Advocate

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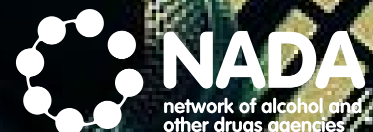
Client outcomes

• The Ted Noffs Foundation • Resli Buchel • SESLHD
• Youth Solutions • MHCC • AIHW • NSW Ministry of Health



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CEO report

Larry Pierce NADA

In this edition of the Advocate we focus on the key issues for our sector in defining, collecting and reporting outcomes data. So, the big question for non government AOD services is—what's in it for us?

Our sector has a long history of performance reporting, and in particular key performance indicator reporting. Many of you have wondered where all the information goes, who reads it and more importantly, how is it used? Without this knowledge it is reasonable to ask, is this move to more outcomes-oriented data reporting going to turn into reporting for reporting sake?

To this, I think the answer is—not if we don't let it!

NADA has long supported members with data collection and reporting in terms of our online National Minimum Data Set and the client outcomes data set contained in NADAbase. Of course, the accurate reporting of the data is important, and there are opportunities for research and analysis of the data that is collected—but we emphatically stress—data collection and reporting can serve your treatment service review and planning, and most importantly, inform the care provided to clients.

I believe there is now a very solid culture of outcomes collection and reporting. And I think it is this strong culture of outcomes collection and reporting that puts us in the driver's seat with respect to the usefulness of the data and the way it is used to inform what we deliver. This is the key to being an evidence based treatment sector: not only do use the evidence, but we actively create it.

We emphatically stress—data collection and reporting can serve your treatment service review and planning, and most importantly, inform the care provided to clients.

In this issue of the Advocate, we want to continue to engage around how you can use your own client outcomes information to continue to assist with client care, along with service planning and design on an ongoing basis. The contributions in this edition will hopefully take us forward in leading the way in client outcomes data collection, reflection and continuing treatment service design and delivery. We look forward to our ongoing work with members, improving our data service for you all.

We use data in these main ways:

Reporting Outcomes are increasingly important as funders become more sophisticated in terms of their reporting requirements. The ability to provide outcomes alongside outputs provides a more in depth analysis of the program that we are providing.

Research We regularly analyse our data with a view to exploring the outcomes of our programs and really 'pull apart the data' to find out if we are indeed doing what we say we are going to do, analyse trends amongst the cohorts we work with and compare different programs and jurisdictions. This provides us with an evidence base for our programs and contributes to the wider evidence base of the sector.

Program review and design Programs should not be static but rather fluid and responsive. By using data we constantly change the way things are done to keep up with the trends and be responsive to changing needs.

Staff feedback Finally a really big aspect is feedback to staff who do the work. This is about providing feedback and data demonstrating that what they do 'works', exactly how they are contributing to changes within our populations and understanding the different trends and areas for change or improvement.

cc by-nc-nd 2.0 Ryszard Rizz Wozniak

'Data is really important to Noffs. It informs everything we do, provides information around impact and helps paint a picture of our work.' Mark Ferry, COO, Noffs Foundation

Preventing relapse with outcomes data

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Mollie Snelling Assessment, Research and Counselling Clinician Triple Care Farm

How do you and your team use outcomes measurement in your service delivery?

We use a variety of measurements ranging from program-wide statistics which assess broad trends, to individual assessments which allow us to monitor a single client's progress through treatment. One such measurement is the Brief situational confidence questionnaire (BSCQ), which examines a person's confidence to resist using substances in a variety of situations. The BSCQ provides a unique look at the individual's triggers for using and the situations in which they feel least confident to avoid using substances. We are able to use the data from this measure to tailor treatment including preparing for weekend leave and noting how their triggers and patterns change through treatment.

Can you describe an example of how this was done with a young person accessing your service?

A client completed the BSCQ in their first week of treatment and was preparing to go off-campus for weekend leave at the end of their fifth week. Using the data from the BSCQ, their counsellor was able to tailor the discussion around their two lowest rated situations (e.g., conflict with others and urges/temptations). The counsellor added extra focus on urge surfing, coping with distress and interpersonal effectiveness to help boost the client's skills in the targeted areas.

After they returned from weekend leave, their confidence levels had changed as they had been able to test out their new skills in these areas. This provided more information which the counsellor could use to direct treatment.

How did you feel as a clinician using this data? Was it useful and if so, how? Or if not, why?

The data is certainly useful because it is unique to each client. People use substances for different reasons and will struggle to resist using in different situations. By looking at their individual BSCQ ratings, clinicians can tailor discussion in a more meaningful way and help the client explore their personal triggers and patterns.

What advice can you give other programs about how they can embed the use of outcomes measurement into their service delivery?

It is important to explain to the clients what information you are collecting, why you are collecting it and how it will be used. It can make the clients more likely to provide accurate data and help them to understand the process as part of their treatment.

Actively review your data collection processes. If you are not using the data to assess and potentially change your processes, why collect it?

Feedback informed treatment

Shape the way you practice by asking your clients whether the therapy you are providing is helpful—while they're still in the room. Learn more about feedback informed treatment at our outcomes forum.

More on page 13.

Change is possible

A supportive family, connection to peers and access to treatment helped Resli Buchel achieve her ultimate outcome.

cc by-nc 2.0 Khürt Williams

It's been more than 13 years since I last injected heroin. In fact, I've been entirely abstinent from any illicit drugs and alcohol during this time. I've studied, worked, and paid my rent, bills and taxes. I've travelled, grown friendships, and started a family. I've discovered new interests and passions and have found fun and enjoyment in life that I never knew existed. I've also done a lot of therapy and addressed my underlying mental illness and trauma.

Despite entering resi-rehab with a bad attitude and a total lack of faith in the process, somehow, this is where I find myself today. I am what many would consider a recovered 'addict'. In many ways, a kind of unicorn of drug treatment. So, what magic took place on my journey that doesn't cast the long-term recovery spell for so many others?

A combination of ongoing family support and a relative lack of childhood trauma definitely improved my chances. Access to treatment was a key factor, of course, along with having good ongoing relationships with my psychiatrist, a connection with recovering peers and being fortunate to have no lasting legal consequences following over a decade of using definitely. Combined with a large portion of dumb luck, all of these things have played a role.

When I walk down the street today, there is no evidence of my earlier life (...bar a few track mark scars evident only to a knowing observer and my long-suffering mother). Over the past decade, my life has gradually changed for the better. The outcomes of my stint in treatment are positive, measurable and clear for others to see. However, the true change that has underpinned all of these other more tangible outcomes actually took place during my first couple of weeks in rehab.

My mother often recalls the first phone call I made to her after entering treatment. With an almost impossible shift in mindset, I said to her: 'I think that maybe I can do this'. While there was no single defining moment, in a little over a week in a healthy, supportive environment, I had gone from believing that I could never stop using to realising that freedom from drug dependence was indeed possible for me. More than this, I had realised that there might actually be a point to living a life without using drugs.

This fundamental gift of hope continues to sustain me.

This fundamental gift of hope continues to sustain me. The fact that I so ardently believed that I would never stop injecting heroin—*and then did*—serves as a perpetual reminder that change is possible. Even if I were to use drugs again, I now know that I can do something about it.

Today, I still have to work at keeping my dependence in remission, but I no longer break the law, sell my body or sleep on the street. I have a home, job, a family, and a place in the community. However, the shift in perception that happened for me while in treatment is more powerful and valuable than any period of sobriety.

How can we harness client outcomes

Lauren Senior Psychologist, Triple Care Farm

How does your team use outcomes data in their direct client practice? We use it in a variety of ways across the organisation, on both micro and macro levels. That is, it can be used to inform individual client treatment and case planning, and it can also be used to shape and manage organisational development/direction. Most importantly, collecting/analysing data is important as it can directly impact the treatment that can be provided to people accessing services. It can contribute to ensuring we are using evidence based treatment and doing what we say we are doing as an organisation (and if we are not, looking at ways we can do better by our clients and creating opportunities for quality improvement).

How can outcomes measurement be embedded into service delivery? Generally speaking, I think it's important to see the value in why we would collect the data in the first place, otherwise it can become another 'task' that we have to complete. It can be helpful to check in with the team from NADA or other organisations using the data to see how it may serve your organisations and clients. It may also be about allocating the tasks of collection to key individuals to 'champion' the project, particularly initially, so that data isn't being re-handled by multiple people and contribute to the feeling that is unmanageable.

Jeanette Program Manager, Elouera

How does your team use outcomes data in their direct client practice? Outcome measures follow the client throughout their treatment. For example, they are completed on admission to our withdrawal unit, then four weeks later and again after three months if they are in one of our residential rehab programs. This provides a good opportunity for staff to use this data to guide brief interventions with some clients. In our community based services they use the outcomes data the same. Case workers can use outcome measures with clients to show progress and assist in treatment planning.

How can outcomes measurement be embedded into service delivery? Solid training and embedding quality in every day practice. Elaborate to the staff about the benefits of outcome measures for the clients and how they can improve service delivery rather than purely as a funding requirement. Find a champion within the service who can lead and inspire other staff.

Belinda Clinical Coordinator, SDECC

How does your team use outcomes data in their direct client practice? We don't have a prescribed way of doing this as it's based on where clinicians are at with their client. It's not uncommon for us to use the 'Depression, anxiety and stress scale' 21 scores in our practice but we mainly use the 'Outcome rating scales' for graphing progress or we revisit this data when we're stuck with a client. We also use the Session Rating Scale with some clients but this is not standardised however we find it a valuable tool for getting feedback informed treatment.

How can outcomes measurement be embedded into service delivery? You need buy in from the whole team. We really didn't place a value on them until NADA (Suzie) talked about how they can assist our work as clinicians. Services need to spend time helping their staff understand what they don't know—outcome measures are not just about meeting the needs of reporting, but they are also a way to prove what we do. Proof is not only about highlighting success but when we do this honestly, it is also a tool to educate the powers that be about how complicated our work is. Outcome scores can focus very much on the positive of 'this works' but they also are about 'this works and takes time', they can highlight the complexity.

Paul Manager—AOD Transitions Program, Community Restorative Centre (CRC)

How does your team use outcomes data in their direct client practice? Measures are delivered conversationally and used to deepen discussions with our clients. We use outcome measure scores with our clients to show them their progress over time.

How can outcomes measurement be embedded into service delivery? By recognising that there is a need to improve the integrity and consistency of data capture to better demonstrate program outcomes. However they also need to understand that the data they capture of itself will not necessarily effectively convey program benefits for clients given the complexity of their support needs.

Youth AOD Services Network

How can outcomes measurement be embedded into service delivery? Make it routine—set up the expectation that the service values outcome measures. Make it meaningful and relevant and useful for both the client and clinician. Use it and feed it back!

A tale of two measures

Outcomes measurement in NSW has developed along parallel tracks, according to whether treatment was provided by a government or non government service provider. Peer into the past, and future, of outcomes.

Government

Dr Nicholas Lintzeris
SESLHD

How did the Clinical Outcomes and Quality Indicators (COQI) evolve? About a decade ago a group of clinicians working at Langton, Jacaranda House and Newcastle AOD services were looking to introduce an approach to ask and document information about a client's recent substance use, related high risk behaviours (e.g. BBV risks) and general health and wellbeing (e.g. psychological, physical health, quality of life, housing, employment) in a simple and quick way that could be easily incorporated in routine clinical care, and to be used with all clients. Previous attempts in Australia (e.g. BTOM) had been somewhat 'clunky', and whilst lots of information may have been collected—it was rarely ever fed back to clients or used by services. Lots of 'data in' but very little 'data out'. Such systems are unsustainable, and not much use to anyone.

A key milestone was finding and adapting the Treatment outcomes profile (TOP), a one-page instrument developed in the UK. We asked clinicians and clients at those three services their perspectives on the TOP, and how it could be adapted to be better suited to Australian services. They provided feedback to modify the tool that was then 'validated' against other 'gold standard' instruments (e.g. Timeline follow back, K-10, SF-36, DASS-21, WHOQOL BREF). We named it the Australian treatment outcomes profile (ATOP).

Another milestone was the development of an electronic medical record system for NSW Health AOD services a few years ago called CHOC. The system also linked us to the electronic clinical information systems used by rest of the public health system, such as emergency departments, mental health services and hospital admissions. This greatly improved safety for our clients—and without doubt has saved lives. We had a window of opportunity and we seized it—we integrated the ATOP into the AOD CHOC system—and now all NSW public sector AOD services (with the exception of Justice Health and Children's Specialty Networks) are using the same platforms.

Non government

Dr Suzie Hudson
NADA

How did NADAbase evolve? In 2008 the then Mental Health and Drug and Alcohol Office granted some funds to explore what outcome measures might be suitable for non government specialist AOD providers to collect. Through a comprehensive review of outcome measures[1] and consultation with service providers, the NADAbase Client outcome measures system (COMS) database included domains for psychological health (K10), drug and alcohol use (AOD use frequency questions that mirror the ATOP in addition to the SDS) and overall health and social functioning (WHO QOL-8) was created.

Consideration was given to the brevity of the survey questions, the emphasis on self-report by the client, validity of the measures and their utility by a range of clinicians. The introduction of NADAbase COMS in the non government specialist AOD sector kickstarted a culture of outcomes measurement that has seen all services currently receiving state and federal government funds, collecting, and in many cases reporting, on the treatment outcomes of their clients.

What are the benefits of creating a culture of outcomes collection? NADA has worked with its members to develop reports for a number of different funding requirements, and most importantly reports that allow clinicians to feedback outcomes to clients in real-time to inform the treatment being provided. The publishing of non government AOD treatment data snapshots has also allowed individual organisations to engage in evaluations of the services they provide, and while two different approaches have been adopted in the NSW AOD sector, many of the challenges of implementation have been the same. Progress towards a culture of client outcome measurement has been invaluable in helping to demonstrate the effectiveness of AOD treatment. However, there is much more to achieve in relation to how we use

What are the benefits of creating a culture of outcomes collection? The cultural change that has occurred is not so much about 'collecting outcomes', rather it is being clear about how we, as services providers, work with our clients and what a client can expect will happen as part of their treatment. Furthermore, it is having a broader focus than just substance use. Applying an integrated health model of care that recognises that clients move around many different parts of the health and welfare system and we need to engage them in that journey better and no be just focused on 'treating their addiction'.

The COQI team has conducted a number of studies across several Local Health Districts, validating the ATOP in different client populations (in people with alcohol, opioid, cannabis and methamphetamines as their primary drug of concern) and modes of administration (telephone administered, face to face). We have also developed 'cut offs' for identifying clients who are reporting 'poor' physical, psychological and QOL related health, enabling clinicians to use the ATOP as a screener for further intervention/assessment.

What do you think needs to happen next? The need to focus on consumer engagement is ever more salient. Who controls the data, who has access to it, what are patients and clinicians consenting to, what mechanisms are put in place to ensure data security—these are all important questions. However, the benefits of going down this approach will outweigh the risks if we work collectively, in partnership between service users, clinicians, governments and health informatics experts.

I predict that using clinical information for quality improvement and research using these kinds of systems will change how we approach clinical research. 'Pragmatic' or 'point of care' trials become feasible and shifts the balance away from the academic institutions to the client and clinician as to what questions get asked and researched. We will be able to use the evidence from our own services.

Ultimately, we as a sector need to be more accountable—to our clients, and to the broader community if we expect governments or private insurers to invest hugely in the AOD system. We need to be able to demonstrate that the money is well spent, that our services are high quality and achieve good outcomes.

Dr Nicholas Lintzeris would like to acknowledge the work of Jennifer Holmes and Kristie Mammen.

the data we collect, and the potential it has to shape and improve the services we provide to consumers, clients and the people who support them in the community.

What do you think needs to happen next? One of the key areas for work in both the government and non government sectors in relation to outcome measurement is how data is interpreted. While a number of organisations and Local Health Districts have sought to review and reflect on the results of their outcome data, the most appropriate ways to interpret outcomes, specifically in relation to accurate indications of improvements across outcome domains remains unclear. An ongoing iterative process of respectful, collaborative benchmarking is one way forward and Nick indicates similar goals from the COQI team perspective in terms of the potential for benchmarking and the need to explore data linkage and workforce development as a priority.

There is also more to be done in the sector to improve data collection, harnessing new technologies and most importantly to implement a consistent patient reported experience measure (PREM) across the sector.

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Translating research and policy into practice

Developing AOD sector outcomes

Robert Stirling
NADA

As a sector, we have been aware of the move by government to outcomes based funding and reporting. Whilst there are a range of studies that demonstrate AOD treatment outcomes for particular interventions, there is less clarity on how this can contribute to measuring the performance of AOD treatment services and the broader service system.[1]

What does Australian policy say?

Australia has a Conceptual Framework for Performance Reporting that seeks to 'enhance the accountability of governments to the public through simpler, standardised and more transparent public reporting'.[2] This has been used to inform the Australian Health Performance Framework.[3] Whilst services are all too familiar with reporting on outputs, the framework articulates that output indicators should only be used when an outcome indicator is unable to be directly measured, and that there is a clear link between the output and the desired outcome. In line with this framework, the NSW Government has introduced a Human Services Outcomes Framework to support NSW Government agencies and non government organisations to embed outcomes measurement into planning, delivery and evaluation.[4] It provides a guide that sets out practical steps for implementing outcomes focused approaches and encourages collaboration between funder and services. The framework defines outcomes focused performance management as 'an approach to performance management that emphasises the use of outcomes data to inform strategic planning and decision making', though this is not to the exclusion of input and output measures which are still seen as critically important to provide minimum standards of performance.

There is currently no framework for the AOD sector specifically. The National Drug Strategy recognises this and has an action to develop and share data and research, measure performance and evaluate outcomes. This is suggested to be done through 'robust evaluation processes to effectively measure impact or outcome of work undertaken, including consistent monitoring and reporting of treatment outcomes'.[5] The National Aboriginal and Torres Strait Islander Peoples' Drug Strategy has a similar priority area with an intended outcome that 'performance measures reflect meaningful outcomes aimed at the individual, family and community'.[6]

What's been done so far?

A study from the USA argued that the lack of clarity on terminology related to outcomes and performance has contributed to significant confusion among service providers and policymakers in the AOD field. The article describes the differences between the most common terms. They report that 'outcome domains' are the collection of outcome measures that define the common outcome areas in AOD—those that go beyond cessation or reduction of AOD use. The most common domains that has general agreement by the AOD field relate to health and social functioning (AOD use, physical and mental health, housing, employment, crime). The article highlights the use of previous treatment outcome evaluations as the foundation for the use of measures that have demonstrated the effectiveness of AOD treatment.[1]

In 2000, NDARC explored the development of an outcome monitoring system for NSW. They cautioned the ability of outcome monitoring to attribute treatment participation to the change measured, as there are no comparison groups to validate change. They did however suggest that with baseline and follow-up measures together, the system can still do a good job at assessing change in relation to an AOD treatment intervention. The major issue identified is the need to measure over time, with follow up having significant resource implications and potential bias as a result of attrition. They also reported that outcome monitoring may meet the needs of funders of treatment, but not the needs of treatment providers, service users and their families, and the general public. Even service users themselves may have differing expectations of outcomes for their treatment. From an accountability perspective they reported that effective treatment should not only be measured in terms of reduction of use, but on its potential wider impact on other public health, personal and safety concerns.[7]

In consulting with the AOD sector in the development of the New Horizons Report, Ritter and colleagues reported that whilst there is an appetite to move to outcomes based reporting, reaching a consensus on the development of suitable measures was described as 'fraught'. In particular, deciding what is a good outcome and for whom. This is further challenged by the impact on co-funded services by two levels of government and the ability to attribute

outcomes to funding.[8] These issues were raised in the earlier study by NDARC; they similarly reported that treatment providers usually receive funds from multiple funding sources, meaning that funders may only be contributing to part of the service, but may receive outcomes data relating to all clients of the service, making attribution to a particular funding source difficult.

In 2008, NADA brought together non government AOD service providers to identify a set of validated tools that could be used by a diverse workforce to improve the way that routine outcome assessment data were collected and used. The Client Outcomes Management System (COMS) was established that provides the non government sector with a brief, self-report outcome assessment tool that measures substance use and related risk, psychological health and physical health and social functioning.[9] COMS is now the most used outcomes management system for non government organisations in NSW (71% of NADAbase users), with many bespoke data systems from non government organisations providing a direct import. At the same time, the public services were implementing the Australian Treatment Outcomes Profile—modified from the UK Treatment Outcomes Profile for use with the Australian population. Initial validation was undertaken in three public opioid treatment settings in NSW. The ATOP also uses outcome domains identified earlier. The study found that ATOP was well received by both service users and clinical staff for its shortness, applicability and ease of use.[10] The tool has since been validated for other drugs of concern and treatment settings, except for residential settings. Both COMS and ATOP are now used in a small number of performance agreements, with both tools accepted by major funders of AOD treatment.

Two studies have sought the perspectives of service providers in implementing outcome monitoring systems. A study in the USA found that the most important factors to implementation were: treatment provider ethos—client centred approach; staff buy-in; resources; clinical time taken to undertake outcome monitoring; and clinician and program discretion—which related to flexibility in treatment provided and when tools were administered.[11] In Australia, an outcome monitoring tool was piloted in a small number of AOD service providers in Victoria. The study found that implementation of an outcome monitoring tool was complex and unpredictable, with a quantitative approach that was viewed by workers as favouring cessation or reduction of AOD use as being more important than qualitative improvements in areas such as mental health and quality of life.[12]

Where are we heading?

Gaining more prominence in the literature is the use of patient reported measures (PRMs), which collect information from the perspective of service users about their experience of the healthcare they receive. There are two types of PRMs, patient reported outcome measures (PROMs) collect information on a person's health status, usually through validated survey instruments. Patient reported experience measures (PREMs) on the other hand collect information on the observations and views of the healthcare that a person has received.[13] A study that compared the performance measurements systems in the Netherlands and the USA reported that the use of PRMs may assist in reducing the burden of collection of data, by utilising multiple purposes for use of collected data that has relevance to funders, providers and service users. They reported the need for data collection that is clinically useful and can assist in quality improvement but can also be aggregated a high-level for the purposes of accountability and performance management.[14] An example in AOD is the Substance Use Recovery Evaluator, a PROM developed in the UK that is quick, easy to complete, psychometrically valid outcome measure, acceptable to both services users and providers, that can be used for: self-monitoring by service users, use in clinical practice, auditing by treatment providers, research and possibly commissioning of services.[15] Whilst there is much agreement on the use of PRMs, a recent study has questioned the ability of PREMs to identify high and low performing providers due to the variability in use and responses.[16]

What needs to be done?

- Meaningful involvement of funders, providers and service users in the development and utilisation of outcome data
- Leadership and involvement of Aboriginal communities in the development of culturally appropriate measures
- More study on the purpose and utilisation of PRMs for use in performance measurement of AOD services
- Translating the use of client outcome data to demonstrate service and system level performance

What should treatment services be doing?

- Use validated outcome measures that go across the outcome domains identified above
- Ensure that measures are clinically relevant to the people accessing your service
- Use aggregate outcomes data to look at trends in your organisation. What is the data saying? How can you improve? What story do you want to tell your funders using the data?

IN A NUTSHELL

PROMs

Patient reported outcome measures

Patient reported outcome measures (PROMs) ask patients/clients to assess elements of their own health, quality of life, and functioning. The resulting data can be used to show how healthcare interventions and treatments affect these aspects of a person's day-to-day life and assist in making improvements to the services that are delivered.[1] In the AOD treatment sector, the types of PROMS that are collected include questions about: frequency of substance use, severity of dependence, quality of life, experience of physical and mental health symptoms and social impacts such as financial issues, homelessness and engagement in work, study and relationships.

PREMs

Patient reported experience measures

Patient reported experience measures (PREMs) ask patients/clients to assess their experience and perception of their health care—these are completed anonymously. This information can provide a more realistic gauge of patient satisfaction as well as real-time information for local service improvement and to enable a more rapid response to identified issues.[2] PREMs are more than a person's satisfaction with a service, it includes what they value about service provision, what they prefer and what they expect from a service or treatment. An example of a specific question might be 'would you recommend this service to a friend or family member?'

Consumer's view: 'PROMs and PREMS can lead to increased communication between consumers, clinicians and service providers. It is a process for consumers to see where they have been, and where they are going. Consumers can provide real-time feedback on the lived experiences and health outcomes which are important to them. Their insights can illustrate how the experience of health care impacts not only on their own physical and mental wellbeing, but when collated with others, it forms a big picture. From this big picture you can drill down to local areas and make relevant local supports and referrals, and capture the experiences and satisfaction (and dissatisfaction) of service received, to integrate local care.'

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Translating research and policy into practice

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Promoting health. Preventing harm.

Dr Emily Deans Research and Design Coordinator

Youth Solutions

AOD is an important public health priority in Australia, contributing to thousands of deaths, illness and injury, relationship breakdown, lost productivity and community wellbeing and safety issues.[1]

Since the late 1980s the Australian government has worked to reduce drug related harm among populations by adopting a harm minimisation approach to policy.[1,2] This has included efforts towards preventive strategies and funding towards AOD health promotion initiatives.

Delaying initiation to AOD use has important implications for the development of long term protective factors against drug dependency and mental illness.[3] Research also shows that underage drinking and drug use have significant health and social consequences, some of which can include impaired brain function, memory loss, risky sexual behaviour and self-harm.[4]

Youth Solutions is a youth AOD health promotion charity servicing the Macarthur and Wingecarribee regions of South Western Sydney, and is funded by NSW Health and the SWSLHD. Youth Solutions has a suite of AOD education projects, which are delivered to young people in school and community settings.

Youth Solutions exists to empower young people to be healthy and safe through drug, alcohol and wellbeing education and our vision is to see a community of healthy, safe and connected young people.

We believe strongly in capturing the expressed needs of young people and with a commitment to quality improvement, are striving to continuously develop our project work to meet the needs of local youth populations.

During 2017–2018, Youth Solutions engaged with 1182 young people in our health education projects which include PEEP, DAIR and ARTucation. We engaged with a further 980 young people through other workshops and presentations.

The DAIR project continues to be Youth Solution's most frequently booked health promotion workshop series aimed at young people aged 14–16 years. Last financial year, DAIR was delivered to 348 young people from 25 different groups. Notable results from program participant evaluations include the following:

- 97.8% of respondents reporting improved knowledge of the types and effects of AOD
- 98.7% of respondents reporting improved knowledge of what to do in an emergency
- 97.4% of respondents reporting improved knowledge of healthy ways to deal with stress
- 98.2% of respondents reporting improved knowledge and skills around accessing support services.

An important part of our work is to provide an alternative commentary to the range of socio-cultural and media factors that may influence and shape young people's AOD use. We believe that it is courageous and measured to ask for help when needed, and it is our responsibility to ensure that young people who move through our programs are aware of the local services working to help prevent and minimise AOD harm among youth populations and our broader communities.

Youth Solutions exists to empower young people to be healthy and safe through drug, alcohol and wellbeing education and our vision is to see a community of healthy, safe and connected young people.

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Feedback informed practice

Dr Suzie Hudson
NADA

What might it be like to ask our clients whether the therapy we are providing is helpful—while they are still with us in the counselling room? Your response might be that you do ask your clients, in different ways and at different times this question—but does it shape the way you practice?

We know that in AOD treatment one of our key areas for improvement relates to high drop-out rates. One way to address this is to engage clients early-on in conversations about the importance of the therapeutic relationship or alliance. Letting our clients and consumers know that we will be regularly asking them about how they are finding the services we provide combined with whether they feel their quality of life is improving—these practices are the foundation for providing feedback informed treatment (FIT).

Feedback informed treatment is an empirically supported, pantheoretical approach for evaluating and improving the quality and effectiveness of behavior health services. It involves routinely and formally soliciting feedback from clients regarding the therapeutic alliance and outcome of care and using the resulting information to inform and tailor service delivery.[1]

Currently, across the specialist AOD treatment sector we are asking about treatment outcomes and client satisfaction—but it usually occurs outside of the therapeutic interaction with the client. If we were to ask for feedback, within a counselling session for example, it would enable us to modify what we were providing and the manner in which it was being delivered to suit the client that was in front of us. Tools such as the 'Outcome rating scale' and the 'Session rating' can serve this purpose and have been found to decrease dropout rates by as much as half.[2]

We have done a fantastic job to create a culture of outcome measurement—but we need to start work on the next step, and that is responding in real-time to feedback from our clients. Would you like to hear more about how to improve your therapeutic practice through feedback informed treatment—then come along to the NADA outcomes forum.

14 Aug

NADA outcomes forum
Surry Hills

How can we translate client outcomes, experiences and feedback into practice?

This forum will shine a light on how to embed reflective practice to improve service provision.

We'll explore a range of topics, including:

- using data to shape therapeutic work
- implementing feedback informed treatment to boost the effectiveness of therapeutic work.

Dr Diana Kopua and Mark Kopua from Hauora Tairawhiti (NZ) will present their evaluation on the use of feedback informed treatment with Maori and indigenous people.

Click here to register

References and resources

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Patient reported experience measures in mental health

Mental Health Coordinating Council

In the last five years in the health sector there has been a specific focus on patient reported experience measurement (PREMs) to compliment the outcomes measures that have been implemented. While many services in the AOD sector ask their clients to complete satisfaction surveys, there is no consistency in relation to the tools used, timing of surveys, collection, collation ore reporting. It is useful for us to look at how things are being done in other health-related sectors, here is an example from the NGO mental health sector that might provide us some useful insights.

Your experience of service YES and CES project

In 2018 the Community Managed Organisations Your Experience of Service and the Carer Experience Survey Project (CMO YES and CES) was established. The project demonstrated the NSW Government's commitment to greater accountability and transparency in response to the NSW Mental Health Commission's Living Well report. The YES and CES project will support consistent experience measurement in NSW mental health CMOs, to allow services to compare consumer and carer experiences. MHCC is working with InforMH, an analytics branch of NSW Health, and members to ensure only they receive the feedback that relates to their service delivery type category.

Twelve CMOs are participating in the advisory working group, working with MHCC and InforMH to develop the lived experience measurement. The advisory working group will consult the sector on issues raised during pilot implementation, such as survey use, impact on practice, consumers and carers and the business processes of CMOs. The YES questionnaire, which is the first cab off the rank, is designed to gather information from consumers about their experiences of care. It aims to help mental health services work with consumers to build better services.

The second pilot, CES, will similarly gather evidence from carers of people using mental health CMO services. The YES questionnaire was developed with mental health consumers based on recovery principles described in the 2010 National Standards for Mental Health Services. The YES questionnaire data is confidential and does not include personal identifiers, such as a medical record number. Services will receive feedback combined under a particular service type. Feedback will help organisations identify what they do well and areas for improvement. We are at the information gathering stage and expect the pilot to be trialled in July and August, when CMOs will start offering the questionnaire to service users. Evaluation will occur after 12 months. The pilot is expected to run for a year-and-a-half ending June 2020. This will include the YES CMO and CES design and implementation, and implementation of e-YES.

Learn more

All of our members ask their clients about their experience of treatment using many different measures. This article focuses on client report experience of treatment that you may find particularly useful:
The Client Satisfaction Questionnaire-8: Psychometric properties in a cross-sectional survey of people attending residential substance abuse treatment [PDF]

Could the YES be a useful tool for the AOD sector?
The Australian Institute of Health Welfare and the NSW Ministry of Health are exploring the possibility of using a survey like the YES in the AOD sector.
YES questionnaire and brochure [PDF]
YES Survey outcomes for Mental Health Report [PDF]

Contact Suzie Hudson to discuss.

Do you have something to share

Contribute to the Advocate to connect with NADA members and stakeholders. Promote new services and projects, innovative partnerships, awards and achievements, or research activity.

Email an expression of interest to Sharon Lee.

Engaging around outcome measures

Australian Institute of Health and Welfare

The inclusion of treatment outcomes information in the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS) has been a key area of interest for many people in the AOD sector over a long period of time.

While many organisations in the sector are collecting information on treatment outcomes, currently there are no nationally consistent treatment outcome measures. This makes it difficult to measure and compare treatment outcomes across Australia.

The development of nationally consistent treatment outcomes measures would help improve our understanding of what factors contribute to different outcomes for people receiving AOD treatment. Throughout 2018–19, the Australian Institute of Health and Welfare (AIHW) has been talking to people in the AOD sector about the development of national treatment outcomes measures in the AODTS NMDS.

As part of this work, the AIHW visited capital cities and a number of regional areas to speak to a broad range of people, including clients, clinicians and AOD workers, researchers and data managers. People who could not attend these sessions (as well as those who could), were also able to provide feedback about issues to do with, and priorities for, the development of national treatment outcomes information via online surveys and written submissions.

Thank you to all of the people who contributed to these sessions and gave their feedback to us. Through this work we were able to get a much greater understanding of what outcome measures are currently being collected, what measures suit the needs of the sector, (particularly the clinical and client needs), and how the current information system and data flows might impact on the collection of treatment outcomes information.

The AIHW has reviewed all of the information collected from the sector, and is currently preparing a report to the Australian Government Department of Health, the funder of this project. This report will highlight key findings from consultation, consider broader contextual information, including mechanisms for measuring outcomes and recommend options for the future.

Thanks again to consultation participants for your participation and contribution.

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Keep up-to-date with best practice articles, resources and training. Frontline is sent every three weeks.

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Reporting against the new NSW Health Core Performance Indicators

Tanya Merinda, Principal Project Officer
Eliza Quinert, Assistant Project Officer
Clinical Quality and Safety, NSW Ministry of Health

The first six months

Funding contracts with non government organisations (NGOs) providing AOD treatment now include five new core performance indicators
All funding contracts between NSW Health and non government organisations providing AOD treatment services now include five new core performance indicators. The new core performance indicators aim to support the NSW Health vision that people with AOD related harms experience person centred, safe, high quality intervention and care. Further, implementation of the new core performance indicators reduces the administrative burden on NGO contract stakeholders by streamlining indicators, providing consistency across contracts and reducing reporting requirements.

NGO contract stakeholders reported a mostly positive experience with the first round of reporting
In January 2019, NGOs funded by NSW Health to provide AOD treatment completed their first round of six-monthly reporting against the new core performance indicators. NGO contract stakeholders reported a mostly positive experience. Implementing the core performance indicators was said to have reduced the administrative burden on NGO contract stakeholders and also encouraged meaningful conversations around clinical quality and safety. Many NGO contract stakeholders also reported that the change to six-monthly reporting cycles, reduced the burden associated with reporting and was less time consuming.

NSW Health and NADA are working to address reported challenges to improve outcomes
NSW Health and NADA are working with NGOs to address a few challenges that were reported from the first round of reporting. We are developing new resources that will clarify data and evidence reporting requirements, including an outline of what the expectations for recent data analysis and trend reports are. We will also be providing information and training to support funded NGOs to align their clinical incident management systems with the NSW Health clinical incident management policy and guidelines. Finally, NSW Health and NADA are reviewing reporting templates to improve usability and to include examples of satisfactory reporting.

Resources are available to support NGO contract stakeholders
NSW Health and NADA encourage all NGO contract stakeholders to continue to refer to the following resources, to clarify the performance indicator implementation and reporting requirements:

- Performance indicator frequently asked questions
- Performance indicator specifications
- Performance indicator fact sheets
- Performance indicator support templates

The NGO State-wide AOD Working Group with representatives from contracted NGOs, LHDs, primary health networks, NADA and the Ministry continues to provide a forum to work through contracting improvements.

For more information about the NGO State-wide AOD Working Group or about improving contractual arrangement activities, please contact:
Tanya Merinda Ministry of Health
Robert Stirling NADA
Clinical Safety and Quality Team Ministry of Health

Useful resources

The Agency for Clinical Innovation is a part of the NSW Ministry of Health and runs the Patient reported measures program. This program is divided into two parts: patient reported outcome measures (**PROMs**) which are used to help assess and follow up a patient's clinical progress and patient reported experience measures (**PREMs**) which help to assess the patient's experience of health care. PROMs and PREMs resources include forms and videos.

The **International Centre for Clinical Excellence** promotes excellence in behavioural health services. They have identified four competency areas [PDF] for clinical performance which includes using consumer reported measures. These are: research foundations, implementation, measurement and reporting, and continuous professional improvement.

Feedback informed treatment Studies show improved quality, retention, and effectiveness of behavioural health services when standardised measures are used to solicit feedback from consumers. Scott D. Miller is the founder of the International Centre for Clinical Excellence.

The **Mental Health Coordinating Council** is the peak body for community mental health organisations in New South Wales.

Implementing routine outcome measures in community managed organisations. Although the focus is mental health, this guidebook [PDF] provides useful information to implement the routine use of outcomes measures in community managed organisations (CMOs).

Consumer perspectives of mental health care
The Australian Institute of Health and Welfare presents information about consumer-rated experiences of care in public specialised mental health services using the nationally developed Your Experience of Service (YES) survey. See more on page 14.

Alcohol and Drug Outcome Measure This is the New Zealand Ministry of Health's website, which focuses on all community based outpatient adult addiction services. AOD practitioners support service users to regularly rate how they are doing and to view the results using the ADOM

Alcohol and drug outcome measure tools The following tools support the use of New Zealand Ministry of Health's Alcohol and Drug Outcome Measure.

Two interesting PROMs are being developed in England. The first is a measure of **addiction recovery** and the second is a measure of **sleep quality**.

The **International Consortium for Health Outcome Measures** focuses on value based healthcare by defining measures that matter most to patients. Organisations and clinicians can learn from the outcomes data they gather to improve the lives of their own patients and to provide high-quality care efficiently. ICHOM is currently working on an outcome measure set for AOD.

Why use outcome measures? Watch videos from The International Consortium for Health Outcome Measures.

NADAbase

Dr Suzie Hudson

NADA

Staff changes

Tata de Jesus stepped up since **Cass McNamara** left, and has been providing excellent support and kept the expansion ticking along with our Reports and Dashboard Design (RADD) working group.

We've welcomed **Sue Hailstone**, a data systems analyst from the Ministry of Health on a six-month secondment. Sue's most recent Ministry work included the implementation of the 5 Common KPIs for non government AOD treatment services, which at its heart focuses on quality and safety. Sue will be looking at number of data related projects in her time with NADA and is sure visit you at some point soon.

The big picture

The total budget for the NSW Drug and Alcohol program is $225 million. In the most recent public release of Alcohol and Other Drug Treatment Services National Minimum Data Set data, the non government sector in NSW accounts for 34% of the treatment agencies and 32% of all the closed treatment episodes. The non government sector plays a substantial role in the delivery of AOD services in NSW; data also plays an important role in our future work too.

What's been happening?

- Releasing the NADAbase data dictionary [PDF]
- Incorporating the suicide, blood borne virus and sexual health, domestic family violence risk, nicotine dependence risk screeners into NADAbase
- Convening the RADD working group
- Updating the NADAbase data reporting agreement
- Updating the Privacy and Confidentiality policy to include the Privacy Amendment (Notifiable Data Breaches) Act 2017

What's in the pipeline?

- Conducting a review of the existing screeners (suicide, blood borne virus and sexual health, domestic family violence risk and nicotine dependence).
- Investigating how all the very rich COMs data (drug and alcohol use, psychological health, health and social functioning, blood borne virus risk) which has been collected over several years can be analysed. With a focus on value based healthcare in NSW, this includes improving the health outcomes that matter to patients.
- Drafting the next NADAbase workplan in consultation with members.

NADA board

Consumer engagement sub-committee

Recently NADA has undertaken work with its members in relation to consumer participation. With growth in this area of our work, we recognized that leadership and direction from the NADA Board was required.

The NADA Board Consumer Engagement Sub-Committee was thus created to support and guide NADA to ensure our operations, programs and services (both within the organisation and with members) are informed by consumer experiences. The sub-committee supports the board by providing advice based on sub-committee members' lived experience and expertise, evidence based practice, evaluation related considerations and other stakeholder expertise.

The subcommittee will advise on innovative consumer engagement initiatives. They will ensure the consumer voice is incorporated in NADA resources and projects. They will also act as a forum for NADA members to explore how consumer participation can support effective engagement to improve treatment options, access and equity. And finally, they will promote links to other services.

Membership of the sub-committee includes the NADA President, consumer representatives with recent experience of AOD treatment and a service providers with experience in consumer integration.

Welcomes and farewells

Changes to the NADA team

At the end of May we farewelled **Rubi Montecinos**, a valued member of the NADA team. Rubi has done an excellent job facilitating and supporting the Women's Network and managing the family project, coordinating extremely successful workshops across the state and developed family inclusive practice eLearning modules.

We also farewelled highly valued and respected team member, **Victoria Lopis**, who left NADA in June. Vicky has been instrumental to ensuring NADA's grants and events management programs run smoothly. We wish Vicky well in her future endeavours.

At the end of June, we will farewell **Fiona Poeder** who initiated the NADA Consumer Participation project and has laid the foundation for important work in this area. Fiona brought with her a wealth of experience and wisdom from the consumer and peer work perspectives, raising the profile of the work that still needs to be done in relation to the experiences of stigma and discrimination by people who use drugs. We wish her all the best for her future.

Maricar Navarro has been promoted to office manager, with oversight of event logistics and an incoming team member.

We've also had changes to the NADAbase team. **Tata de Jesus** stepped up since **Cass McNamara** left, and we've welcomed **Sue Hailstone**, on secondment from the Ministry of Health. (More details on page 18).

New project coordinator at CMHDARN

Jo Penhallurick is passionate about implementing ethical systems of practice to support the valuable work undertaken by the community based workforce. Jo is keen to promote research and data collection that is representative of our communities; which is accessible and translatable into practice.

Jo has spent the last ten years working in non profit community based organisations in Australia and the USA, in homelessness and social housing, LGBTI counselling, AOD, mental health and community health. She holds an honours degree in psychology from the University of Sydney.

Profile

NADA board member

Gabriella Holmes
President

How long have you been associated with NADA?

When I first commenced working in the AOD sector at Mission Australia's Triple Care Farm in 2000, I attended NADA training and conferences. I was excited about the impact NADA is able to have in advocating for the sector and was nominated for the board in 2009. It has been my pleasure to serve the NADA members as a board member for the last 10 years.

What does an average day look like for you?

I don't know that there is an average day when you are working in a residential service. There are days when I am responding to a water supply interruption when the pump at the main dam is faulty and other days celebrating with young people as they move from the program back into the community. No two days are ever the same!

What experiences do you bring to the NADA board?

I have over 19 years' experience working in the AOD sector, specialising in supporting young people through residential AOD services. This includes residential rehabilitation and an inpatient withdrawal program. I am also a registered psychologist, with a Masters in Child and Adolescent Mental Health.

What are you most excited about as being part of the NADA board?

One of the most exciting projects that I have been involved in, is the advocacy to double the number of residential treatment beds for AOD services in NSW. The other project that I am most excited about is the advocacy for stable long term funding for the sector. This will enable services to go from strength to strength in quality service delivery.

What else are you currently involved in?

I enjoy life on the coast with my family. I love reading and keeping my garden from going wild.

A day in the life of...

Sector worker profile

Bianca Clear Youth AOD Clinical Worker
Drug ARM Australasia

How long have you been working with your organisation?

I have been with Drug ARM for over a year and working in this role for close to 10 months.

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

I started with a BSc in psychology back in 2006 and then completed my masters in counselling. I used to run my own counselling practice in Melbourne and upon arrival in Brisbane, I began volunteering with Drug ARM which eventually lead me to the youth clinical worker position here for the Moree LGA.

What does an average work day involve for you?

I drive to one of my outreach locations or clients homes where we pick them up for a session. The young person and I engage in an eight week journey addressing the cause of the AOD use. We use evidence based interventions and relapse prevention programs along with working on developing the positive, supportive aspects of their lives.

What is the best thing about your job?

The absolute best is seeing improvement in my clients. When I watch a young person learn the value of self-care and become passionate about opportunities it makes all the challenges of this role worth it.

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

There are not many resources to connect the young people with here in Moree LGA. I would like to see more outdoor programs made available to youth so they have something positive to focus on in the absence of their substance use.

What do you find works for you in terms of self-care?

Meditation and tea.

Keep informed with quarterly updates from the Women's AOD Services Network, the Youth AOD Services Network, the NADA Practice Leadership Group and CMHDARN.

NADA network updates

Women's AOD Services Network

The last quarter has been a busy period for the network, with the hosting of the 'Working with women, children and families in AOD services' forum and celebrating International Women's Day in March 2019. The forum was well attended by representatives from AOD services and cross-sector services, who learned of the innovative work happening within services for women accessing AOD service treatments.

Additionally, the network is:

- updating the Women's AOD Services Network profile
- working with Associate Professor Carolyn Day on 'who is coming into treatment' based on N/MDS and COMS data

Staff of network members will be undertaking 'Dialectical behaviour therapy' training.

The Women's Network welcomes Olivia Nguy, the new General Manager for Detour House and wishes Christine Duggan, Manager of Guthrie House, the best during her maternity leave.

Youth AOD Services Network

The NADA Youth AOD Services Network met for their bi-annual network meeting on 9 April 2019.

Representatives from 16 Network member organisations were in attendance—resulting in a fantastic collaborative event.

The group discussed sector funding, upcoming projects and future Network activities, and were pleased to hear two presentations around upcoming University research focused on improving outcomes for young people in AOD treatment. The network is looking forward to an upcoming training session, and the development of the next iteration of the Youth AOD Services Network profile.

NADA network updates
continued

NADA Practice Leadership Group

The NADA Practice Leadership Group has been hard at work over the last couple of months providing feedback on advocacy positions around the effectiveness of treatment, contributing to a set of standardised AOD specific position descriptions and developing ideas regarding the upcoming NADA Access and Equity project. June will see members of the NPLG come together for a planning day to contribute to some key NADA projects for 2019/20—including healthy relationships, increasing consumer participation in AOD service delivery and the all-important NADA Conference 2020. Stay tuned for more updates and keep an eye out on Frontline for tips and resources to inform best practice in AOD treatment.

Contact Suzie Hudson, Tata de Jesus or any of the current NPLG members if you would like to know more about our activities.

CMHDARN

CMHDARN held its annual symposium on 5 June. The CMHDARN Symposium brings together academics, consumers / clients, carers and those that deliver services in the AOD and mental health sectors. It is a unique opportunity to explore the intersection of research and service delivery and how this inform practice.

'Exploring the potential—experience, outcome measures and practice' was this year's theme. The presentations and panel explored topics such as: how to determine which measures (experience, outputs or outcomes) tell us what we need to know; how does the context in which we evaluate experience and outcome measures impact the information gathered; and how can we embed reflective practice as a response to experiences of service provision. There was lively discussions and many questions posed. Thanks to all the presenters and attendees!

Member profile

Orana Haven

Service overview

Orana Haven is an Aboriginal residential AOD rehabilitation centre located on a 10-hectare property in Gongolgon in far north west New South Wales. Orana Haven provides a safe, understanding and culturally sensitive sanctuary primarily for Aboriginal men aged 18 years and older; we also accept non-Aboriginal men.

Overlooking the Bogan River, Orana Haven is peaceful and serene. Here, clients reconnect with their spirituality and are encouraged to participate in activities. Creating artwork, visiting cultural places of interest, cooking food (including bush tucker), and household chores are all part of the program. There's a structure to each day and everything is geared towards the residents gaining or relearning life skills. There is also a strong emphasis on education and acquiring work skills through TAFE courses. Staff also facilitate workshops including: relapse prevention, anger management, the effects of substance use, smoking cessation and Aboriginal and Torres Strait Islander first aid mental health.

'I like being at Orana Haven because the environment provides me with spiritual healing, the structure of the program and staff help me stay focus on the program. I also like the freedom and wide open spaces. The workers with lived experience that I can relate to helps me in my recovery.'
Client feedback

Orana Haven reopened in 2011 after being appointed a special administration in June 2010, which ended in March 2011. 'The corporation was handed back to its members in a much healthier state and several good things have followed.' Orana Haven now has a highly qualified board with extensive experience in the community health sector, a clear corporate governance structure and dedicated skilled staff. Through the dedication and hard work from both the board and staff, Orana Haven was recognised and received two awards at the 2016 National Indigenous Drug and Alcohol conference for Recognition Service and Remote Worker Male.

Clients with complex needs

Clients who access the Orana Haven present with complex issues ranging from trauma, abuse, homeliness, health, mental health and legal. Treatment requires a holistic approach that is provided by skilled staff with assistance from other service providers through referrals and strong partnerships. The Brewarrina Aboriginal Medical Service provides health checks, pathology, hep-C treatment, with a psychologist and GP. The Brewarrina Local Hospital provides a range of specialist services including detoxification, mental health, x-rays, psychiatrist and pathology. Dental treatment is provided by CSU Oral Dental Clinic, Royal Flying Doctors and the Walgett Aboriginal Medical Service. Orana Haven is currently in the process of establishing a six-bed onsite detoxification treatment facility that will be available to males and females, aged 18 years and older.

Our staff

The staff of Orana Haven all have something special to offer in the way of skills, knowledge, lived experience. Skills include but not limited to: ability to motivate clients, ability to communication with clients, teach clients new skills and pass down Aboriginal cultural knowledge.

1 Byrock Road Gongolgon NSW 2839
Phone: (02) 6874 4886 or (02) 6874 4983
Fax: (02) 6874 4987

NADA training

21 June

Engaging with families and significant others in the AOD sector—Newcastle

Develop your skills for supporting families and significant others of people with substance use.

This workshop will explore best practice principles and approaches to working with families/significant others. Participants will have the opportunity to:

- acquire insights into family/significant other experiences
- gain knowledge of best practice principles and approaches to working with families from all backgrounds
- become familiar with AOD terminology and information that can be provided to families
- increase awareness about local referral pathways.

14 Aug

NADA outcomes forum

How can we translate client outcomes, experiences and feedback into practice?

This forum will shine a light on how to embed reflective practice to improve service provision.

We'll explore a range of topics, including:

- using data to shape therapeutic work
- implementing feedback informed treatment to boost the effectiveness of therapeutic work.

Dr Diana Kopua and Mark Kopua from Hauora Tairawhiti (NZ) will present their evaluation on the use of feedback informed treatment with Maori and indigenous people.

Click here to register

Or click here to learn online

Asking the question, MERIT and Complex needs capable

Congratulations on reaching 20 years

This May, NADA's CEO, Larry Pierce, celebrates 20 years at the helm of NADA. Over this time, the non government AOD sector in NSW has undergone significant changes, and Larry has been integral in ensuring NADA members have been able to navigate this. He is a strong leader, courageous in his advocacy, and has led a successful program of improvement and professionalisation of the sector.

From an organisational perspective, Larry has fostered a positive workplace culture at NADA that encourages leadership, independent thought and autonomy for staff. All with the wit and banter that makes NADA a great place to work.

NADA board members say:
'Larry is an effective relationship builder, connecting service delivery with policy makers. Thank you for advocating and supporting the non government AOD sector for over 20 years.'

'I want to acknowledge the growth that has occurred under your leadership—NADA has gone from a small office with a couple of staff to the enterprise it is today. Thanks for your work and your commitment to the NADA membership and their needs. It is all very much appreciated.'

'Larry is available to talk through any ideas, challenges and successes. He is well informed and well connected politically and understands how the systems and sector work.'

Congratulations Larry!

NADA Practice Leadership Group

Meet a member

Grace Ivy Rullis Manager—Homelessness Programs and Clinical Lead, The Haymarket Foundation

How long have you been working with your organisation? How long have you been a part of the NPLG?
I have been working within complex homelessness sector for 15 years and at The Haymarket Foundation for over ten. I joined the NPLG in September 2017.

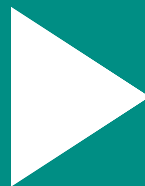
What has the NPLG been working on lately?
One of the NPLG's focus areas is access and equity; removing barriers to equitable treatment. We are facilitating a forum where experts will provide practical solutions for providers to ensure inclusive referral pathways for vulnerable populations, such as people experiencing homelessness, people exiting correctional facilities, LGBTIAQ+, Aboriginal and Torres Strait Islander peoples.

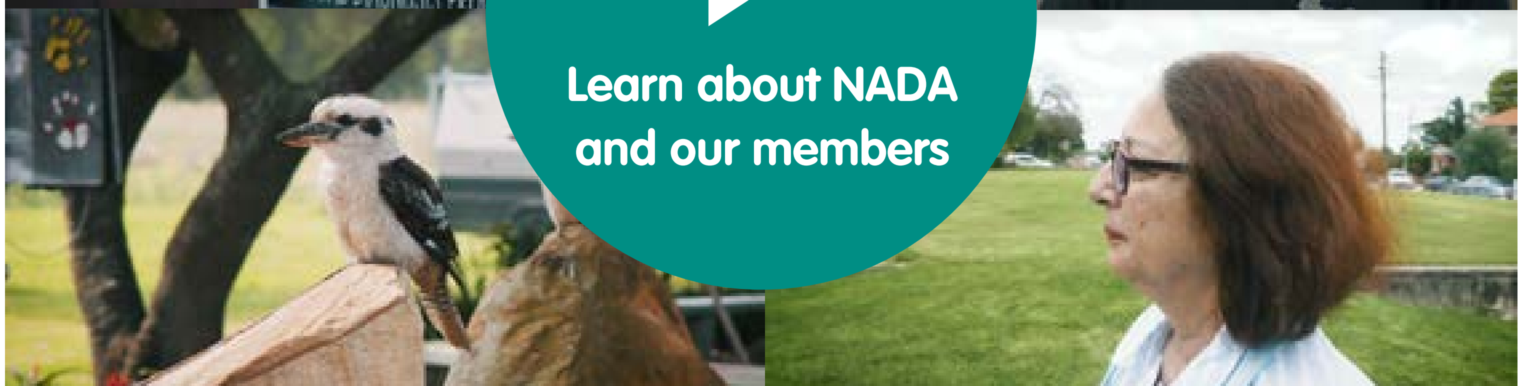
What are your areas of interest/experience—in terms of practice, clinical approaches and research?
My expertise sits with people experiencing lifelong trauma and complex homelessness. Through sector alliances, I advocate for systemic and organisational change, ensuring opportunities for adaptive clinical intervention to provide a quality of life for people facing sector and community rejection.

What do you find works for you in terms of self-care?
I am a major fan of daily (essential oil) baths. I recently joined a book club and a meditation and mindfulness course on self-compassion. Did I mention I am massively into sci-fi? My recommendations are Fringe and Black Mirror.

What support can you offer to NADA members in terms of advice?
I can offer guidance in leading adaptive interventions and sector navigation, where the person is at the centre of service delivery. I can offer my expertise in quality program improvement, ensuring inclusivity for people experiencing discrimination and service rejection. For those in the human services sector, the removal of barriers to equitable treatment should be prioritised to counter-balance the continued traumatisation of highly marginalised populations.

VIDEO





Learn about NADA and our members

What we're working on

Program update

Worker wellbeing

NADA is excited to launch a series of new worker wellbeing and self-care resources.

How are you going

Developed in partnership with the Centre for Rural and Remote Mental Health, this poster encourages workers to check-in to see where they're at regularly and to take steps to nurture and protect their wellbeing.

The ABCs of self-care

This poster promotes the ABCs of self-care. Being aware of how the work can impact us and achieving and maintaining a sense of balance and connection, can prevent us from experiencing work-induced stress and trauma and/or mitigate its harmful effects.

Worker self-care check

Complete this survey to assess your current self-care practice. The survey is designed to highlight the good things you're already doing and will help you identify whether there's is an imbalance in the areas in which you practice self-care.

Professional quality of life scale

The ProQol is a commonly used measure of compassion satisfaction, burnout, and secondary traumatic stress. While the resource isn't intended as a diagnostic tool, how you score will provide a guide on how likely you are experiencing compassion fatigue, so that you can take steps to protect and nurture your health and wellbeing.

Contact sianne@nada.org.au to learn more.

Consumer engagement project

The Consumer Engagement Project is steaming along. We're currently developing reports for each of the five sites identified in the project. These reports include descriptions on issues arising during the project. Advocacy strategies are included in the reports with the aim of supporting sites in sustaining their consumer engagement activities.

Recently launched, the consumer participation audit tool allows member organisations to gauge where they sit in relation to engagement. This tool was focus tested by members of the newly established NADA Board Sub-Committee on Consumer Engagement.

Lastly, NADA in partnership with APSAD hosted a webinar on consumer engagement on 13 June. Titled 'Engaging consumers: Tricky or transformational', the webinar explored issues around language, research and lived experience. Facilitated by Dr Suzie Hudson (NADA), presenters include Annie Madden—recent recipient of Order of Australia, PhD student, former CEO of the Australian Injecting Drug Users League (AIVL), and co-founder of Harm Reduction Australia. Fiona Poeder (NADA) and consumers with extensive lived experience used their narrative to explore the practicalities of consumer engagement. Watch the video recording.

For more information on consumer issues contact fiona@nada.org.au.

Continuing coordinated care

The clinical consultant presented workshops to CCC teams across the state to build capacity in areas such as domestic and family violence, working with child protection and opioid replacement therapy.

Access and equity

Beginning a new project, NADA has engaged the University of New South Wales Centre for Social Research in Health to conduct research regarding access and equity to NSW non government AOD services. This research will involve client and stakeholder interviews across NSW, with the aim to better understand the barriers and enablers for clients accessing AOD services, and subsequently their experiences of treatment. This research will assist NADA in shaping advocacy and capacity development opportunities to better support its members in their service delivery.

Healthy relationships

NADA held a consultation workshop, the first stage of a new project that aims to support members around working with their clients regarding healthy relationships and family and domestic violence. Mr Rodney Vlais, one of Australia's leaders in engaging men who cause domestic and family violence, facilitated the workshop.

For more information, contact michelle@nada.org.au.

Advocacy highlights

Photo by Kris Ashpole

Policy and submissions

- NADA provided a submission to the NSW Health Minister and NSW Ministry of Health calling for a doubling of the number of beds in NSW based on DASMP calculations.
- NADA provided a submission to the Special Commission of Inquiry into the Drug 'Ice'.
- NADA is part of a group of AOD leaders provided a media release: Alcohol and other drug treatment services desperate for Federal Budget relief (29/3/19). Resulting media in SMH here.
- The AOD Peaks Network provided a submission to the Pharmaceutical Benefits Advisory Committee (PBAC) to express its support for the Australian Government to list the Naloxone Nasal Spray as a reimbursed medication in Australia on the PBS.
- NUAA and NADA sent a joint letter to NSW Ministry of health re NGO involvement in state-wide rollout of the Overdose Response and Take-Home Naloxone project.

Advocacy and representation

- Ministerial meetings: NSW Ministry of Health, Department of Health, Department of Social Services.
- NADA staff have been attending the NSW Ministry of Health consultation workshops on the Clinical Care Standards for AOD Treatment Services.
- A staff member attended the Clinical Incident Management Training provided by the Australian Council on Healthcare Standards with the NSW Ministry of Health AOD Branch.
- A NADA update was provided at the NSW Aboriginal Residential Healing Drug and Alcohol Network (NARHDAN) meeting.
- NADA is participating in Quarterly Sector Roundtable on Families and Communities with Minister Ward and other agencies such as; FACS, ABSec, Uniting, The Smith Family, ACWA, NCOSS, MHC, FAMS, YFoundations, Barnardos and other Out of Home Care Providers.
- NADA attended the launch of Mindframe for AOD, a new strategy to support the media to communicate responsibly about AOD.
- NADA met with researchers from the University of Sydney and University of NSW to discuss upcoming projects involving young people who use AOD.
- NADA is providing clinical advice to the review of the Withdrawal Management and Psychosocial Guidelines reviews.
- NADA presented at the Family Drug Support International Day.

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Feedback **Training grants**