

NATIONAL IMPROVED SERVICES INITIATIVE FORUM  
(2010)

OUTCOMES FROM THE NATIONAL  
IMPROVED SERVICES INITIATIVE  
FORUM:

A Tale of Two Systems

*A Report by the  
Australian State and  
Territory Peak  
Bodies representing  
the Alcohol and  
Other Drugs Non-  
Government  
Organisation Sector*



National Improved Services Initiative Forum (2010). Outcomes from the National Improved Services Initiative Forum: A Tale of Two Systems. A Report Prepared by the Australian State and Territory Peak Alcohol and Other Drugs (AOD) Non-Government Organisations. Adelaide 2011

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## Common Acronyms and Definition

AOD	alcohol and other drugs
CALD	culturally and linguistically diverse
C-CONG	Comorbidity Coordinators Networking Group
COAG	Council of Australian Governments'
CSSSPP	Cross Sectoral Support and Strategic Partnerships Project
COSS	Council of Social Services
DDCAT	Dual Diagnosis Capability in Addiction Treatment Index Toolkit
DoHA	Australian Government Department of Health and Ageing
GLBT	Gay, Lesbian, Bisexual and Transgender
ISI	Improved Services Initiative
MoU	Memorandum of Understanding
NCETA	National Centre for Education and Training on Addiction, Flinders University
NGO	non-government organisations

### State and Territory Peak Bodies

ATODA	Alcohol, Tobacco and Other Drugs Association ACT
ATDC	Alcohol, Tobacco and Other Drugs Council of Tasmania Inc
NADA	Network of Alcohol and Other Drugs Agencies
NTCOSS	Northern Territory Council of Social Service
QNADA	Queensland Network of Alcohol and Other Drugs Agencies
SANDAS	South Australian Network of Drug and Alcohol Services
VAADA	Victorian Alcohol and Drug Association
WANADA	Western Australian Network of Alcohol and Other Drug Agencies

Comorbidity    Coexisting alcohol and other drug problem and mental illness

## Acknowledgements

The National Improved Services Initiative (ISI) Forum (the Forum) could not have taken place without the support of the Australian Government through the Department of Health and Ageing (DoHA) through the Council of Australian Governments' (COAG) Mental Health – Improved Services for People with Drug and Alcohol Problems and Mental Illness Initiative (also known as ISI). A strong recommendation coming from the forum was to acknowledge the unique nature of the ISI where funding was provided for capacity building rather than service delivery and the role of DoHA in proposing and supporting this focus. The forum was largely organised by the National Centre for Education and Training on Addiction (NCETA) and the forum evaluations from the participants were universally complementary about the venue and forum organisation.

This report would not have been possible without the contributions of the participants of the forum who enthusiastically engaged in the workshop session on the second day where many of the recommendations were developed. Thanks are also extended to the workshop facilitators; staff at the National Centre for Education and Training on Addiction (NCETA) for providing access to the evaluation forms, program details and contact information; Professors Margaret Hamilton and John Mendoza for reviewing and giving permission for summaries of their presentations to be included.

The Cross Sectoral Support and Strategic Partnerships project (CSSSPP) Coordinators from the Peak Bodies worked closely with NCETA, particularly with the development work behind the forum and for providing guidance and feedback for this report. Those involved were Amanda Bode of the Alcohol, Tobacco and Other Drugs Association ACT (ATODA), Robert Stirling from the Network of Alcohol and Other Drugs Agencies (NADA), Barry White from the Northern Territory Council of Social Service (NTCOSS), Lauren Trask from the Queensland Network of Alcohol and Other Drugs Agencies (QNADA), Rosie Way and Andrew Biven from the South Australian Network of Drug and Alcohol Services (SANDAS), Jann Smith from the Alcohol, Tobacco and Other Drugs Council of Tasmania Inc (ATDC), Edita Kennedy and Merissa Van Setten from the Victorian Alcohol and Drug Association (VAADA) and Angela Corry and Maree Stallard from the Western Australian Network of Alcohol and Other Drug Agencies (WANADA).

Amanda Tovell was contracted by the Peak Bodies to attend the forum, gather information from all sessions and to prepare a report of the forum including recommendations coming from participants. She was assisted in this task by Merve Hosgelen.

## Executive Summary

### Achievements of the Improved Services Initiative

There was general consensus that ISI was an important and effective undertaking by DoHA, which provided significant opportunities for the upskilling of personnel working in the alcohol and other drugs (AOD) non-government organisation (NGO) sector, greater collaboration between the Peaks and their local membership and between the Peak bodies nationally, and the development of strong linkages with mental health services and other health and community welfare providers.

Services reported making significant achievements in developing policies and procedures which extended well beyond increasing organisational and sector capacity to provide mental health and substance use comorbidity screening and assessment, treatment and referrals. A significant number of services utilised their Capacity Building Grants funding to employ a Project Officer to undertake a complete review and developed policy review working groups including consumer and carer representatives. Many also focused on implementing new strategies to increase individual staffs' access to and understanding of new and revised policies and procedures through the use of web based technology and incorporating policies and procedures components into staff development activities.

The ISI funding was fundamental to increasing the professionalism of staff in the sector as services and the Peaks collaborated in the development and provision of training opportunities in AOD and mental health comorbidity; cultural awareness for working with diverse clients including Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse background and gay, lesbian, bisexual and transgender clients; suicide intervention; and applying standardised Australian comorbidity screening, assessment and intervention tools such as PsyCheck and the Indigenous Risk Impact Screen. A significant number of services also used this funding to increase staff access to clinical supervision, to develop mentoring and job shadowing programs, and to provide regular local networking forums for mental health and AOD staff.

The scope of linkages and partnerships developed as a result of ISI went broader than the expected partnerships between the NGO AOD sector and mental health and other community health service providers. Many services extended the array of their partnerships to include Local Government, community welfare services, legal and correctional services, universities and other training providers. Participants observed many benefits gained through these linkages and partnerships including opportunities to share resources to provide outreach services to clients, to seek or provide

secondary consultations where appropriate, to develop regional referral pathways, and in some instances, to develop regional frameworks for mental health and AOD services to deliver seamless client comorbidity support. All of those at the Forum made note of the considerable increase in the skills and confidence of individual staff to work with external services to provide better client outcomes.

The success of services applying Continuous Quality Improvement (CQI) processes through ISI funding was demonstrated by the considerable number of services who applied and obtained or are currently applying for health service accreditation. Other achievements in this area included services developing minimum benchmarks for staff AOD and mental health qualifications and training; strategies to ensure staff apply a standard consistency in screening and assessing for comorbidity; and improved mechanisms for staff to access and maintain data collection and client records.

Perhaps the most significant benefit identified through the improvements services made in data collection systems was an the increased capacity of workers to identify and record evidence of clients' needs across a broad range of areas, which in turn enabled them to advocate for access to additional support on the client's behalf. The widespread application of standardised tools to measure organisational comorbidity capacity evaluation, undertake clinical comorbidity screening and assessment, and systematically assess professional development needs were other significant achievements identified in this area.

All participants acknowledged the importance of the support provided by the Peaks through the CSSSPP positions in assisting their services to undertake work in all of these areas.

### **Value of the National Improved Services Initiative Forum**

Participants who attended the two-day forum agreed that the Forum was a rare and much appreciated networking and information exchange opportunity for those working in the AOD NGO sector to come together at a national level. The keynote presentations made by Professors John Mendoza and Margaret Hamilton were the highlights for many attendees and all expressed their sincere appreciation to the Peaks for providing them the opportunity to participate in the Friday workshop, identifying the achievements and challenges of ISI and developing recommendations regarding the future of comorbidity capacity building initiatives for the sector. The only concerns noted were that the Forum could have been of greater value to services if a) it had been held earlier

in the 3-year funding cycle of the Initiative to enable services to implement the new ideas they gained and b) presentation sessions had been longer to allow services to explain 'how' they had implemented changes. At the closing of the Forum, workshop participants were especially cognisant of the benefits they had gained as grant recipients and were keen to see these benefits shared with services that had not been funded. There was unanimous agreement for future sector-focused Forums to be held on an annual or bi-annual basis.

## Recommendations

Workshop participants came up with a range of recommendations regarding continuation of funding, new directions for ISI, mechanisms for sharing the knowledge and raising awareness of capacity building and comorbidity. The seventeen recommendations which had broad support from all at the Forum are provided in *Section 1.6 Future Recommendations*.

Some significant recommendations were:-

- That funding for the ISI should be continued and expanded to include other AOD NGOs not funded in the first funding rounds.
- That further national ISI forums be conducted to enable networking and information sharing to continue.
- That state and territory AOD NGO Peak Bodies continue to play a pivotal role in coordinating and facilitating collaborative approaches to capacity building.
- That an independent evaluation of the Capacity Building Grants and the CSSSPP funded under ISI should be undertaken to enable the learning from this unique capacity building initiative to be recorded and disseminated.

## Introduction

### Background of the Improved Services Initiative

In April 2006 a \$1.9 billion Mental Health package was announced by the COAG. This package included funding for the *Improved Services for People with Drug and Alcohol Problems and Mental Illness* Initiative (ISI) to strengthen the capacity of AOD NGO services to build their capacity to manage and treat people with comorbidity.

Through two ISI capacity building grant rounds, funding of \$44.8 million has been provided to 122 AOD NGO services from 2007-08 through to 2010-11. The intention of the capacity building grants was to support activities including workforce training, developing partnerships with the mental health and community care sectors, and implementing policies and procedures supporting the identification and management of clients experiencing comorbidity.

To support the AOD treatment services and develop partnerships locally and nationally, funding of \$5 million has also been provided to the AOD peak bodies (or equivalent) in each State and Territory through the CSSSPP. Through this project the Peaks are expected to undertake support activities by:

1. Building sustainable linkages and strategic partnerships
2. Assisting AOD NGO treatment services to undertake service improvement
3. Identifying and facilitating training opportunities, and
4. Providing targeted and relevant information and resources.

The capacity building activities of the funded AOD treatment services focus on five key areas:

1. Policies and Procedures, in order to better support the identification and management of comorbid conditions
2. Professional Development and Training, in order to develop appropriate skills for the organisation's workforce and provide access to professional support
3. Linkages and Partnerships that are sustainable and embedded with the wider local health and community service network
4. Quality Improvement Framework with consideration given to the identification and management of comorbid clients
5. Data Collection Systems which capture client profile and changes to the organisation's capacity to identify and manage comorbid clients.

It is these five key areas that provide the groundwork for reporting in *Section 1: Improved Services Initiative Workshop Outcomes and Key Recommendations for the Future*, whilst *Section 2: Overview of the Forum* briefly presents participants views on the highlights of the Forum, summaries of the two keynote presentations and other feedback obtained through the Forum evaluation forms.

### **The National Improved Services Initiative Forum and this Report**

On the 7<sup>th</sup> and 8<sup>th</sup> of October 2010, the State and Territory Peak Bodies representing the Australian AOD NGO Sector, in conjunction with the NCETA, held an invitation-only Forum for services who were recipients of an Improved Services Initiative (ISI) Capacity Building Grant, in Adelaide, South Australia. The Forum was funded by the Australian Government Department of Health and Ageing (DoHA).

The aims of the Forum were to:

- a) Showcase examples of best practice in capacity building
- b) Hear from experts across the sector
- c) Discuss outcomes, successes and challenges experienced
- d) Explore and discuss opportunities to sustain advances made to date.

The Forum was attended by 169 participants and all states and territories were represented.

In early October 2010, the Comorbidity Coordinators Networking Group (C-CONG), a group consisting of all State and Territory CSSSPP staff, contracted an external consultant to attend the Forum with the aim of producing a report on the outcomes of the Forum on behalf of the following Peak Bodies:

ACT	Alcohol, Tobacco and Other Drugs Association ACT (ATODA)*
NSW	Network of Alcohol and Other Drugs Agencies (NADA)
NT	Northern Territory Council of Social Service (NTCOSS)**
QLD	Queensland Network of Alcohol and Other Drugs Agencies (QNADA)
SA	South Australian Network of Drug and Alcohol Services (SANDAS)
TAS	Alcohol, Tobacco and Other Drugs Council of Tasmania Inc (ATDC)
VIC	Victorian Alcohol and Drug Association (VAADA)
WA	Western Australian Network of Alcohol and Other Drug Agencies (WANADA)

\*ATODA and WANADA represent both government and non-government AOD services in the ACT and WA respectively.

\*\* The Northern Territory does not yet have its own AOD NGO Peak, therefore NGO sector support is currently auspiced through the peak COSS.

A key component of the Forum was a 75 minute workshop developed and coordinated by the Peaks to give participants the opportunity to provide feedback on the key achievements obtained and the challenges they faced when implementing the objectives of ISI and to provide advice to Government to assist in informing the future development of any continuation of this initiative. Summaries of workshop discussions and participant evaluation forms formed an integral part of this report.

This report is one of the collaborative initiatives being undertaken by the Peaks to assist in the transfer of knowledge to those services not funded through ISI. The intention is to provide open access to this report on each of the State and Territory Peaks' websites.

## Section 1: Improved Services Initiative Workshop Outcomes and Key Recommendations for the Future

This section provides an overview of workshop participants’ feedback on the key achievements gained and the challenges they faced implementing the objectives of ISI over the last three years, and what recommendations they would make for the future direction of comorbidity capacity development and service delivery in the AOD sector. It also draws on examples provided during the presentations. The workshop outcomes are presented under the following themes:

1. Policies and Procedures
2. Professional Development and Training
3. Linkages and Partnerships
4. Quality Improvement Framework
5. Data Collection Systems
6. Future Recommendations.

For the 75 minute workshop session conducted on the final day, participants were assigned to one of 14 facilitated groups based on a shared commonality such as type of service provision, for example, therapeutic community or rural service. There was also one group which consisted of representatives from DoHA and other government agencies and one group for Executive Officers representing each of the State and Territory Peak Bodies. Table 1 below provides a summary of the number of groups and the common interest they shared.

Table 1: Summary of Session 5: Facilitated Workshop Groups

Common Interest	No. of Groups
City Counselling Services	3
Youth Services	2
Therapeutic Community	2
Other Residential Services	1
Homeless Day Centres	1
Aboriginal Services	1
Rural Services	1
Women and/or Culturally and Linguistically Diverse (CALD) Services	1
Peaks Executive Officers	1
Government	1
<b>TOTAL</b>	<b>14</b>

## Policies and Procedures

### Achievements

The ISI Capacity Building Grant recipients gained significant achievements in the area of Policies and Procedures as many funded services found there was a natural progression from developing comorbidity policies and procedures to reviewing all organisational policies and procedures. As such, many participants wished to acknowledge the importance of the ISI in enabling services to undertake a review and development of policies and procedures, as many had not previously had the resources available to undertake this kind of work on the scale that was accomplished. The ISI provided many organisations with the opportunity to employ a specific project officer, enabling clinical and other client support staff to continue providing direct client services. The table below illustrates the broad types of new policies developed as a result of the ISI funding.

Table 2: Snapshot of new policies developed

<b>Client Focused</b>
<ul style="list-style-type: none"> <li>• Screening and assessment for mental health and substance use comorbidity</li> <li>• Client access to services</li> <li>• Referrals</li> <li>• Suicide</li> </ul>
<b>Staff Focused</b>
<ul style="list-style-type: none"> <li>• Managing client medications</li> <li>• Secondary consultation</li> <li>• Clinical supervision</li> <li>• After-hours procedures for staff</li> </ul>
<b>Organisation Focused</b>
<ul style="list-style-type: none"> <li>• Consumer and carer engagement in service development</li> <li>• Consumer and carer engagement in service evaluation</li> <li>• Workplace violence</li> </ul>

Through the ISI, all services introduced a range of standardised ‘tools’ into their policies and procedures to better support the identification and management of clients with comorbid conditions; these tools fell into two general categories, organisational and clinical.

The tools specifically designed to be applied at the organisational level included the Dual Diagnosis Capability in Addiction Treatment Index Toolkit (DDCAT), which is a specific evaluation and planning tool for organisations to assess how well they can provide services to clients with comorbidity. Agencies who were already undertaking self-assessment using the validated tool, Comorbidity

Program Audit and Self Survey (COMPASS™) for Behavioural Health Services were able to continue using this tool in place of the DDCAT. The Women's Health Consortium in Western Australia also developed and implemented a Gender Impact Assessment (GIA) tool to incorporate consideration of gender in the development and planning of policies, procedures and activities.

In terms of the clinical tools utilised to incorporate a mental health screening and assessment perspective into organisational procedures, many services opted to use PsyCheck which was developed in Australia, through funding from the Australian Government, and includes the 7P Framework for Case Formulation. Others elected to use the Baseline Mental State Examination (MSE), Brief Suicide Assessment (BSA) or Kessler Psychological Distress Scale (K10). At least one Aboriginal service reported that none of these tools felt appropriate for Aboriginal clients and choose to use the Indigenous Risk Impact Screening (IRIS) and Brief Intervention tool and the Australian Integrated Mental Health Initiative (AIMHi). Both of these suites of resources are relatively recent Australian developments which incorporate holistic Aboriginal ways of working including culturally appropriate language, pictorial representations and story-telling. AIMHi was also selected as the tool of choice by another Western Australian consortium for staff working with both Aboriginal and Torres Strait Islander (ATSI) and non-ATSI clients.

A number of services found that the review of policies and procedures provided an opportunity to reflect on how workers engage with their policy and procedures, with many noticing that workers appeared to have limited knowledge of them. In response to these observations, several services were able to improve workers access to documentation by making them available to staff electronically via intranets or as internal document hyperlinks rather than large paper tomes. Service innovations included staff undertaking an electronic quiz on individual policies and procedures to ensure they had read and understood what was expected of them; incorporating the discussion of a new/revised policy into monthly team meetings; and re-inducting all staff following an overhaul of policies and procedures.

The Executive Officers of the AOD NGO Peaks reported that the overall achievements gained in policies and procedures in the sector were:

- Increased appreciation of the need to align policy and procedure to actual practice
- Increased organisational support to ensure policies and procedures are reflected in practice
- Increased reflection on organisational systems and how systems impact on worker's practice

- Increased recognition by senior management regarding the skills and knowledge of their employees
- Increased acknowledgement of the importance of up-to-date policies and procedures on organisational governance.

Participants also reported an increase in benefits to individual workers in the sector as the new policies and procedures:

- Legitimised the importance of AOD worker's role, and provided support and a rationale for why particular tools were being used, etc
- Incorporated workable procedures and focused on the duty of care in a more client-centred approach
- Provided greater organisational support for reflective practice and opportunities to further develop their skills.

An added outcome for several services was that the work they undertook on policies and procedures significantly contributed to their CQI process on the way to achieving formal accreditation through the Quality Improvement Council (QIC) and the Australian Council on Healthcare Standards (ACHS).

## Challenges

Making gains in organisational policies and procedures was not without its challenges for some. Some services had very few organisational policies to start with and they found themselves starting from scratch. This resulted in considerable time over the three years being devoted to the development of policy and procedures and getting the organisation engaged in the process. Some also found it difficult to access staff that had the skills to undertake these tasks. They found themselves challenged by the assumption that these skills naturally exist in the AOD sector. One group noted that they felt the NGO sector does not necessarily attract or remunerate this level of skill.

Some organisations who felt they didn't experience difficulty in developing policies and procedures did express other challenges when it came to implementing them. In a few instances, project managers encountered staff resistance to change whilst others experienced staff confusion, especially when procedures did not appear to match what actually happened in practice. Other project officers found they did not have the 'authority' to effect change and that without

appropriate endorsement and support from senior management they were unable to bring about the culture change required.

Participants commented that implementing changed policies also requires training, reinforcing and monitoring which is time consuming, and raised concern that without continued resources, policies and procedures will again get out of date. This was also acknowledged as an ongoing challenge for the sector within the Government workshop group.

From the Peaks perspective, their Executive Officers also noted that the overall CSSSPP coordination role was sometimes difficult as individual organisation policies and procedures became the primary role for many. There was concern expressed that some services worked individually on policies and “re-invented the wheel” where there could have been greater collaboration. As an additional hindrance to this there were anecdotal instances of ‘ownership’ of policies and some organisations appearing unwilling to share their work with others. However, in light of government funding models continuing to focus on competitive tendering, this ‘ownership’ is not altogether surprising. Given this, the Peaks noted the importance of embedding a process of CQI within organisations/agencies and that this requires dedicated resources.

Nearly all participants agreed that the duplication of time spent on developing policies and procedures across the country could be avoided in the future if a range of template options from one central repository could be accessed by all services *early* in a funding lifecycle. Participants were also especially keen to support the collection of all materials and resources developed through ISI funding to date and to make this material available electronically via one central clearinghouse on the internet.

One final but very important note on challenges to policies and procedures was the timing of the release of the *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions* from DoHA. These guidelines were released later than anticipated, after most services had rewritten their policies and were in the implementation stage, which resulted in another review and potential re-write of policies.

## Professional Development and Training

### Achievements

Services acknowledged that achievements in professional development and training were many, thanks largely to dedicated funding available for workforce development. The greatest reported benefit for many organisations was an increase in staff retention and more stable work teams. Through this funding some organisations that also operate as Registered Training Organisations were able to add a mental health qualification to their training scope. Several organisations also reported benefits to volunteers and consumer representatives through providing the opportunity to undertake Certificate IV in Mental Health qualifications at no-cost.

It was particularly noted that the ISI funding provided significant opportunities for ATSI workers, employed in both ATSI specific and mainstream NGO's, to participate in a broad range of professional development activities.

Many participants reported that they observed increased legitimacy of the AOD worker role by other health services and sectors, especially when those sectors were able to participate in the training being offered. The effectiveness of ISI funded services to provide cross-sectoral training was highlighted in the dual presentation from Ovens and King Community Health Service and Gateway Community Health in Victoria's Hume region where 120 AOD and mental health staff were trained in dual diagnosis within two years, and this training is now being extended to the housing sector, justice system and youth specific service providers.

In terms of ensuring sustainability of the increased level of professionalism in the sector, many services developed mandatory skills sets for all staff in the organisation and embedded these in organisational policies and procedures. An example of this came from one of the Western Australian ATSI consortiums where training in ATSI Mental Health First Aid was widely adopted by all involved and some services have since made it a requirement.

Other services took a whole-of-service approach to extend training to administrative staff, clients and the broader community.

One example of this was the Applied Suicide Intervention Skills Training (ASIST) package used by We Help Ourselves (WHOs) in New South Wales to deliver the following training:

- Basic 2 day suicide intervention (ASIST) course (all staff from Executive Director to gardener)
- Safe Talk (for administrative and non-treatment staff)
- Suicide Talk (for clients and community)
- ASIST Tune-up (booster session)
- 5 day Suicide ASIST T4T (Train-the-trainer).

A significant number of other services reported that they had implemented internal train-the-trainer programs as an additional measure of building sustainability into gains made possible through ISI funding. Furthermore, the addition of the training role to staff responsibilities led to greater job satisfaction for some staff.

Other examples of training accessed through the ISI funding include:

- Cultural awareness (ATSI and/or CALD clients)
- Indigenous Risk Impact Screening (IRIS)
- Australian Integrated Mental Health Initiative (AIMHi)
- PsyCheck
- Mindfulness therapies
- Motivational interviewing
- Youth Mental Health First Aid
- Safety protocols for blood borne virus and bodily fluid exposure
- Clinical counselling guidelines for engaging with GLBT clients
- Clinical supervision.

In addition to training opportunities to support workforce development of the sector, many services implemented extensive clinical supervision programs for staff, often accessing external supervisors from the fields of psychiatry, mental health nursing and psychology. Other services also implemented mentoring programs, introduced job shadowing across different services, scheduled guest speakers at monthly or bi-monthly team meetings, and offered regular networking days to continue to increase individual staff skills and knowledge and to build/maintain partnerships across services. The Aboriginal Sobriety Group in South Australia also reported that following the success of implementing their external clinical supervision and mentoring program, they now ensure that all new funding applications include provision for purchasing supervision.

Overall, the professional development benefits of the ISI funding reported for staff included:

- Increased skills and confidence to undertake client assessments and collaborate with mental health services
- Reduced fear and stigma when seeing clients with comorbidity or who had challenging behaviours
- Qualifications for workers who had been in the sector for a long time, but had not had workplace-supported opportunities to gain qualifications.

The Peaks' Executive Officers observed an overall increase in agency workforce planning, leading to a more strategic and goal-oriented planning approach, with services often using a structured needs analysis to inform their professional development needs. The dedicated CSSSPP funding also provided the opportunity for greater collaboration between the Peaks' and their memberships. This relationship was apparent throughout the presentations where partnerships to develop training packages or assist with the delivery of training content were highlighted.

## Challenges

There were four challenges to delivering professional development and training that appeared common amongst many of the grant recipients across Australia. Firstly, all groups reported various experiences of staff resistance to participating in training, and they noted that in instances where training didn't have the mandated support from managers and executive personnel, resistance was more likely to be encountered. Some also reported that training which was delivered online sometimes encountered resistance either due to technology issues or individual staff's computer literacy levels.

Secondly, many reported back that with the significant increase in training opportunities in such a short period of time, some workers began to experience training fatigue or burn-out. The Peaks in particular, commented that there was perhaps an over-reliance still on 'training' as the preferred option to upskill the current workforce, as it was seen as the 'easy and quick' option, and more emphasis could have been placed on alternative workforce development strategies. Training fatigue also appeared to be exacerbated by differences in the quality of training provided and again, the Peak's Executive Officers noted that the sector was now more cautious about the quality of training that is available and promoted. Most groups noted that there remains a need for greater standardisation of training.

The third major challenge came as staff became more skilled and knowledgeable in comorbidity, they were often poached by, or sought positions in, government services that are able to provide better remuneration and greater job security. The high staff turnover rate has been and will continue to be a challenge for all NGO's until there is greater salary and employment conditions parity across the service sectors in Australia. This highlights the need for an overhaul of the type of funding models applied to the non-government sector. A critically important associated issue was the imminent closure of many ISI projects as their funding period ended (from 31 December 2010 onwards). Many highly skilled and experienced Project Officers were likely to jump ship early if their future in their ISI funded project was uncertain. (NOTE: extensions to funding agreements to 30 June 2012 were announced in early December 2010)

The fourth challenge identified was the lack of relevant AOD and mental health training that sits between Certificate IV and post graduate level; there was frustration with the sense that all of the available training is either pitched at an introductory or advanced level, with no mid-range.

Services located in less populated states and regions of Australia reported that they faced additional challenges in this area when trying to backfill positions to cover training. Even though the financial resources were available to provide backfill, there weren't the staff resources available locally to do so.

Similarly, many of these same services reported difficulties with finding trainers who were either willing or able to come to them to provide training rather than staff having to leave home to attend training. This appeared to be more of an issue when seeking access to accredited training. Furthermore, the impost of attending training was especially high for staff and services in the Northern Territory and Western Australia as staff generally had to travel a minimum of an extra day each side of any training opportunities.

## Linkages and Partnerships

### Achievements

The linkages and partnerships accomplished through ISI funding were many, and for a considerable number of services these partnerships went beyond just their relationship with local mental health service providers. The range of partnerships developed extended to:

- Correctional services
- Refugee services
- Youth services
- Sexual health services
- Homelessness services
- General Practitioners
- Private psychologists and psychiatrists
- Universities
- Other training providers
- Local hospitals
- Local Council community development teams.
- Aboriginal Medical Services
- Women's services
- Family and domestic violence service

The ways in which partnerships and linkages were established and recognised varied. Some agencies expended considerable effort in developing formal Memorandum of Understandings (MoUs) with other service providers, whilst others found that developing a less formalised 'partnership agreement protocol' was more beneficial. Nearly all groups reported that their service was now involved in a formalised regional AOD and mental health services networking group which met on a regular basis and that these formal networks often extended to include representatives from General Practice, local community health and Aboriginal medical services. Some services in remote areas also reported that through ISI they had increased opportunities to develop relationships with key community members. Smaller services also reported that with increased emphasis on partnerships between services and internally between teams, there was a reduction in staff isolation, especially if there was only one AOD worker in an organisation, as is the case for many located in less populated areas.

Recognising the importance of building and maintaining partnerships, a range of strategies were implemented in some services including:

- review of individual position descriptions
- inclusion of concepts such as ‘the ability, skills, and willingness to work in partnership with other service providers’ into staff roles and responsibilities
- updating websites and promotional materials to promote partnership work as core business, and
- in some instances, the increased ability to articulate organisational scope of practice to funders enabled the creation of new positions.

For many services, the partnerships established were and will continue to be integral to training, peer support, mentoring and clinical supervision arrangements, whereby services are able to share their limited financial and human resources to provide reciprocal services.

One of the most important factors in the success of these partnerships was each sector having opportunities to learn the language and terminology of other sectors. Groups commented that when they learnt how to talk to mental health services using a common language, they were better able to articulate client symptoms for a more informed referral. Many AOD service staff also found they had greater participation in developing client care plans and transitions plans such as from ‘hospital’ to ‘treatment in community’ to ‘community’ leading to better outcomes for clients. There was general consensus that the greater understanding of the mental health sector enabled AOD workers to better negotiate access to mental health services for clients and provide other referral pathways.

The heightened understanding between sectors in turn increased the level of professional respect afforded between services, and a greater awareness and understanding of treatment approaches which assisted in creating a culture of ‘trust’ among different service providers. One service in South Australia and a consortium in Victoria noted that their partnership arrangements had facilitated an increase in requests for secondary consultations. Increased trust also provided impetus for services to collaborate further to offer a range of outreach services to clients. At one Tasmanian service, a shelter youth worker is now available one day per week. At Holyoake in Western Australia, two of their metropolitan sites run a half-day a week alcohol and other drug clinic for local mental health

services and in return, Holyoake staff are invited to attend the monthly clinical development meetings.

Partnerships between various sectors also facilitated mapping activities and supported the development of local service directories. These types of mapping exercises appear to have been particularly significant for rural and remote services covering large geographical areas, as highlighted in the presentation from DrugArm WA in the Mid-West and Gascoyne region and in comments provided by both the rural and ATSI workshop group participants.

Formal and informal partnership arrangements also helped promote greater coordination of specific initiatives and enabled services to work towards other common regional goals such as increasing comorbidity awareness and understanding in the community. The presentation on the South East Mental Health Network Group in Mount Gambier highlighted this issue. Several groups further commented that due to the increased public awareness of comorbidity and reduced stigma they observed an increase in the number of clients actively seeking help to address their mental health issues, and also an increase in client capacity to provide peer support to other clients.

The ISI also had considerable impact in strengthening the working partnerships between state and national DoHA personnel, the Peaks and their members. Some states and territories were able to coordinate regular forums between the NGO and government AOD and mental health services, resulting in better linkages and, in some cases, this brought about the opportunity to develop regional and state frameworks for working with clients with comorbidity where such frameworks had not previously existed.

There was significant support from all of those in attendance at the Forum for any future phase of the ISI to include the development of a mentoring/strategic alliance program between the Capacity Building Grant recipient services and those not previously funded to foster the development of new partnerships within the sector.

## Challenges

In spite of good in-roads made by ISI into bringing about partnerships and linkages between the alcohol and other drug and the mental health sectors, one of the greatest challenges expressed by most groups at the Forum was trying to engage mental health services in ISI funded project activities when they (mental health) were not also funding recipients. It was not uncommon for project officers to be met by statements such as “we aren’t funded to do it, so why should we?” Similarly,

some services reported that they felt an unfair burden to create the workable partnerships between the two sectors, as the mental health sector was not accountable in the process. Linked to this, some groups said that on occasions they still encountered mental health services or other health providers such as general practitioners (GPs) and psychiatrists who did not respect the skills of the AOD sector. Others noted that different models of addiction are used by different health service providers and finding some common ground when working from, for example, a recovery model, a social inclusive model or a medical model remains a challenge.

It was argued that DoHA could have developed processes through which the mental health sector was introduced to the aims of ISI and that the Peaks and representatives from mental health could have been consulted to establish a framework for developing partnerships and coordination. Other suggestions made through the workshop groups to overcome some of these barriers were for DoHA to work towards developing a suitable partnership assessment tool and, should a similar initiative be implemented in other sectors, that mental health and GP services in particular, are provided with some funding as a means of holding them accountable. The Peaks also commented that if GP Care Planning for comorbidity was to become a Medicare item then GP's would be more receptive to working with services to support clients with AOD and mental health comorbidity.

In terms of building partnerships between the NGO and government sectors, some participants acknowledged that whilst some state and territory government mental health and AOD services were willing and able to cooperate with individual services and with the Peaks, others faced substantial barriers. These participants noted that some of the resistance came as a result of several state government health systems undergoing considerable review and observed that whilst many of those approached would have liked to have been involved, they were unable to while their own services were in such a state of flux. For those who were able to engage with government organisations, several commented on difficulties formalising arrangements with MoUs.

Other issues identified with MoUs were that they were very time-consuming to develop, too business and budget orientated, and then tended to sit on the shelf as they lacked the practicality of shared targets and actions and didn't provide appropriate guidance to workers for engaging services such as mental health, housing and police. Some participants also noted that MoUs were created at the higher management level but did not filter down to operational levels.

Not surprisingly, staff movements within organisations created major challenges to developing and maintaining partnerships and linkages. Some services commented that relationship building was initially delayed due to difficulties they experienced trying to recruit people with appropriate skills when many other similar organisations were also competing to recruit staff to undertake their ISI project. Meanwhile, the tyranny of distance for services in the Northern Territory and remote Western Australia created difficulties for some in developing partnering arrangements and that there were instances where there was no mental health clinical support, psychologist or GP Network nearby with which to build a relationship.

Several groups observed that the overall engagement with educational bodies such as universities or colleges was limited and recommended that further effort be made to involve these educational bodies in the linkages.

Of deep concern for many participants at the Forum was that they did not know whether their service was likely to receive further funding to enable them to continue nurturing the partnerships and linkages that had been developed over the previous three years. The success of such linkages and partnerships are largely dependent on the commitment of the staff involved, and if there is a loss of current ISI project officers from services and the Peaks lose their CSSSP project officers, much of that commitment could be lost.

## Quality Improvement Processes

### Achievements

While there was little direct discussion in the workshops on the topic of Quality Improvement Frameworks, it was apparent through the presentations that many services incorporated Continuous Quality Improvement (CQI) in their processes, and the number of services who had achieved accreditation is a testimony to the sector's achievements in this area. Many of the other achievements in this area have also been highlighted in other sections of this report, e.g. Policies and Procedures and Professional Development and Training.

Services involved in ISI were unanimous in their agreement that having the resources (e.g. funding for staff and support from the Peaks) and the tool (e.g. DDCAT) to measure their organisational capacity to identify and respond to clients with comorbidity issues was a great advantage towards developing and implementing quality improvement processes. Some participants commented that overall, this initiative was a great opportunity for services to embed a CQI process and create a

greater commitment to engage in regular practice review, reflection and evaluation processes within services. It was also considered a significant factor in facilitating whole-of-organisation linkages with other health professionals such as GP services, psychologists, psychiatrists and complex needs nurses. This was especially the case for those services that are now accessing these professionals to provide staff with external clinical supervision.

Adopting an internal process of CQI enabled many organisations to include a greater focus on consumer/client participation in the development and evaluation of services. In some cases this resulted in the establishment of consumer panels (e.g. DrugArm Australasia, Queensland), a dedicated paid consumer consultant position (e.g. Mission Australia's Triple Care Farm and the No Wrong Door project), and consumer and carer representation on steering committees and conducting regular consumer and carer regional forums (Eastern Hume Dual Diagnosis Group and No Wrong Door collaboration in regional Victoria).

During the Forum, some presenters highlighted how ISI Capacity Building Grants enabled their organisation to conduct research and run pilot programs with standardised assessment tools or recognised treatment/intervention approaches to find the best-fit for clients and staff before deciding which would be applied across the whole of the organisation and written in policies and procedures.

In summary, other benefits of applying CQI processes identified by workshop participants were:

- Added confidence and competence of staff to provide more holistic support to clients around both their substance use and mental health
- Increased legitimacy for the sector (both internally and externally)
- Increased professionalism for the sector (both internally and externally)
- Provision of a framework for organisational change from one which could treat AOD issues only to one that was 'dual diagnosis/comorbidity enhanced or capable'
- Application of a broad workforce development approach to maintaining and upgrading staff skills beyond the life of the initiative
- Evidence to lobby for future funding.

## Challenges

Once again the resources required by agencies to adopt a quality improvement framework was one of the greatest challenges reported by participants, and there were significant fears that without

ongoing dedicated funding for a policy or quality improvement officer that the gains currently made would easily lapse.

Several participants from various consortiums reported difficulties applying the DDCAT to the range of agencies involved due to the clinical/medical orientation of the tool. Similar concerns were echoed by some participants from women's, youth, ATSI and culturally and linguistically diverse services who found that the DDCAT did not enable them to factor in their strengths such as ability to work with specific population groups, families and communities, and to provide comorbidity services within a broader health service organisation.

Other participants believed there was a need for appropriate training in using the DDCAT to support its use, while others felt it was not specific enough for the objectives of ISI. While acknowledging the value of the DDCAT, there were calls for it to be revised to better reflect the situation in which it is being used – in largely non-clinical NGO settings in the Australian health sector. Work should be done to bring the indicators into line with the work practices and conditions of Australian AOD NGOs and the across the page ratings be revised and validated accordingly.

Incorporating change in an environment where there are different expectations from the sector's funding bodies and not having the necessary knowledge and guidance to apply a change management process both within organisations, in the sector and across other health sectors also created difficulties for some services. Several groups stated that if their organisation had been provided education and training on change management processes at the outset of ISI this would have benefited them greatly in gaining cooperation and buy-in for CQI at all levels, from executive level staff, to individual workers and to the broader health sector.

The Peaks workshop group observed that while some services have identified key things to do to maintain momentum of CQI, there remains a need for CQI to be applied across all aspects of organisations, from a review of Mission Statements through to practice procedures. This will require further resourcing for organisations. Resources are also required to enable the achievements and challenges in Quality Improvement processes to be collected to better inform policy and planning from a whole of sector perspective.

## Data Collection Systems

### Achievements

Like quality improvement framework, there was not a great deal of discussion during the workshop session on data collection systems. Not all services were funded to undertake work in this area.

One data collection system which all Capacity Building Grant recipients were required to use on an annual basis was the DDCAT. All services also conducted a two-week 'data snapshot' annually and reported these to DoHA. The DDCAT provides a measure of each services capacity to assist clients with comorbidity based on a continuum from *Alcohol and Other Drug Treatment Services Only* to *Dual Diagnosis Capable* or *Dual Diagnosis Enhanced*, in the following seven dimensions:

- Program Structure
- Program Milieu
- Clinical Process: Assessment
- Clinical Process: Treatment
- Continuity of Care
- Training
- Staffing<sup>1</sup>.

It was generally agreed that the DDCAT was a good tool to support service level data collection and measure capacity building. It also allowed services to see improvement, which was encouraging, and the use of the DDCAT assisted many staff in developing an increased understanding of and appreciation for the significance of data collection and collation.

The increased emphasis on collecting data and understanding the purpose of data was a significant accomplishment for many services as it provided individual staff greater impetus to ensure they systematically collected and reported data using a wide range of mental health assessment tools such as PsyCheck, IRIS and Brief Suicide Assessment which were mentioned previously in the section on policies and procedures. Many also observed that staff felt increased validation for the effort they expended to complete assessment forms, and collect and report data for the various national/ state health and funding bodies' data collection systems. It was further stated that being able to set

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<sup>1</sup> Further information on the DDCAT can be accessed at <http://www.comorbidity.org.au/sites/default/files/DDCAT%20Toolkit.pdf>

a benchmark and having the tools for both comparison and reflection led to significant improvements across the sector in clinical excellence, feedback and quality assurance.

As previously identified, another significant benefit identified through improvements in data collection was the better evidence of clients' needs across a range of areas, which in turn could be used to engage other services on the client's behalf. The Peaks observed a further achievement in that the increased use of training needs analysis tools provided organisations with the opportunity to take a more systematic approach to professional development needs overall.

The presentation by the Western Region Alcohol and Drug Centre in Victoria was a good example of how a service was able to use ISI funding to link current state-based data collected, such as Alcohol and Drug Information System (ADIS) to the commonly available Microsoft Office Access Database to provide a wealth of valuable data to both the organisation and to the individual clinician to assist with client case management through the development of a clinical database. From an organisational perspective, data was able to be reported in a user-friendly format to observe trends in presenting AOD and mental health issues, the types of drugs being used, current levels of substance use influencing client presentations to the AOD service (e.g. abuse, dependence, intoxication, withdrawal, no current use) and other associated conditions (such as pregnancy, acquired brain injury, psychiatric, chronic pain, other medical, other and unknown). Reports could also be generated to monitor the percentage of clients being screened for AOD use and mental health, and to identify gaps in individual staff confidence or ability to undertake screening and assessment for comorbidity. From the individual staff member's perspective, the new database was linked to case notes and they had immediate access to the tools required to undertake screening, assessment and brief interventions. The database was also used to trigger action prompts for staff such as when clients were due for an Individualised Treatment Plan review or 3 and 6 month post-closure follow up (for those clients who had consented to participating in these).

A similar clinical database was also highlighted by the Salvation Army Recovery Services (Eastern Territory). There, staff across the organisation, were able to access standardised clinical tools such as Addiction Severity Index (ASI), the Camera, the Compass, and the Map and then record and recall all data using the same database.

One other presentation which highlighted a significant achievement in data collection systems achieved through ISI funding was that from the Women's Health Consortium in Western Australia.

This presentation described how an ethnicity data questionnaire was being used to capture higher-level socio-economic information of clients to better inform health practices and to enhance service delivery to clients from culturally and linguistically diverse backgrounds. The inclusion of the ethnicity data was based on the awareness that knowing a client's 'country of birth' was not enough to capture the diversity of differences in a migrant's life and to understand how linguistic diversity and religion effects this person's health beliefs and health practices. To date, this additional data has been seen as invaluable to services that have applied it and there is considerable interest from other services to incorporate this data into their assessment and treatment processes also, and to lobby for its inclusion in the Alcohol and Other Drugs Treatment Services National Minimum Data Set (AODTS NMDS).

Many workshop participants also recommended that the AODTS NMDS needs to include a comorbidity item to ensure comorbidity interventions carried out within the sector are adequately identified and reported.

## Challenges

Several challenges were reported in terms of services improving their data collection systems. Some groups observed confusion related to the vast array of data collection tools used within organisations, for state and territory health systems, for the AODTS NMDS and for other funding bodies. They believed this confusion was confounded by the high costs and lengthy time required in finding the right product. Another group commented that they were aware of one database project which took two years to develop the appropriate computer software and cost around \$100,000; it was their belief that three people are still currently employed to keep the software updated and running. Ongoing costs were acknowledged by another group who recognised that the accurate use of the databases by clinicians is an area that will always need constant monitoring to ensure accuracy. When the generally lower level of access to information technology amongst the NGO sector (e.g. not all services are able to provide each staff member with their own computer and fewer still have the resources to regularly manage websites or intranets) was factored in, increasing capacity in this area still requires significant investment.

One of the greatest concerns expressed by participants was the lack of national guidance and frustration at the ongoing discussion surrounding national data collection. One group commented that this discussion has been going on for 10 years and there has been no real progress to date. Another group commented that the inconsistency across service types and jurisdictions did not

enable data collection to be appropriately utilised for evidence building. Several groups also noted that having multiple databases that were not streamlined led to staff frustration at having to repeat information. There were calls for a nationally agreed model beyond the AODTS NMDS.

Other challenges expressed were:

- The ‘turnaway snapshot’ had very limited use
- Trying to find appropriate definitions of episodes of care to include in databases was difficult
- General suspicion remains regarding how data is used
- The use of databases raises significant concerns regarding client confidentiality and privacy
- State data collection systems were not flexible enough to incorporate mental health assessments.

## Recommendations

Participants at the National Forum made many suggestions and recommendations about the Capacity Building Grants and CSSSPP. Recommendations with broad support from the Forum are presented under the following themes; Continuation of Funding, New Directions for ISI, Mechanisms for Sharing the Knowledge and Raising Awareness of Capacity Building and Comorbidity.

### Continuation of Funding

1. Funding for comorbidity capacity building for AOD NGOs should be maintained and extended to be available to all AOD NGOs. Future funding models should include consideration of the size and geographic location of individual organisations or consortia. Decisions relating to continuation of funding should be made in a timely manner to ensure that the skills, resources and staffing acquired as a result of progress made to-date are not lost.
2. In light of the increasing competencies of staff in the sector and the need to maintain professional staff in a competitive environment, it is recommended that a review of the NGO AOD award structure be undertaken. This review should also be linked to establishing a set of nationally agreed core competencies in AOD, including competencies in comorbidity service delivery.
3. The AOD Peak organisations should continue to be funded to provide a state/territory coordination role to support capacity building initiatives in the sector. This will ensure that

the accomplishments achieved to date are sustained and that further strengthening of the sector will occur.

4. Linked to Recommendation 3 is the recommendation that the Peak bodies should have a key consultation role in any future funding discussions regarding comorbidity capacity building in the sector.

### **New Directions for the Improved Services Initiative**

5. It is recommended that greater attention is focused on identifying appropriate ways in which the whole-of-sector can offer comorbidity services to specific population groups such as Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse (CALD) backgrounds and prison populations.
6. It is recommended that mental health reporting item(s) be included in the Alcohol and Other Drugs Treatment Services National Minimum Data Set (AODTS NMDS) to ensure comorbidity interventions carried out within the sector are adequately identified and reported.
7. By way of acknowledging the importance of the non-clinical expertise within the sector, it is recommended that an agreed model of non-clinical supervision be developed.
8. It is recommended that the AOD NGO sector continue to be supported to expand their scope of collaboration to include dental, housing, primary health, GP's and the tertiary education sectors. This collaboration could extend to participation in evidence-based research on community care plans and treatment models and to develop appropriate curricula in comorbidity and capacity building for medical and allied health courses.
9. It is recommended that the DDCAT be further reviewed and adapted to meet the needs of the AOD NGO's that often provide non-clinical services or incorporate holistic concepts of wellbeing that are not captured in the current tool. Most services found the DDCAT to be a useful tool but, as it was developed in the USA for specialist clinical comorbidity services, a number of the indicators were not applicable in the Australian AOD NGO context.

### **Mechanisms for Sharing the Knowledge**

10. To share the knowledge, resources and skills developed to date, and to support any future phase of ISI, the development of a central clearinghouse website is recommended. This website should include a collation of all of the resources developed to date including training manuals, policy and procedure templates, referral and partnership protocols, etc.
11. To enable other NGO AOD services to share the current knowledge and develop their capacity to respond to comorbidity issues, it is recommended that a capacity building mentoring program be established between previously funded and non-funded services. This would further serve to utilise and strengthen the skills and knowledge of those involved in the initial initiative and reduce duplication of effort for new services, and achieve consistency across the sector.
12. In light of the highly successful National Forum held in Adelaide in October 2010, it is strongly recommended that an annual or bi-annual NGO AOD sector capacity building workshop be funded and that funding be allocated in each grantee's budget to ensure their attendance
13. It is recommended that when initiating the next phase of the ISI or future initiatives consideration be given to conducting extensive consultation with AOD services and Peak Bodies before program commencement, and services are provided with practice framework templates and with greater direction on how funding could be spent. This should also include the establishment of mechanisms to increase collaboration between federal, state and territory government services to ensure consistency of information.
14. In regards to the future of ISI and consolidating the change to comorbidity capable services across the whole-of-sector, it is recommended that consideration be given by the Peaks to offer all of their members the opportunity to participate in a change management course.

### **Raising Awareness of Capacity Building and Comorbidity**

15. To understand the full benefits of ISI, it is recommended that DoHA commission an independent evaluation of the Capacity Building Grants and the CSSSPP and that the findings are used to inform future developments of the two projects and any future capacity building initiatives within the sector.

16. It is recommended that DoHA ensures that in all its funding agreements with services in the mental health, primary health care and GP service sectors include an obligation to actively collaborate with AOD services to improve outcomes for comorbid clients.
  
17. It is recommended that public health education messages include information aimed at educating consumers, community and other health sectors about comorbidity in order to reduce the stigma related to these issues, to improve the recognition of comorbidity and to increase help-seeking behaviours by families of, and persons with, co-occurring AOD and mental health problems.

## Section 2: Overview of the Forum

### Day One: Thursday 7<sup>th</sup> October

The Forum was opened by Professor Ann Roche from the NCETA, Flinders University, and Aunty Coral Wilson welcomed participants to Kurna land.

Professor John Mendoza gave the first key note presentation: *Health Reform under the Gillard Government – what it means for Mental Health & AOD Services*. Professor Mendoza's current professional roles include Director, ConNetica Consulting, Adjunct Professor, Faculty of Health Science, University of the Sunshine Coast, Adjunct Associate Professor, Faculty of Medicine, University of Sydney and Vice President, Alcohol and Other Drugs Council of Australia (ADCA). A summary of Professor Mendoza's presentation is included below.

The Executive Officers of the AOD NGO Peak Bodies then had an opportunity to provide a brief response to points made during the keynote presentation. A key concern expressed by the Peaks' was the sense that the NGO sector is not being consulted in the National Health Reform process and that the Health Reform focus lacks clarity and relevance for primary health care providers who make up a significant proportion on the Peaks membership. One Executive Officer voiced serious concern regarding how the new Medicare Locals boundaries will impact on the delivery of primary health care services such as the youth mental health and drug and alcohol Headspace programs. Others expressed fear that the current trend to subsume AOD services within a mental health service/framework could become a step backwards for community health care in Australia.

The remainder of the day was devoted to 18 presentations/workshops from services who received the Capacity Building Grant funding, offered in two concurrent sessions. A complete list of Thursday's presentations is provided in Appendix 2.

Participants comments made on the NCETA feedback forms indicate that the following sessions were considered the highlights of Day One:

- Keynote presentation by Professor John Mendoza
- *IT Futures: A creative response to 'connect' and empower people experiencing homelessness* presentation by Daniela Musolino from the Salvation Army: Towards Independence Network of Services, South Australia

- *Responding to clients suicidal ideation: outlining a whole organisation approach* workshop by Jo Lunn and David Kelly from We Help Ourselves (WHO), New South Wales
- *Effective Intervention: The development of a case formulation using the 7P Framework* workshop presented by Michelle Mayes from OARS Community Transitions, South Australia
- *Clinical Peer Reviews: A strategy for sustainable practice supervision in the workplace* presentation also presented by Michelle Mayes
- *Implementing Mindfulness Therapies in community health drug treatment counselling* workshop presented by Jenni Thompson, Knox Community Health Service, Victoria.

### **Keynote Presentation 1: Professor John Mendoza: *Health Reform under the Gillard Government – what it means for Mental Health & AOD Services***

Professor Mendoza's presented his views on the National Health Reform, and in particular the implications of the Local Hospital Networks (LHNs) initiative and Medicare Locals on community mental health and AOD sectors. He offered the following key positions or principles for services and the Peak Bodies to consider during 'negotiations' for reform:

1. Independent and transparent accountability is critical to the reforms, especially in terms of significant risks to 'patient safety' and client wellbeing during any transition period
2. There must be an alignment of boundaries for Local Hospital Networks and Medicare Locals with each other, and at the federal, state and local jurisdictional levels wherever possible, to assist in planning and reporting
3. There is a need for significant new investment in both community mental health and AOD services, as at present the system continues to be imbalanced in favour of resource investment into acute and extended care services
4. Local Hospital Networks should be subject to state wide planning and resourcing to avoid fragmentation
5. The integrity of specific funding streams such as mental health and AOD needs to be retained to ensure core and project funding is not blocked or diverted

He also drew attention to key positions or principles required to specifically address negotiation related to the development of Medicare Locals. These include:

1. There is a need for clarity in the COAG Health Reform regarding what health conditions are covered under Primary Health Care
2. Primary health care, specialist community care and hospital care services need to be integrated to provide seamless services for all clients across the lifespan

3. Consumers, carers and non-government mental and alcohol and other drug organisations must be adequately represented within the governance arrangements for the new Medicare Locals

Professor Mendoza noted that the State and Territory Governments will report back to COAG on AOD in December 2010 and mental health in mid-2011. He called on the sector to demand that relevant Ministers look at what the evidence supports as good mental health and AOD outcomes for clients. For example, current literature shows a strong evidence base for:

- Collaborative care
- Collaborative recovery
- Psychosocial treatment of psychosis
- Assertive Community Treatment (ACT)
- Supported employment
- Housing
- Peer support
- E-therapy for mild-moderate mood disorders.

The evidence supporting the merits of acute inpatient care is unclear.

It should be noted that on 13 February 2011 the Council of Australian Government's (COAG) established a new Heads of Agreement on National Health Reform. Under that Heads of Agreement, changes to roles and responsibilities for AOD treatment services will no longer be considered.

### Day Two: Friday 8th October

Experienced AOD clinician, and former Chair of Victoria's 'Multiple and Complex Needs Initiative' Panel, Professor Margaret Hamilton gave the second keynote presentation: *Comorbidity, dual diagnosis, dual disorders ... and what about the rest?* to start the second and final day of the Forum. Professor Hamilton was also the first Director of Turning Point Alcohol and Drug Centre and currently sits as an Executive Member of the Australian National Council of Drugs (ANCD). A summary of Professor Hamilton's presentation is included below.

Following the keynote presentation, participants broke off into two concurrent sessions to listen to presentations before morning tea. All participants then gathered into one of 14 workshop groups for facilitated discussion on the achievements and challenges that services experienced through their involvement in ISI.

A short afternoon session, finishing at 3.30pm, gave participants the opportunity to listen to more presentations in concurrent sessions before Professor Hamilton gave a wrap up of the two days and Lauren Trask (QNADA) and Angela Corry (WANADA) provided a short summary of the key issues that emerged from the workshop groups held earlier in the day. See Appendix 3 for the presentations made by Capacity Building Grant recipients on the Friday.

Feedback from participants indicated that the following sessions were Friday's highlights:

- Keynote presentation by Professor Margaret Hamilton
- Session 5 Workshop coordinated by SANDAS, and workshop summary feedback provided in the Wrap Up by the workshop coordinators
- *Creative capacity building in a Community Health Service* presentation by Maria Yap, from MonashLink Community Health Service, Victoria

### **Keynote Presentation 2: Professor Margaret Hamilton AO: *Comorbidity, dual diagnosis, dual disorders ... and what about the rest?***

Professor Hamilton's keynote presentation focused on the challenges ahead for the sector and individual services as the time had arrived to start thinking past comorbidity and dual diagnosis to now focus on the multiple needs or multiple morbidities of clients. At the service level, there needs to be a shift to the provision of holistic care and an integrated service delivery model with a 'no wrong door' policy. This does not mean that AOD services have to necessarily provide all of the services; they need to be aware of them and be smarter about working in coordinated ways with other services to ensure delivery of an expert AOD component in the mix (either directly or through secondary consultation to others).

She suggested that this new way of thinking and working could be accomplished by:

1. A need for the AOD sector to be identified as **expert** in responding to people with AOD problems. This needs to include:
  - a. AOD assessments need to be more precise; especially with regard to AOD use, history of this, help seeking and what has been learned from previous efforts to change. They also need to take note of other aspects of life affected such as physical health, mental health and to consider child protection issues and other domains such as housing, family support, community involvement, etc. A move

away from 'deficit-based only' assessments, to include a reflection on the strengths of the client is also required.

- b. Better management of intoxication as well as interventions designed to assist people to change their AOD using patterns. This is needed if AOD services are to be seen as credible and useful by the broader community of service providers. This is especially evident in relation to the link between intoxication and the correctional/justice systems.
  - c. Use of clear evidence-based interventions with a rationale grounded in evaluation and linked to the menu of services offered by a service.
2. The need for formal accreditation processes - for *both* AOD services and individual workers.
  3. A need to build capacity of the AOD workforce, in conjunction with increasing the willingness of the mental health and other health and welfare workforce, to enable necessary collaboration and care coordination using secondary and tertiary consultation and referrals.
  4. Increased 'strategic' use of computer-assisted assessments and interventions.

## Participants General Feedback on the Forum

The National Centre for Education and Training on Addiction (NCETA) provided participants with the opportunity to complete an evaluation on the Forum. Eighty six forms were returned, and the relevant results<sup>2</sup> are briefly presented here.

Question 1 asked respondents to indicate their level of agreement with "*Did the Forum meet your expectations*" on 11 items. The ranked response for those who responded either 'Strongly Agreed' or 'Agreed' is as follows:

1. Opportunity for networking (n=73)
2. Interesting program topics (n=69)
3. Opportunity for information exchange (n=67)
4. Applicability to your workplace (n=66)
5. Quality of presentations (n=65)
6. Presentation content (n=63)
7. Opportunity for access to comorbidity resources (n=62)
8. Facilitation of learning (n=61)
9. Improving your knowledge of relevant work related comorbidity issues (n=60)

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<sup>2</sup> Responses to Questions 7-10 which asked for feedback on the general organisation of the forum, feedback from presenters and specification of current work role have not been included.

10. Increased your capacity to respond to comorbidity in the workplace (n=54)
11. Awareness of cutting edge information (n=45)

Question 2 asked “*Will the Forum assist your organisation to improve*” on five items. The ranked responses for ‘Strongly Agree’ and ‘Agree’ below indicate there was slightly less agreement and consensus among participants on this set of questions.

1. Development of staff (n=57)
2. Partnerships and linkages (n=54)
3. Policy and procedures (n=53)
4. Quality improvement systems (n=50)
5. Client and health data collection systems (n=38)

Responses to Question 3 “*What sessions were of most interest to you and/or most enjoyable?*” have already been presented in the previous highlights of Day One and Day Two sections.

The number of participants who responded to Question 4 “*Will the Forum influence the way you respond to comorbidity issues in the future?*” was small. However, there were common themes which emerged from comments provided.

Firstly, the Forum presentations prompted attendees to consider how they will implement greater consumer and carer participation within their service. Similarly, attendees were keen to explore how they can implement case formulation into case coordination to be more responsive to clients’ needs and improve client outcomes, especially in relation to vulnerable groups such as those people experiencing homelessness and prison populations.

Another common theme identified was the ongoing need to review organisational structures and look for ways in which greater service cohesion could be achieved. In addition to this, there was reference to the need for implementation of strategies to support the culture change required for services to move from an AOD service to one which can also provide adequate mental health support.

The following statement provided by one respondent is representative of most other comments.

*'Would have done more if [Forum had been] held earlier or if presentations focused on 'how' instead of 'what' was done '.*

This statement mirrored many comments made on many feedback forms which indicated that a) there was a general consensus that the Forum should have been held earlier in the 3-year funding cycle to enable the opportunity for implementing ideas from the Forum to be adequately supported and also importantly, b) there were concerns expressed by numerous participants that the time constraints placed on most presentations (the majority were 20 minutes in duration) prevented services from sharing their 'how-to' knowledge.

Several attendees also expressed a strong interest in developing suicide policies and procedures within their organisations, and one person planned to discuss implementing an organisational-wide Policy Working Group with their service following the Forum.

There were numerous comments provided in response to Question 5 *"Do you have any comments on the workshop component of the Forum on Day 2?"*. There was almost unanimous agreement that the workshop was a valuable, if not the most valuable component of the two days and that greater time should have been dedicated to the workshop. The majority of responses praised the concept and overall organisation of the workshop and most rated the effectiveness of the facilitators highly. There were a couple of dissenting voices however, who commented that their group had been dominated by one person's opinions, that the facilitator didn't allow time for discussion, or that they came away feeling that there was still a lack of understanding of issues faced by rural and ATSI services.

Below is a snapshot of the comments provided in response to Question 5.

- *One of the key highlights of the 2 days*
- *Fantastic opportunity to discuss with other agencies in other states and territories*
- *Worked well, facilitator kept us on track whilst encouraging and allowing lots of opinions to be expressed*
- *There needed to be more time to explore strengths of other agencies work and share solutions for troubleshooting difficulties*
- *Good to know we are informing a process*
- *Excellent – learnt heaps in strengths and weaknesses of the project and 'fear' of rug being pulled from underneath organisations' feet*
- *Loved the discussion part of it. I wanted to learn as much as speak. I learned heaps.*

- *Great idea and really appreciated the sharing of information and views and the ability to collate themes for feedback recommendations*
- *One of the few interactive sessions. Well done Andrew*
- *Great opportunity to meet with other youth focused people to discuss outcomes*
- *I found it a fundamental part of the forum*
- *Good to know our feedback/opinions will be heard at a higher level*
- *Workshop helpful especially as there will be no formal evaluation of projects*
- *Brilliant! Almost therapeutic to share and celebrate success while debriefing the challenges/resistance to implementing the ISI*
- *Very worthwhile, interesting to hear common issues and all the great things that have been implemented and need to continue*
- *Was worthwhile and important. I would even say essential*

**Workshop/Feedback Format for Future Consideration**

The following practical suggestions made by participants for any similar workshops/Forums to be held in the future included:

- Allow half a day for a more comprehensive and structured workshop session
- Conduct the workshop in two parts over two days, allowing for participants to be allocated to different groups on each day
- Have service providers respond to questions prior to the Forum, collate responses and use the workshop to develop proposals for action plans
- Incorporate a number of interactive ‘workshop’ sessions into the daily program
- Would be good for organisations to submit a written response\*.

\*Author’s note: Following the Forum an invitation was extended to all Capacity Building Grant recipient organisations by their relevant State/Territory Peak to submit a written response, and only three responses were received.

Question 6 provided participants with the opportunity to provide comment on “*Following the Forum, do you have any ideas on priorities for future funding to support people experiencing comorbidity?*” Participants’ comments are listed below and reflect many of the recommendations made during the workshop.

- *Broad dissemination of resources already developed through ISI funding*
- *ISI recipients to be funded to mentor agencies who weren’t recipients*
- *Funded trainer positions to work with organisations to sustain comorbidity capacity*
- *Better linkages with physical health services, dental, GP’s health checks and nutrition*
- *Better access for CALD clients to comorbidity services*

- *Annual comorbidity conference for non-government organisations*
- *Increased consumer and carer involvement*
- *Suicide prevention training*
- *Develop a universal comprehensive assessment tool which agencies will be required to use to establish more seamless care and improved collaborative care*
- *Increase in rehabilitation services and housing whilst people are in recovery*
- *Comprehensive case coordination*
- *Working with complex needs*
- *Building partnerships with housing, disability and chronic disease [service providers]*
- *Reducing stigma, raising awareness.*

## Appendix 1

### Capacity Building Grant Recipient Organisations by State and Territory\*

<b>Australian Capital Territory</b>
Alcohol and Drug Foundation ACT
Canberra Alliance for Harm Minimisation and Advocacy
CatholicCare Canberra and Goulburn
DIRECTIONS ACT
Ted Noffs Foundation ACT
<b>New South Wales</b>
ACON
Benelong's Haven
Calvary Health Care Riverina
Drug and Alcohol Multicultural Education Centre (DAMEC)
Hawkesbury District Health Service
Hunter Region Drug and Alcohol Services Consortia*
Kedesh Rehabilitation Services
Manly Drug Education and Counselling Centre (MDECC)
Mercy Community Services
Mission Australia: Triple Care Farm
Odyssey House
Oolong House
Phoebe House Consortia
Salvation Army: Australian Eastern Recovery Services Command
Salvation Army: OASIS St Vincent De Paul - Maryfields Day Recovery Centre
South Sydney Youth Service
Ted Noffs Foundation Consortia*
The Buttery
The Haymarket Foundation
Upper Hunter Drug and Alcohol Service
Watershed Drug and Alcohol Recovery and Education Centre
Weigelli Centre Aboriginal Corporation
We Help Ourselves (WHOS)
Wesley Mission
Women's Alcohol and Drug Advisory Centre
Youth Off The Streets Limited
<b>Northern Territory</b>
Amity Community Services
Banyan House
Catholic Care NT
Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women's Council
Salvation Army: Drug and Alcohol Services Top End
<b>Queensland</b>
Alcohol and Drug Foundation Queensland (ADFQ)
Brisbane Youth Service
Drug Arm
Goldbridge Rehabilitation Services
Gold Coast Drug Council Inc
Lyons House Inc
Ozcare
Queensland Aboriginal Islander Alcohol and Drug Services (QAIAS)
Queensland Injectors Health Network (QuiHN)
Teen Challenge Queensland
Youth Empowered Towards Independence

Outcomes from the National Improved Services Initiative Forum: A Tale of Two Systems

<b>South Australia</b>
Aboriginal Sobriety Group (ASG)
Anglicare: Archway Services
Baptist Care Consortium*
Mission Australia: Hindmarsh Centre
OARS Community Transitions
Salvation Army: Towards Independence Network of Services
South East Drug and Alcohol Counselling Service (SEDACS)
Teen Challenge
UnitingCare Wesley Adelaide: Streetlink Youth Health Service
UnitingCare Wesley Adelaide: Kuinto Community
Vietnamese Community (SA)
<b>Tasmania</b>
City Mission: Missiondale Recovery Centre
Community Connections Inc
Holyoake
Salvation Army: Bridge Program
The Link Youth Health Service
Youth and Family Focus Inc
<b>Victoria</b>
Anglicare Victoria
Banyule Community Health
Bass Coast Community Health Service Inc
Bendigo Community Health Services
Bentleigh Bayside Community Health Service
Gateway Community Health
Inner East Community Health Services Inc
ISIS Primary Care Inc
Jesuit Social Services
Knox Community Health Service Inc
Monashlink Community Health Service
Odyssey House Victoria
Ovens and King Community Health Service
Open Family Australia
Peninsula Drug and Alcohol Program (PENDap)
Plenty Valley Community Health Inc
Reconnexion Inc
Self Help Addiction Resource Centre (SHARC)
Taskforce Community Agency
The Buoyancy Foundation of Victoria Inc
The Windana Society
The Western Region Alcohol and Drug (WRAD) Centre Inc
Turning Point Alcohol and Drug Centre Inc
UnitingCare Moreland Hall
Western Region Health Centre
Youth Projects Inc
Youth Substance Abuse Service
<b>Western Australia</b>
Centrecare: Goldfields
Drug Arm: Rosella House
East Kimberley Consortium Agencies*
Holyoake
Milliya Rumurra Aboriginal Corporation
Mission Australia
Palmerston Association: Great Southern Community Drug Service Team
Perth Metropolitan Non Residential & Family Alcohol and Other Drug Services Consortium Agencies*
Perth Metro Residential AOD Services Consortium*
Women's Health Services Consortium Agencies*

\*Total number does not equal 122 as some agencies sit within a consortium.

## Appendix 2

### Forum Program

#### Thursday 7<sup>th</sup> October 2010 Presentations

Thursday 7 <sup>th</sup> October 2010			
State	Capacity Building Grant Recipient	Presentation	Presenter(s)
NSW	Youth Off The Streets	Building sustainability through partnerships	Alison Trowbridge
QLD	DRUG ARM Australasia	Implementing consumer participation in your organisation	Kathryn Kenny and Sarah Dewar
SA	The Salvation Army: Towards Independence Network of Services	IT Futures: A creative response to 'connect' and empower people experiencing homelessness	Daniela Musolino
ACT	Directions ACT	Responding to the changing needs of staff	Jason Morrissey
NSW	The Salvation Army: Recovery Services (Eastern Territory)	Change in staff attitudes toward working with people with coexisting mental health and substance use problems following training	Gerard Byrne
NSW	ACON	Success! Empowering workers in Australia's largest GLBT health promotion organisation to deal with comorbid health issues	Jeff Johnston and Marni Low
SA	OARS Community Transitions	Clinical Peer Reviews: A strategy for sustainable practice supervision in the workplace	Michelle Mayes
WA	Perth Metropolitan Non Residential AOD and Family Services (PMNRF ISI) Consortium	Working together to enhance workforce capacity: Producing a baseline MSE training DVD for PMNRF AOD workers	Wendy Shannon
NSW	Manly Drug Education and Counselling Centre (MDECC)	MDECC "Master Chef" Master Class	Kerri Lawrence and Susan Gomola
NSW	Triple Care Farm, Mission Australia	"Say it again Sam" Developing the Consumer Advocate Role at TCF	Marie Rose Hyland
NSW	Watershed Drug and Alcohol Recovery and Education Centre	Implementing a CBT Model of substance misuse into a traditional 12-Step Program to manage and treat comorbid disorders	Rod Ward and Jenny Curtin
VIC	Knox Community Health Service	Implementing Mindfulness Therapies in community health drug treatment counselling	Jenni Thompson
SA	OARS Community Transitions	Effective Intervention: The development of a case formulation using the 7P Framework	Michelle Mayes
WA	Women's Health Service	Sustainable resources for women's services	Susan Lee
WA	Holyoake	Sustainability - Beyond the Five Pillars	Mario Gallo
VIC	Bendigo Community Health Services	Dual Tools - Bendigo Community Health Services approach to implementing PsyCheck into practice	Lisa Walklate
VIC	Ovens and King Community Health Service & Gateway Community Health Service	"Two heads are better than one" The journey of the Hume region towards sustainable, systematic dual diagnosis capability	Renee Williams and Darren Bate
NSW	We Help Ourselves (WHOs)	Responding to clients suicidal ideation: outlining a whole organisation approach	Jo Lunn and David Kelly

### Friday 8<sup>th</sup> October 2010 Presentations

Friday 8 <sup>th</sup> October 2010			
State	Capacity Building Grant Recipient	Presentation	Presenter(s)
QLD	Brisbane Youth Service	The Improved Services experience in a holistic youth service	Maria Model
QLD	DRUG ARM Australasia	Changing Governance - Structural approach to improving services	Kathryn Kenny and Sarah Dewar
VIC	MonashLink CHS Ltd	Creative capacity building in a Community Health Service	Maria Yap
SA	South East Drug and Alcohol Counselling Service (SEDECS)	"Don't be afraid to share it - It's not what you know, it's who you know" The story of the South East Mental Health Network Group	Liz Jarrett
WA	Drug ARM	Linkages and Partnerships	John Hopkins
VIC	Western Region Alcohol and Drug Centre	WRADIS - The Collaboration of Database Collections	Maya Raschel
VIC	Moreland Hall	Dual Diagnosis - A Workforce Development Approach	Brandon Jones
QLD	Gold Coast Drug Council Inc	Time for Change? Bottom Up or Top Down?	Julie Fox
SA	Aboriginal Sobriety Group (ASG)	Clinical Supervision for comorbidity capacity building - An Action Learning case study at ASG	Chris Riley
WA	Ngnowar-Aerwah Aboriginal Corporation	Building capacity in a remote Aboriginal Service in the East Kimberly	James Birch
TAS	The Link Youth Health Service	Delivering psychological treatment in a youth AOD setting	Michelle Fay
NSW	Kedesh Rehabilitation Service (KRS)	KRS – Mental Illness and Substance Use (MISU) Training	Mark Buckingham and Luke Downie