target of the message
- acknowledge the care that couples provide each other, not only in relation to HCV prevention but in all aspects of their lives
- acknowledge that many actors have responsibility for hepatitis C prevention (including health agencies and government, as well as people who inject drugs)
- recognise that couples' decisions about hepatitis C risk will prioritise protection of their relationship
- consider the role of equipment design in addressing the needs of couples and, in turn, supporting safer injecting within couples; and
- promote the participation of the target group (couples who inject drugs) as fundamental to producing new harm reduction/hepatitis C prevention messages and approaches.

3. Consider other programs within the harm reduction, drug treatment and hepatitis C-care sectors that are amenable to including a focus on couples who inject drugs, such as

- provision of naloxone programs for overdose management
- detoxification and opiate substitution treatment programs (where couples could be assessed and undertake treatment together, if appropriate); and
- hepatitis C care and treatment (where couples could jointly discuss the challenges involved in undertaking treatment and access support if/when treatment commences, including for the partner not undertaking treatment).

4. Consider programs in the broader social welfare field that do not acknowledge the resources of couples, or indeed exclude couples as clients, such as drug rehabilitation facilities or crisis accommodation services to which couples cannot usually be admitted.

Click here for more information about the CUPID project.

CSRH
Centre for Social Research in Health

Publications to date

Fraser, Suzanne. 2013. "The missing mass of morality: A new fitpack design for hepatitis C prevention in sexual partnerships." *International Journal of Drug Policy* 24: 212–219.

Fraser, Suzanne, Carla Treloar, Joanne Bryant, and Tim Rhodes. 2014. "Hepatitis C prevention education needs to be grounded in social relationships." *Drugs: Education, Prevention, and Policy* 21: 88–92.

Fraser, Suzanne, Jake Rance, and Carla Treloar. 2016. "Hepatitis C prevention and convenience: why do people who inject drugs in sexual partnerships 'run out' of sterile equipment?" *Critical Public Health* 26: 294–06.

Treloar, Carla, Jake Rance, Joanne Bryant, and Suzanne Fraser. 2016. "Understanding decisions made about hepatitis C treatment by couples who inject drugs." *Journal of Viral Hepatitis* 23: 89–95.

Acknowledgements

We would like to thank all the participants who so generously shared their time and insights and the services who assisted us with recruiting participants. We would also like to acknowledge the chief investigators, Carla Treloar, Suzanne Fraser, Joanne Bryant and Tim Rhodes, and associate investigators, Nicky Bath and Mary Ellen Harrod, and researcher Jake Rance.

Integrating consumers' views into service delivery in a supervised injecting facility

Mark Goodhew Mental Health Nurse Co-ordinator, MSIC

The Sydney Medically Supervised Injecting Centre (MSIC) is a health service where people can legally inject drugs under the supervision of professionals in order to reduce the harms of injecting. The majority of MSIC clients are socially marginalized, because they are often homeless, unemployed and have low levels of education. To better integrate their ideas into service delivery and provide services that reflect clients' needs, MSIC commenced a consumer participation group in June 2015. Consumer participation occurs when consumers are actively and "meaningfully involved in decision-making about health policy and planning, care and treatment, and the wellbeing of themselves and their community." [1]

Mental health services have used consumer participation since the 1980s and they have well established mechanisms to involve consumers in service delivery and planning. Consumer participation was introduced into drug treatment services in Australia a decade ago, but participation is mainly through satisfaction surveys, a method of participation that often does not lead to improved service delivery.[2] Research into consumer participation in drug treatment services indicates that participation that involves activities beyond satisfaction surveys can improve service quality and help consumers learn new skills and achieve high levels of satisfaction and goal achievement.[3, 4, 5] On the other hand, studies have also reported that people who use drugs may not have the capacity to be involved in service delivery planning because of their drug use and lifestyles.

The MSIC consumer group comprises eight consumers and five staff who meet every three weeks to discuss and plan activities to enhance consumers' involvement in service delivery. This group is part of my PhD project that is investigating how the process of forming a consumer group influences active consumer participation in service planning and delivery at MSIC.

At first there were concerns that consumer attendance would be low because of their marginalized lifestyles; but on average consumers' attendance has been around 75%. In addition, there was apprehension that the consumers may attend meetings intoxicated and this would disrupt the group's functioning. Yet to date, all consumers have been alert, attentive, passionate and have been discussing important issues and suggesting creative ideas. Both consumer and staff group members say they enjoyed attending the meetings as it removes the power dynamics that occur between health care consumers and staff, and it has allowed both parties to see each other's humanistic qualities. The consumers have also reported that the group has provided them with a voice that they rarely get in society, because of the stigma and discrimination associated with their drug use and lifestyles.

While consumer group members agreed to complete tasks outside the group, they often do not complete them. On reflection, having an opioid addiction can be a full time job and homework tasks are not their first priority. This is because consumers have to obtain their drugs every four hours or so to avoid uncomfortable withdrawals and emotional pain that usually has its origins in early childhood. Furthermore, some of the consumers are without a home and do not have access to tools such as computers to complete their tasks. Overall, even if consumers do not actively influence MSIC service delivery, having a forum to voice their opinions will help to both empower them and shape a service that is more reflective of consumers' needs.

Members have designed T-shirts to promote the group, obtained a computer for client use, and accessed a police liaison officer so MSIC clients have an avenue of redress. The group will also attend a safer injecting workshop so they can teach their peers the safest techniques to inject. These achievements demonstrate that highly marginalized people such as MSIC clients can positively influence service delivery when they are given a voice, listened too, and have a part in shaping a service that reflects their needs.

Bibliography

1. ACT Government Health. 2011. Consumer & Carer Participation Framework, health.act.gov.au/c/health?a=dlpubpoldoc&document=2771, viewed 8th November 2011. (page 7)
2. Trujols, Joan, Ioseba Iraurgi, Eugenia Oviedo-Joekes, and Joan Guàrdia. 2014. "A critical analysis of user satisfaction surveys in addiction services: opioid maintenance treatment as a representative case study." *Patient Prefer Adherence*. 8: 107–17.
3. Bryant, Joanne, Melissa Saxton, Annie Madden, Nicky Bath, and Suzanne Robinson. 2008. "Consumers' and providers' perspectives about consumer participation in drug treatment services: is there support to do more? What are the obstacles?" *Drug and Alcohol Review*. 27(2): 138-44.
4. Brener, Loren, Ilyse Resnick, Jeanne Ellard, Carla Treloar, and Joanne Bryant. 2009. "Exploring the role of consumer participation in drug treatment." *Drug and Alcohol Dependence*. 105(1-2): 172–5.
5. Rance, Jake, and Carla Treloar. 2015. ""We are people too": consumer participation and the potential transformation of therapeutic relations within drug treatment." *International Journal of Drug Policy*. 26(1): 30–6.

Uniting

Creating safe pathways

The CRC and a collaborative pre-release approach

Paul Hardy Senior Transitional AOD Worker, The Community Restorative Centre

The Community Restorative Centre (CRC) Transitional Alcohol and Other Drugs (AOD) Project works with men and women on release from custody who have identified problematic AOD use as well as other complex needs, including mental illness and cognitive impairment. Transitional AOD workers provide outreach AOD counselling and support to people in the Sydney metropolitan region who have difficulty accessing mainstream AOD services.

84% of AOD transition clients have a mental illness, 22.5% have a cognitive disability, and 19% have both a mental illness and a cognitive disability. All clients are also rated to be at a medium to high risk of recidivism on the Corrective Services risk assessment tool, the *Level of Service Inventory—Revised*, that considers the areas of criminal history, education/employment, finance, family, accommodation, leisure/recreation, AOD problems, emotional/personal and attitudes/orientation.

Comprehensively addressing these support needs requires a variety of providers working together in an integrated manner. Gisey[1] notes "a collaborative, multi-agency response is necessary to support clients who live with chronic primary and mental health issues and face a number of barriers to service provision." However there are frequent barriers to collaboration when working with men and women on release from prison, including, significantly, an absence of community based pre-release engagement. This paper suggests that pre-release engagement is frequently the missing link in terms of collaboration between criminal justice and community sector agencies.

In most cases, community based services do not work with clients before they are released from prison. CRC's model provides an example of the manner in which the community sector can collaborate with corrections (and ideally other service providers) to work with people prior to their release. Providing support in this context allows therapeutic relationships to be built, and affords time to plan for the high-risk period immediately after release. Pre-release engagement can also provide the key to laying a stable foundation for community based work. Many clients tell us that simply visiting them in custody is significant. Our experience of navigating the Corrective Services bureaucracy and the difficulties that arise when planning and carrying out visits, gives us some insight into the daily life of an inmate. This shared experience helps when building relationships. In addition, we use a deliberate approach of listening to the stories of clients without making their offending history the focus of the conversation. Focusing attention on the parts of peoples' lives that are not defined by criminal behaviour is key to assisting people to create an identity outside of the criminal justice system.

Relationships of trust help overcome social isolation; they facilitate information sharing and safe pathways to other services. Ensuring that clients keep crucial appointments to maintain their primary and mental health reduces the risk of relapse due to self-medicating. In addition to explaining available services and the processes involved in accessing them, clients are supported to develop confidence and communication skills which empower and enable them to benefit from other supports.

Some of the challenges in encouraging collaboration between the community sector and the criminal justice system arise from misconceptions about the level of risk people on release from prison pose to the community and a lack of awareness of the level of support people in prison receive. Community agencies are sometimes reticent to engage with people in custody because of the assumption that people on release from prison are significantly different or more dangerous to other vulnerable complex needs populations, and also because of the perception that people are already linked with services because they are incarcerated. Neither assumption is true.

In order to build collaborative pathways outside of the criminal justice system, it is necessary for the community to first link in to the prisons. This allows perceived barriers between people in prison and "other" clients to be broken down, facilitates trust between incarcerated people and external agencies, and allows clients to be viewed as more than a line on a sentencing sheet, which is often the worst thing they have ever done. Our aim is to help them connect with the other parts of themselves that are so much more rewarding.

The Community Restorative Centre provides a range of services to people involved in the criminal justice system and their families.

1. Gisev et al (2015) Determining the Impact of Opioid Substitution Therapy Upon Mortality and Recidivism Among Prisoners. *Trends and Issues in Crime and Criminal Justice*. 498 (June).

Dianella's merger with Lyndon

Ed Zarnow CEO, The Lyndon Community

In 2014 the management committee of Blue Mountains Drug and Alcohol Recovery Service (BMDARS), who operate Dianella Cottage in Katoomba, approached Lyndon Community to start discussions on a possible merger. BMDARS management committee was finding it increasingly difficult to find interested committee members and also to provide adequate support to the organisation in what is becoming an increasingly competitive environment.

According to Antonia Ravesi, manager of Dianella Cottage, Lyndon was chosen because of our values, principles, culture and the program models we have. Lyndon Community saw the potential merger as an opportunity to gain the experiences of a service model which Lyndon did not operate—a women's day program—but also as an opportunity to support an organisation delivering an important program that was at risk of disappearing.

For Dianella Cottage, the significant benefits of a merger included access to an electronic client management system, linking into Lyndon's accreditation system and processes, access to Lyndon's research programs and a strong governance, management and back office structure for payroll and finance.

In the early stages, the management teams of both organisations met on a number of occasions to talk to staff who would be affected by the merger to assure them that there would be no adverse effects on their continued employment. There was also lengthy discussion on the benefits that staff and clients would get from a merger. This was one of the most important areas that needed to be addressed to ensure the process went smoothly.

As neither organisation had any experience in managing a merger process we looked for organisations that would be able to assist. We located a firm called Justice Connect who sourced legal firms that provide not for profits with pro bono work. After submitting an application we were successful in contracting two law firms to support both organisations through the merger processes and legalities involved.

There are complex legal issues that surround mergers and it was deemed necessary to involve experienced legal support in the process to protect both organisations from any potential or unforeseen liability. It became clear early on that this merger would not be all that complicated as BMDARS had limited assets and a small staffing complement which would need to be transferred, and fortunately the service only had one funding body with which to negotiate.

The formal merger process commenced early 2015 and was expected to be completed towards the end of that year. The merger took 18 months to complete and the final transfer was signed on 1 April 2016. The merger was a staged process. Staff were transferred to Lyndon in November 2015 and the transfer of the funding agreement with the Australian Government was completed in December 2015.

Some of the things we needed to discuss and agree on, included future branding and logos, websites, board member representation, tithing of surplus funds, program structure and staff pay levels. None of these proved to be difficult and were easily worked through.

The formal transfer document could not include everything. The one thing that was most important for the management committee and staff of Dianella Cottage, was that the community in the Blue Mountains continued to have a locally based drug and alcohol treatment service. Although there was a funding agreement that dictated the service model and location it was also important that there was a genuine commitment from Lyndon's management to support the service, clients and community into the future.

The most important things I have learnt from this merger process include

- governments do not purchase services on reputation or sovereignty
- clients and community value our services and not our sovereignty, so we will be judged on this
- it's better to be proactive in relation to looking at partnerships and possible mergers than to wait for it to be a matter of survival; and
- organisational identity and culture can be maintained after a merger.

It is still early days but so far the merger of Dianella Cottage under the Lyndon umbrella has gone well. I believe success will be measured once funding is gained for a further period past June 2017.

lyndon

Useful resources

Resources and reports

Providing Integrated Care:
Experiences of healthcare providers

Undertaken by The Joanna Briggs Institute, this rapid review [PDF] aimed to identify and assess existing literature that has assessed healthcare professionals' experiences and satisfaction with the provision of integrated care, and to provide a synopsis of surveys and qualitative studies.

Integrating Care for People with
Co-occurring Alcohol and Other Drug

Most people with AOD use disorders suffer from co-occurring disorders (CODs), including mental health and medical problems, which complicate treatment and may contribute to poorer outcomes. However, care for the patients' AOD, mental health, and medical problems primarily is provided in separate treatment systems, and integrated care addressing all of a patient's CODs in a coordinated fashion is the exception in most settings. This paper explores barriers and best practice approaches to integrated care. Click here [PDF].

Effective models of care for comorbid mental illness and illicit substance use evidence check review

Produced by the Mental Health and Drug and Alcohol Office, this report addresses three key questions:

1. What are existing models of care for adults with comorbid mental illness and substance use?
2. What is the efficacy of existing models of care for adults with comorbid mental illness and substance use?
3. What are the key considerations and recommendations in the design and evaluation of best practice models of care for adults with comorbid mental illness and substance use?

The report also provides specific recommendations for a NSW setting on the basis of these findings.

A study of patient pathways in alcohol and other drug treatment: Patient pathways national project

This study focuses on treatment systems and pathways through specialist and linked services rather than focusing exclusively on the client AOD treatment journey.

Guidelines

New Zealand Ministry of Health

Te Ariari o te Oranga: The assessment and management of people with co-existing mental health and drug problems

The guidelines [PDF] present a clinical framework to assist health professionals working with co-existing substance use and mental health problems.

Service delivery for people with co-existing mental health and addiction problems: Integrated solutions

This service delivery guidance document [PDF] provides advice to assist mental health and addiction services to enable the provision of more integrated care for people with co-existing mental health and addiction problems.

Websites

NSW Health

The integrated care page on the NSW Health website presents a definition of integrated care and the potential benefits. There are also some useful links to integrated care examples from around the world. Other useful resources include

- NSW Integrated Care Strategy
- Integrated Care Branch
- Objectives and expected benefits

Agency for Clinical Innovation

The Agency for Clinical Innovation has a specific area dedicated to the topic of integrated care and it has links with further information related to Patient Reported Measures—ACI PROMS and PREMS for Integrated Care Scoping Workshop December 2014 [PDF].

- ACI Integrated Care: Patient reported outcome measures and patient reported experience measures a rapid scoping review [PDF]

Member profile

Manly Drug Education & Counselling Centre

Manly Drug Education & Counselling Centre (MDECC) is a comorbid alcohol and other drug (AOD) and mental health service that provides a model of evidence-based, outcome-focused counselling and support for young people (14 to 25) with problematic AOD use, and their families.

As a "harm minimisation" organisation, MDECC is able to engage young people whether they choose to abstain or not. Young people who present at MDECC are often in stages of precontemplation or contemplation, that is, thinking that their current drug use is not impacting on their life in a way that would encourage a change in behaviour.

By also engaging their parents, an opportunity is created to address the issues within the family system that may be blocking pathways for the young person to move into a preparation stage and ultimately into an action stage. It is known that treatment is more effective when people have willingness for change. It is important to note that young people who have families who are not willing to access the service are also seen as priorities and are supported to achieve their goals.

MDECC is also able to provide a psychiatric consultation for our young clients through a brokerage program with headspace and referral pathways into the mainstream health system if required.

When a young person or parents enter the service, they are informed that MDECC is a family inclusive service and should their parent or son/daughter present at MDECC, the clinical team will discuss the family as a whole and assess the best way to support each member. It is explained that our experienced and professionally trained counsellors can keep confidentiality and privacy protected and clinically discuss family issues with respect and no judgement.

Intake

At intake a comprehensive assessment is completed including quantitative tools such as Outcome Rating Scale (ORS), Depression, Anxiety and Stress Scale (DASS 21) and Severity of Dependence Scales (SDS) for young people. Young people are allocated their own counsellor and parents are always encouraged to attend MDECC's Paving Ways Group.

Case review

Case review is the opportunity for the clinical team to exercise best practice. This is done by reflecting on cases

from an AOD, mental health and family therapy lens, and sharing thoughts and ideas from each of these fields. All clients are presented at case review before session 12 or if their mental health/AOD use has significantly escalated. The counsellor presents the ORS, SDS and DASS in comparison with data from intake. It is also an opportunity for clinicians to share information and combine their conceptualisations of each case.

Modalities

Modalities utilised at MDECC are all evidence-based, specifically cognitive behaviour therapy, and motivational interviewing. Other modalities include acceptance and commitment therapy, solution focused therapy and narrative therapy.

Outcome measures

MDECC uses validated tools to measure outcomes. These include DASS 21, SDS and ORS. Groups are measured with the Group Session Rating Scale and qualitative feedback.

MDECC runs a SMART Recovery group for young adults between the ages of 18 to 25 and is approved to provide treatment to approved clients under a Work and Development Orders scheme. Juvenile Justice recently approved MDECC as a partner in the Children's Community Service Order Scheme.

MDECC has restructured to work specifically in the 'pointy end' of treatment. The model is highly focussed on keeping the young people we work with safe, out of hospital, and out of the criminal justice system, and to support them to achieve their potential and contribute to their community.

For more information about the Manly Drug Education & Counselling Centre, please visit their website or phone 02 9977 0711.

Profile

NADA staff member

Victoria Lopis
Project Officer

How long have you been with NADA?

I have been working with NADA since September 2015.

What experiences do you bring to NADA?

Before starting with NADA I worked in the policy field in the multicultural sector with a national peak body. I bring a number of skills developed in this role to NADA—including supporting member organisations within an NGO setting, managing grants programs, and coordinating large and small scale training sessions and conferences. I also recently completed my Master of Policy Studies, and bring the ideas and skills developed during this course to my current role.

What activities are you working on at the moment?

My key projects at NADA are coordinating the NADA Workforce Development Grants program, overseeing the ongoing review of the *NADA Policy Toolkit* resource, supporting a number of NADA training events and offering secretariat support to the Youth AOD Services Network and the NADA Practice Leadership Group.

What is the most interesting part of your role?

I am really enjoying getting out to meet the NADA members, and seeing how they work day-to-day. I am also new to the AOD sector so am appreciating all the training opportunities provided by NADA to learn about how the sector operates, and the challenges it faces.

What else are you currently involved in?

I have a very sweet, active little boy of almost three who keeps me pretty busy outside of work hours. You will most likely find us in a playground, at the library or sharing a babyccino.

A day in the life of...

Sector worker profile

Daniel Brightwell AOD Counsellor, Foundation House

How long have you been working with your organisation?

I have worked for Foundation House in a part-time capacity for six years and in my current role as an AOD counsellor since 2012.

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

I was studying business administration and was not finding it fulfilling, so I switched to Certificate IV in AOD. I really enjoyed the experience at TAFE and received an opportunity at Foundation House after my work placement. I have been balancing work and studying a Bachelor of Psychology for the last four years.

What does an average work day involve for you?

My day involves one-on-one counselling with clients who are dealing with AOD and gambling issues. I generally have a case load of four or five clients that I will check in with a few times a week and provide them with case management. My role also involves facilitating education groups on issues such as anger, emotion regulation, dialectic behavioural treatment exercises, boundaries and other life skills. I am also responsible for assessing clients pre-admission and supporting the admission process.

What is the best thing about your job?

The best part of my job is when I get the opportunity to see clients make positive change in their lives. It's very rewarding when ex-residents show how their lives have improved, that they are healthy and happily living in the community.

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?

I would like to see more services work closer together and be more client focused. I think working in the interest of the client should be the primary focus, and if services are able to work closer together, outcomes can be better for clients and less will fall between the gaps.

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

Like the Incredible Hulk, I would like to break down the barriers that prevent people from being empowered to make positive change in their lives.

NADA Conference 2016

NADA held its biannual conference on 6–7 June 2016 at The Grace Hotel in Sydney. *Integrated care: Working together to respond to complexity* was the conference theme.

The conference was opened by the Hon. Pru Goward MP, Minister for Mental Health, Minister for Medical Research, Assistant Minister for Health, Minister for Women, and Minister for the Prevention of Domestic Violence and Sexual Assault.

The majority of survey respondents (94%) agreed that the conference was a worthwhile and valuable event.

Who attended?

The conference brought together around 250 delegates over the two days. According to feedback evaluations most delegates were from NADA member organisations (73%), with almost half of respondents (46%) reported that they work in direct client services/client support positions and 36% in management roles.

Keynote highlights

Suzy Morrison, Consumer Project Lead from Matua Raki of the National Addiction Workforce Development Centre in New Zealand presented on *Consumer perspectives: responding with integrity*. Following the conference NADA hosted a consumer roundtable with Suzy Morrison, the NSW Users and AIDS Association, the NSW Ministry of Health, and the Agency for Clinical Innovation, to progress consumer strategies in the non government alcohol and other drugs sector.

Associate Professor James Ward, Head of Infectious Diseases Research, Aboriginal Health at the South Australian Health and Medical Research Institute Adelaide presented on *Multiple risks yet single approaches: Timely integration of sexual health and AOD work to improve outcomes for young people*. This presentation was very highly regarded by feedback respondents with **81%** of respondents agreeing that the presentation was informative and valuable.

Dr John Toussaint, CEO of ProCare Alliance presented on *The intersect of father attachment and addiction*. Many feedback respondents reported that this presentation was a conference highlight with one respondent stating the "presentation was awesome and a topic that should be explored more."

Kate Jeffries, Director of Family and Interventions Services at Communicare in Western Australia presented on *Navigating together: Domestic and family violence and AOD abuse*. This presentation was very highly regarded by feedback respondents with **80%** of respondents agreeing that the presentation was informative and valuable.

Dr Suzanne Nielsen of the National Drug and Alcohol Research Centre and South Eastern Sydney Local Health District and Dr Anthony Gill of St Vincent's Health Network and Central Coast Local Health District presented on *Problematic use of prescription medications: Integrating research findings into practice*. This presentation was very highly regarded by feedback respondents with **89%** of respondents agreeing that the presentation was informative and valuable.

Dr Jamie Berry of Advanced Neuropsychological Treatment Services and Jo Lunn of We Help Ourselves presented on *Neuropsychological interventions in AOD*. This presentation was also very highly regarded by feedback respondents with **91%** of respondents agreeing that the presentation was informative and valuable, the most highly regarded keynote presentation according to feedback surveys.

What were the best aspects of the conference?

- Better understanding of integrated care in this context
- Connecting with other agencies
- The focus on the peer workforce and issues
- Great content and engaging presenters
- Diverse presentations that will assist in further development of AOD workforce and practice
- Gaining knowledge [and] meeting people to make partnerships with
- Learning the current needs of the sector and new directions and innovations
- [The] strong connection between research and practice

Best tweets of #NADA2016

Participants shared insights with their communities on social media

2016
NSW Non Government Alcohol and other Drugs Awards

NSW has a diverse, strong and effective non government alcohol and other drugs sector that has been providing services to individuals, families and communities for more than forty years.

The NSW Non Government Alcohol and other Drugs Awards were established in 2014 to acknowledge the significant contribution of the non government alcohol and other drugs sector in reducing alcohol and drug related harms to NSW communities through leadership, program design and delivery, and a dedicated workforce.

The awards were presented as part of the NADA Conference dinner on 6 June 2016 by the Hon. Pru Goward MP. Please join us in congratulating the winners of the NSW Non Government Alcohol and other Drugs Awards 2016.

Excellence in Quality Development Award

The award recognises individuals or organisations that have contributed to building their organisations, or the sectors, capacity to deliver quality services to reduce alcohol and drug related harms. This could include quality systems, data management, governance, workforce and organisation development.

Winner A modified DBT group therapy manual, Triple Care Farm (Robertson, NSW) **Certificate of Commendation** The Glen Centre, Ngaimpe Aboriginal Corporation (Central Coast, NSW)

Excellence in Health Promotion Award

The award recognises excellence and/or innovation in health promotion to reduce alcohol and drug related harms. This includes harm reduction, community development and prevention activities.

Winner Drug and Alcohol First Aid, Lyndon Community (Orange, NSW) **Certificate of Commendation** WHOS Harm Reduction Program, WHOS (Sydney, NSW)

Excellence in Research and Evaluation Award

The award recognises individuals or organisations that contributed to building the evidence base for practices to reduce alcohol and drug related harms.

Winner The Salvation Army Recovery Services and the Illawarra Institute for Mental Health, University of Wollongong (NSW) **Certificate of Commendation** Stepping Stones to Success, Family Drug Support NSW)

Excellence in Treatment Award

The award recognises excellence and/or innovation in treatment to reduce alcohol and drug related harms. This includes the delivery of services, programs and initiatives for individuals or specific populations.

Winner Speak Out Dual Diagnosis Program, Weave Youth and Community Services (Waterloo, NSW)

Outstanding Contribution Award

The award recognises the significant contribution of an individual working in the non government |alcohol and other drugs sector.

Winner Tony Trimmingham OAM, CEO, Family Drug Support (NSW)
Certificate of Commendation Paul Hardy, Community Restorative Centre (Sydney, NSW)

Lifetime Achievement Award

The award was established this year to recognise the significant contribution of an individual working in the non government alcohol and other drugs sector over a lifetime.

Winner James Pitts, Odyssey House (Sydney, NSW)

James Pitts has made an outstanding contribution to the AOD field since 1978, including 32 years leading one of Australia's largest rehabilitation services Odyssey House NSW. He is highly respected in the Australian and international treatment sectors.

NADA events

Coming soon

Program Evaluation Workshop
Information and tips to implement and develop program evaluation

NADAbase

Capturing LGBTIQ data from July 1

Suzie Hudson Clinical Director, NADA

As you may be aware, NADA and several members have been advocating for improved capture of treatment data for clients who identify as transgender or intersex, and to document sexual orientation. We are pleased to announce that as of July 1, **NADAbase will include questions that ask about gender and sexual identity**. The items will be found in the Client Info section of NADAbase and will be captured and mapped back to the NSW MDS and NMDS data collection. A second stage of this change process will see a number of NADAbase reports updated to reflect these new data items. If you would like to discuss these changes please feel free to contact Suzie on 8113 1309.

Improvements like these new client elements and the *Measuring outcomes in drug and alcohol services* symposium (see below) demonstrate the ever-evolving NADAbase and the incredible work being done in the non government specialist AOD treatment sector. There has been an ongoing commitment made by our members to the ethical collection and reporting of client outcomes and this is now helping us to drive the development of a client outcome data collection framework for the whole of the sector in NSW.

With the introduction of NADAbase data snapshots at the beginning of the new financial year, we will also be setting the bar for innovation regarding the use of member data for benchmarking purposes. In turn, the reports for the snapshots will become a standard part of the NADAbase reports.

In other news, we have almost completed the change from version one to version two of the NSW MDS extract. Thanks to members for their work to import from their bespoke systems.

If you have any questions regarding NADAbase, please contact ITsupport@nada.org.au.

Measuring outcomes in drug and alcohol services: Shaping the future

Suzie Hudson, Clinical Director, NADA
Robert Stirling, Deputy CEO, NADA

The symposium was held on March 31 as part of the Social Research Conference on HIV, Viral Hepatitis & Related Diseases at UNSW Australia.

The *Measuring outcomes in drug and alcohol services: Shaping the future* symposium was held on March 31 as part of the Social Research Conference on HIV, Viral Hepatitis & Related Diseases held at UNSW Australia, Kensington. The symposium was a collaboration between the Network of Alcohol and other Drugs Agencies (NADA) and the Centre for Social Research in Health (CSRH).

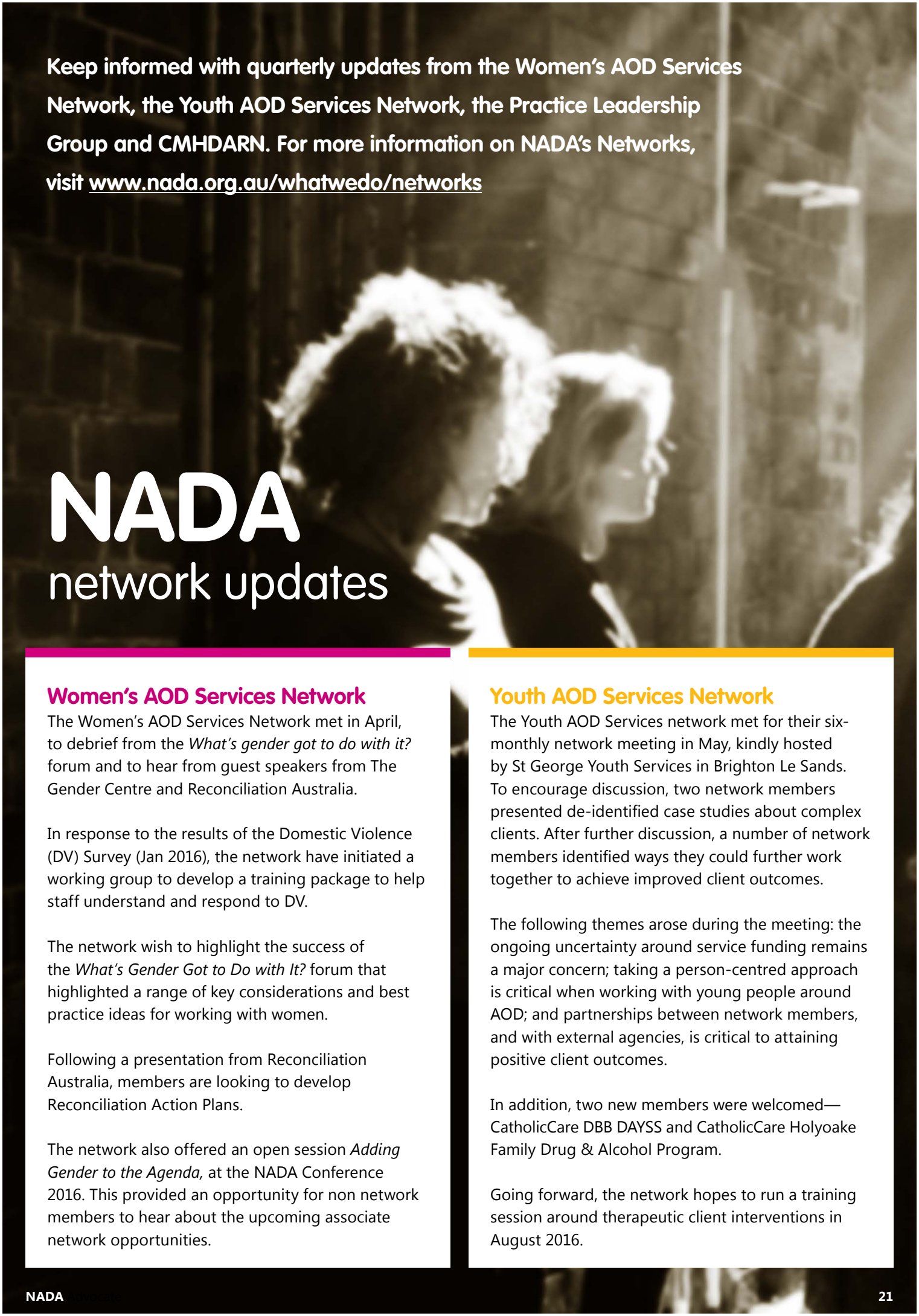
Speakers from local health, AOD services and Kings College London were invited to speak on the current approaches to measuring health and social outcomes for people who access AOD treatment, as well as where the sector needs to be heading in the future. The interactive symposium shared knowledge and expertise from a range of stakeholders on the current situation with key suggestions on the collective direction for a collaborative and integrative future. Read more in this report [PDF].

A follow up to the symposium was a roundtable with representatives from NSW Ministry of Health, NUAA, ACI, UNSW and SESLHD in order to explore the path forward. What came out of the meeting was an agreed set of principles:

- emphasis on consumer engagement—in the development of the measure and how data is used
- adequate infrastructure to support the endeavour
- establishing a culture of using the data that is collected through feedback to services and consumers, and
- the measure should inform better practice, be client responsive, and inform system planning and resource allocation.

Furthermore, agreement was reached that work should commence on a client outcomes framework for the AOD sector and there was a commitment made by those in attendance to progress this work as a shared enterprise—so stay tuned!

CSRH Centre for Social Research in Health UNSW AUSTRALIA



Keep informed with quarterly updates from the Women's AOD Services Network, the Youth AOD Services Network, the Practice Leadership Group and CMHDARN. For more information on NADA's Networks, visit www.nada.org.au/whatwedo/networks

NADA network updates

Women's AOD Services Network

The Women's AOD Services Network met in April, to debrief from the *What's gender got to do with it?* forum and to hear from guest speakers from The Gender Centre and Reconciliation Australia.

In response to the results of the Domestic Violence (DV) Survey (Jan 2016), the network have initiated a working group to develop a training package to help staff understand and respond to DV.

The network wish to highlight the success of the *What's Gender Got to Do with It?* forum that highlighted a range of key considerations and best practice ideas for working with women.

Following a presentation from Reconciliation Australia, members are looking to develop Reconciliation Action Plans.

The network also offered an open session *Adding Gender to the Agenda,* at the NADA Conference 2016. This provided an opportunity for non network members to hear about the upcoming associate network opportunities.

Youth AOD Services Network

The Youth AOD Services network met for their six-monthly network meeting in May, kindly hosted by St George Youth Services in Brighton Le Sands. To encourage discussion, two network members presented de-identified case studies about complex clients. After further discussion, a number of network members identified ways they could further work together to achieve improved client outcomes.

The following themes arose during the meeting: the ongoing uncertainty around service funding remains a major concern; taking a person-centred approach is critical when working with young people around AOD; and partnerships between network members, and with external agencies, is critical to attaining positive client outcomes.

In addition, two new members were welcomed—CatholicCare DBB DAYSS and CatholicCare Holyoake Family Drug & Alcohol Program.

Going forward, the network hopes to run a training session around therapeutic client interventions in August 2016.

NADA network updates
continued

NADA Practice Leadership Group

The NPLG met in March and have been assisting NADA in the development of the NADA Conference 2016 program and the review of abstracts.

Other areas that the NPLG are working on relates to the establishment of a research ethics support committee—the aim of which would be to advocate on behalf of the NGO AOD specialist treatment sector and their clients in the development of the research that involves them.

The NPLG will also be involved in consultation regarding the NADA Service Specifications project and the upcoming Health of the Workforce project.

The following outcomes arose from the meeting:

- Health economics—why invest? A development project support by the NPLG
- Health and Wellbeing of the Workforce Project—NPLG to provide input and consultation
- NPLG membership will be rolled over for group into the next 12 months.

To contact the NPLG, email NPLG@nada.org.au.

CMHDARN

Do you work for an NGO and have a burning research question? Would you like a hand shifting gears to decide if your idea is researchable? Do you want to develop your idea?

Our one-day free workshop, *Framing a Research Idea and Getting it Over the Line*, to be held in September, will help you with your process. Come prepared with an idea or research question to workshop and you will have the opportunity to

- pitch your ideas to people who can guide and help you plan for success
- identify the strengths of your idea/research question, as well as the challenges you may face
- garner support, potential mentorship and consider opportunities such as industry partnerships
- think about embedding your ideas in community, getting buy-in from your work-place, and translating your research outcomes into better practices
- cultivate research integrity—include consumers in your research in a real way, and
- walk away from the day with a concrete plan to take your ideas to your workplace and persuade!

Registrations open soon.

Activities

What's Gender Got to Do with It?

A forum on improving outcomes for women in AOD treatment

This forum provided an opportunity to discuss the need for gender responsive practice and highlighted best practice to support services working with women. 75 people attended the event to hear from eleven guests speaking on a range of topics including

- setting the scene for gender responsive practice in AOD treatment
- consumer experiences of accessing AOD treatment
- pregnancy, parenting and family inclusive practice
- working together with Family and Community Services
- emerging research on social anxiety treatment for women
- the impact of trauma and importance of trauma informed practice
- recognising gender based violence, and
- the importance of hope in the workforce.

The forum also included an Open Space session to allow attendees to raise issues of interest for group discussion. Topics raised included domestic violence, pregnancy and parenting methamphetamine and women barriers facing women exiting prison, engaging women in decision making and innovative practice.

97.87% of event feedback respondents indicated that the event was useful and believed that it would lead to improvement in their work and that the event was valuable and worthwhile. Some quotes from participants included:

"Informative, thought-provoking, motivating, energising"

"Really enjoyed the speakers from all services, nice to hear we're not alone in this need for assistance but there's hope out there…"

A range of key messages were generated from the forum include

- reflect and consider how society's gender values impact on you and your work
- ask women what it is they need to be better supported and be hopeful and curious about individual's stories
- provide person-centred, holistic and flexible support
- encourage healthy relationships (including parental)—positive healthy relationships are the number one predictor for a sustainable recovery
- talk about sexual health and contraception and ensure there is no wrong door for pregnant women
- get to know your local child protection workers—find out more about Practice First and the Care and Protection Practice Framework (NSW)
- when experiencing challenging relationships and competing priorities with other service providers or agencies consider *"if I swapped jobs with the agency I am currently in conflict with, would I also change sides on the issue?"* (Scott, 2015 in Ridley M, 2016), and
- any treatment seeking behaviour is an opportunity to build motivation.

Future directions for the network and NADA have been identified as a result of the day. These are documented in the event summary on the NADA website but two of note are the introduction of an associate membership option (see overleaf) for the Women's AOD Services Network to mixed gender services and the continued provision of training opportunities relevant to working with women which will continue in the 2016–2017 year.

Adding Gender to the Agenda

NADA Conference 2016 satellite event

NADA members and stakeholders were invited to attend a one-hour satellite event at the end of the NADA Conference 2016 on June 7.

Twenty five people attended the session that provided non network members an opportunity to hear more about the network including the upcoming associate membership category. In addition, those in attendance were offered an opportunity to discuss issues they see in their roles when working with women and raise some ideas for future activity of the network. The three top items discussed was around improving access to services for pregnant women, looking at engaging younger women and increasing knowledge and awareness of non residential treatment options to support women with children. A summary of the event is available on the Women's AOD Services Network page on the NADA website.

Associate membership coming soon

The Women's AOD Services Network would like to announce the addition of an associate membership category allowing individuals working with women affected by AOD use in mixed gender service settings to participate in network activities. This new category will open in the second half of 2016.

About the Women's AOD Services Network
The Women's AOD Services Network was established in January 2013 to improve pathways and connections for services working with women. The group originally comprised representatives of women's only specialist non government services in NSW that provide services to substance using women, including those providing services to pregnant women and women with children.

The network is intended to facilitate collaboration, knowledge and information sharing on an ongoing basis with the view to strengthen and improve services provided to women with AOD use issues.

The aims of the network are to

- build effective relationships between network members and stakeholders
- respond to opportunities where collaboration adds value to the network purpose, and
- promote shared solutions to common issues.

Benefits of becoming an associate member
Becoming an associate member will support workers in improving professional relationships with other services working with women. In addition, members will receive useful information relevant to working with women and have opportunities to

- access information sharing and networking events
- present on new projects, research or organisational activity relevant to improving services for women
- contribute to the direction of the women's network activities, events and projects; and
- have priority access to network capacity building opportunities.

Who is eligible to be an associate member?
Associate membership is open to staff from organisations that are

- NADA members providing treatment/support to substance using women in mixed gender service settings in NSW, or
- specialist women's services outside of NSW providing AOD treatment/support.

For information on *full* membership—open to NADA members that are specialist women's services—visit the Women's AOD Services Network page.

How to become an associate member?
Information on how to become an associate member will be available on the NADA website soon. For more information or to register your interest, you can also contact Ciara.

NADA Practice Leadership Group

Member profile

Michele Campbell Program Manager—Residential and In-Reach, The Lyndon Community

How long have you been working with your organisation? How long have you been a part of the NPLG?
I have been working for Lyndon for eight and a half years (18 years in the sector) in various roles including positions in residential and non-residential services and have been with the NPLG since it's inception in 2015. For the last few months I have been employed as the manager of the residential services at Lyndon.

What has the NPLG been working on lately?
Lately the NPLG has been involved in providing feedback for the NADA conference, workforce development plan, and health and wellbeing in the workplace project. The NPLG provides a good opportunity for us to give knowledge back to the sector and benefit the workforce into the future.

What are your areas of interest/experience—in terms of practice, clinical approaches and research?
My areas of interest include inpatient detoxification and residential program enhancement, self care for staff and workforce development. I am currently completing a Masters in Strategic Organisational Development and have an interest in human resource development. Patient safety is also a priority and service enhancement to ensure best practice is important. Please contact me at NPLG@nada.org.au if you would like to discuss any of the areas above.

What do you find works for you in terms of self-care?
Self-care is an extremely important aspect of life for our workers and for me that includes spending time with my partner, playing with the horses and dogs, mountain climbing, yoga, meditation and anything else outdoors.

What support can you offer to NADA members in terms of advice?
Look after yourself and be aware vicarious trauma can sneak up on you. A healthy work/life balance is instrumental to a long term future in this sector.

Where do all the good things go?

Good360 is a way for businesses to donate brand new unsold goods to charities and not for profits to help Australians in need. With one simple phone call, businesses can now connect unwanted brand new goods to the people who really need them the most. Our Good360 website provides charities with a one-stop destination for accessing new non-perishable goods from some of Australia's biggest brands, retailers and manufacturers such as 3M, Linen House, Lush and Woolworths.

Like an eBay for charities—but they get the goods they need for free!

From bedding, clothes, shoes and toys—to office supplies, beauty products and electrical goods—any registered Australian charity or not for profit organisation can order the goods they want for free and have it delivered right to their door for a nominal shipping and handling fee.

"The goods that we can obtain from the Good360 program allow us to use our limited dollars directly on client services and still be able to offer our clients goods and materials such as baby bottles and nappies, sheets and blankets, yoga mats, clothes, kitchen items, stationery and a gym. Plus help us with pre-loved office furniture to replace the broken and worn items that as a cash strapped organisation we just settled for, before Good360."—Sandy Kervin, Jarrah House (Women's Drug & Alcohol Advisory Centre) CEO.

Click here to find out more about how Good360 can help you make good happen.

Good360
GOODS FOR THE GREATER GOOD™

Cancer Council NSW: Tackling Tobacco Program

New project grants for NSW community services

Cancer Council NSW has launched a grants program for not-for-profit community services wishing to address smoking in their organisation.

$3,000 grants will be awarded to community services ready to participate in the Tackling Tobacco program. Tackling Tobacco is a free program aiming to reduce smoking-related harm among priority population groups with high smoking rates, including those with alcohol and other drug dependency issues. Your grant will support project activities specially tailored to the needs of your organisation.

Along with the project grant, community services participating in Tackling Tobacco will receive

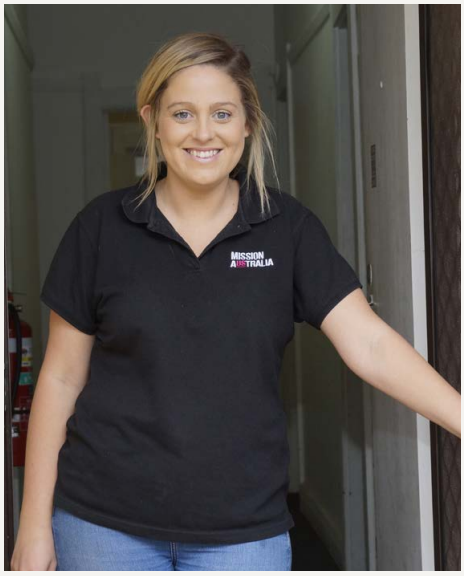
- free staff training on brief interventions, and
- free resources and fact sheets for staff and clients support from a local Cancer Council staff member.

Why should alcohol and other drug agencies tackle tobacco?

- In 2004-2005, tobacco was responsible for 9 in 10 drug-caused deaths in Australia.
- Quit smoking treatment improves treatment for alcohol and other drug use by an average of 25%.

By reducing the barriers to quitting, your organisation will provide real benefits to clients and staff—better health, more money and greater control over their lives. With some personal encouragement and the support of the tools offered by the Tackling Tobacco program, you can make a difference in your organisation.

To apply, visit cancercouncil.com.au/tacklingtobacco or call 02 9334 1911.



"We didn't know what the best procedure was moving forward without the support of the Tackling Tobacco program."

Phoebe, Program Coordinator at Mission Australia's Allum House

Stay in touch

with AOD news, issues and events

The Advocate raises significant issues relating to the NSW non government alcohol and other drug sector, and develops knowledge about, and connections within the sector.

Previous issues have focused on drug trends, domestic and family violence, and AOD treatment for women. Read recent issues of the Advocate.

To subscribe, email Sharon.

Update

Agency for Clinical Innovation Drug and Alcohol Network

Jo Lunn, Improving Organisational Capacity Project Officer, We Help Ourselves (WHOS) and ACI Drug and Alcohol Network (Co-chair)

The Agency of Clinical Innovation Network agency for alcohol and other drugs now has over 250 members. I encourage you to join (it is free) to have your say in the activities of the network and access the opportunities that the network can provide.

There are three main areas of work that the network is currently engaged in and prioritised. These include:

1. A connected system
Facilitating greater communication and connectivity between drug and alcohol services across NSW and improving access to evidence-based, peer reviewed resources. This working party is currently exploring options for connecting people beyond their locality or their service. The focus is on improving the incorporation of research and evidence into service planning and mechanisms for sharing the good work already happening across NSW.

2. Supporting a strong partnership with Primary Health Networks
Strengthening the continuum of care, through improved collaboration and integration between specialist drug and alcohol services and the Primary Health Networks. This is a large working group. The focus is to support PHNs in strengthening relationships across the system and move to improved integration of drug and alcohol services across primary and tertiary health.

3. Being leaders in innovation
Promoting and supporting innovation in drug and alcohol models of care and service delivery. This will include both stimulating new activity and profiling innovations already happening across the system. Don't miss the forum!

Drug and Alcohol Innovation Forum 2016
11 August 2016, 8:30 am to 4:30 pm
Kirribilli Club, Harbourview Crescent,
Lavender Bay NSW

The Drug and Alcohol Innovation Forum showcases innovative solutions to address the diverse and complex needs of people accessing drug and alcohol services. Come along to hear about the inspiring work being done across NSW. At the end of the day you will have an opportunity to vote on your favourite project to be taken forward by the ACI and the Drug and Alcohol Network.

Successful projects for presentation

- Cognitive Remediation: Improving Clients' Capacity to Successfully Engage in AOD Treatment—*WHOS*
- Parenting With Feeling: A Targeted Parenting Program for Parents who use Substances and their Infants—*HNELHD*
- Drug and Alcohol Shared Care: A Evaluated Partnership Between Public and Primary Health Care Services—*SESLHD*
- The Speak Out Dual Diagnosis Program: Responding to Co-existing Issues of AOD Use and Mental Health Experiences Using Trauma Informed, Strengths Based and Person Centred Care—*Weave Youth and Community Services*
- S-Check: An Innovative Service Model to Attract Stimulant Users—*SVHN*

Register now

NADA Practice Resource

WORKING WITH WOMEN ENGAGED IN ALCOHOL AND OTHER DRUG TREATMENT

SECOND EDITION

This edition includes an updated section 3.4 Transgender women. Click here to download the resource. Hardcopies of the second edition are available—contact Ciara to request one now.

NADA highlights

Policy and submissions

- NADA provided NSW Primary Health Networks (PHNs) with a planning tool to support needs assessment and planning activities for commissioning of AOD services.
- NADA and the AOD Peaks Network provided federal politicians with a 2016 Election Position Statement.
- A submission was provided on the legislative review of the MSIC by the NSW Ministry of Health.
- NADA provided a letter of support for Hepatitis NSW PBAC submission regarding Zepatier for the treatment of Hepatitis C.
- NADA provided a substantial submission to the NSW Ministry of Health for changes to the long-term contracts for NGOs.

Advocacy and representation

- NADA met with Minister Pru Goward to discuss planning and funding for the NSW NGO AOD sector.
- NADA and AOD Peaks Network had a teleconference with Senator Fiona Nash to discuss PHN planning and commissioning.
- NADA continues to meet with sector funders: Mental Health and Drug and Alcohol Office, NSW Ministry of Health, the NSW/ACT office of the Australian Government Department of Health, and the NSW Primary Health Networks in their future role as commissioners.
- A number of meetings with Dr Kerry Chant and the executive team at the Centre for Population Health to discuss the transition of the Drug and Alcohol Program.
- Meetings with PHNs across NSW to discuss planning and commissioning of AOD services.
- NADA and AOD Peaks Network had a roundtable to discuss national funding, including PHN commissioning and other national initiatives.
- Presentation delivered at the Australian and New Zealand Addictions Conference on the Women's AOD Services Development Program.
- Facilitated a workshop on working with women engaged in AOD treatment at the Northern Territory Workforce Development Conference.

Sector development

- Highly successful NADA Conference 2016 and the 2nd NSW Non Government Alcohol and other Drugs Awards.
- Mid-year Workforce Development Training Grants round opened.
- A number of events, including Methamphetamine and Gendered Nature of Trauma and Addiction training.
- Reaunched NADAbase and a new online tutorial so members can learn how to use NADAbase at their own convenience.

Contact NADA

Phone 02 9698 8669
Post PO Box 2345
Strawberry Hills
NSW 2012

Larry Pierce
Chief Executive Officer
(02) 8113 1311

Robert Stirling
Deputy Chief Executive Officer
(02) 8113 1320

Suzie Hudson
Clinical Director
(02) 8113 1309

Ciara Donaghy
Program Manager
(02) 8113 1306

Sianne Hodge
Program Manager
(02) 8113 1317

Victoria Lopis
Program Officer
(02) 8113 1308

Sharon Lee
Communications Officer
(02) 8113 1315

Craig Bulley
Administration Officer
(02) 8113 1305

Feedback
Training Grants

NADA is accredited under the Australian Services Excellence Standards (ASES) a quality framework certified by Quality Innovation and Performance (QIP).

Photo by Kris Ashpole