Report on the

2014 Queensland AOD Sector Convention

October 2014

The Queensland Alcohol and Other Drug Sector Convention 2014 was made possible by the generous support (both financial and in kind) of the following organisations:

Financial support for delegate travel was provided by:

Table of Contents

1. Executive Summary

The 2014 Queensland Alcohol and other Drug (AOD) Sector Convention was held in Brisbane on 23 July 2014 and brought together more than 100 service managers, policy officers and other key stakeholders from government and non-government alcohol and drug services across the state to discuss good practice in service delivery, with the aim of informing the development of a statewide framework for the AOD treatment sector. This report documents the information gathered through the pre-Convention surveys, as well as the content of delegate discussions on the day. The Queensland AOD Statewide Framework will be a separate document, informed by the Convention outcomes and will be released in draft form for comment by Convention delegates in October 2014.

The Convention was a joint initiative of the Queensland Network of Alcohol and other Drug Agencies (QNADA), Dovetail, the Queensland Indigenous Substance Misuse Council (QISMC), the Queensland Aboriginal and Islander Health Council (QAIHC) and the Alcohol and other Drug Service Improvement Group (AOD-SIG) and was made possible by funding provided by the Queensland Mental Health Commission (QMHC), the Queensland Department of Health and the Foundation for Alcohol Research and Education (FARE).

Delegates represented the full range of specialist AOD services available in Queensland, including harm reduction, opiate replacement, counselling, residential rehabilitation (including Therapeutic Communities) and services for young people, as well as the range of professions employed in the sector, including doctors, nurses, allied health workers, AOD workers, youth workers and harm reduction specialists. Invited delegates who were unable to attend were forwarded the Convention materials by email and invited to submit their feedback in writing.

The level of engagement from sector leaders was high, with many delegates commenting that they valued the opportunity to meet colleagues from across the state as much as they valued the opportunity to reflect on and discuss the elements of good practice in service delivery. 95% of delegates rated the opportunity to network as either excellent or good.

Delegates demonstrated a good understanding of the evidence base for effective harm reduction and treatment services. There was a high degree of consensus on appropriate screening and assessment and counselling approaches, as well as good practice approaches to waiting list management, treatment planning and referral and working with clients with multiple and complex needs. There was less clarity around good practice approaches to outcome measurement, indicating there would be benefit in supporting the sector to develop good practice approaches in this area.

Delegates identified a range of areas of focus for future workforce and sector development activities, such as stigma reduction, improved access to clinical supervision and professional development opportunities, as well as resourced support for generalist health workers in rural and remote areas. Delegates also indicated an interest in making the Convention a regular event, with 66.7% preferring an annual event and 22.2% favouring a bi-annual event.

2. Background and Context

There has been a significant amount of change in both the alcohol and other drug policy and service delivery environments over the last two years. In terms of the policy environment, this includes the establishment of the Queensland Mental Health Commission (which also has responsibility for substance misuse), the disbanding of the Alcohol and Other Drug Treatment Strategy Unit within Queensland Health as part of the establishment of the Mental Health, Alcohol and Other Drug Branch and the expiry of the Queensland Drug Action Plan 2011-2012. In terms of the service delivery environment, this includes the functional integration of the majority of public mental health and alcohol and other drug teams as part of the establishment of Hospital and Health Services across the state and the re-tendering of non-residential alcohol and other drug treatment services offered by the non-government sector.

Discussions in early 2014 between Dovetail, the Queensland Network of Alcohol and other Drug Agencies (QNADA) and the Alcohol and other Drug Service Improvement Group (which has responsibility for clinical governance in government alcohol and other drug treatment services) indicated that the time was right to bring together key stakeholders to discuss what constitutes good practice in alcohol and other drug treatment in Queensland. The discussions were intended to focus on topics to inform the development of a statewide framework for alcohol and other drug treatment, as well as provide up to date information that could be used by the various policy bodies to inform their work.

The Queensland Mental Health Commission and the Mental Health, Alcohol and other Drugs Branch within Queensland Health were approached and agreed to provide material support to enable the Convention to be held.

The Convention was held on Wednesday 23 July 2014 at Rydges Hotel, South Bank, Brisbane. It was attended by 107 service managers, policy makers and sector representatives across the government and non-government AOD sector in Queensland. The event was facilitated by Michelle Feenan from consultancy firm Engagement Plus and incorporated a range of presentations, session tools and activities including a participant workbook, voting points, case studies and 'Zing' keyboard data collection tool.

2.1 Organising Committee

The Organising Committee consisted of five members who were able to broadly represent the key stakeholders of the Queensland alcohol and other drug treatment and prevention sector:

- Rebecca MacBean, CEO, Qld Network of Alcohol and other Drug Agencies;
- Linda Hipper, Chairperson, Alcohol and other Drug Service Improvement Group;
- Jeff Buckley, Principal Consultant, Dovetail;
- Eddie Fewings, Regional Coordinator (QISMC), Qld Aboriginal and Islander Health Council;
- Pele Bennett, General Manager, Sector Development, Qld Aboriginal and Islander Health Council; and
- Kate Podevin, Principal Policy Officer, Mental Health and Alcohol and other Drugs Branch, Qld Health.

The Organising Committee identified managers of the key service providers across the government, non-government and youth sectors who were invited to attend the Convention, as well as key policy decision makers from the Department of Health and the Qld Mental Health Commission, the Department of Communities, other sector stakeholders and two consumer representatives. The list of invited delegates is included as Appendix 1.

2.2 Sector Surveys

Surveys of the government and non-government alcohol and other drug treatment services were undertaken prior to the Convention via Survey Monkey to gather data on the types of services delivered, the evidence base for those services, the qualifications of staff employed to deliver services, as well as information on the clinical guidelines used and the specific populations targeted by services. Twenty-one government and nineteen non-government service managers completed the survey. A list of the survey questions is included as Appendix 2.

The Organising Committee then met to compare the survey results to identify where appeared to be collective agreement on good practice and where there was a divergence in responses that might indicate less clarity across the sector. The Committee utilised a traffic light approach and agreed that items tagged red would be accorded priority for discussion at the Convention. Analysis of the surveys identified treatment planning and review, case management and case work definitions, services for specific populations and outcome measurement as red (requiring discussion). It was also agreed there would be value in discussing screening and assessment practices, clinical guidelines used by services and the sector and workforce development needs of services.

Section 3 details the results of the surveys across these areas, as well as the outcomes of delegate discussions at the Convention.

2.3 The Alcohol and other Drug Sector in Queensland

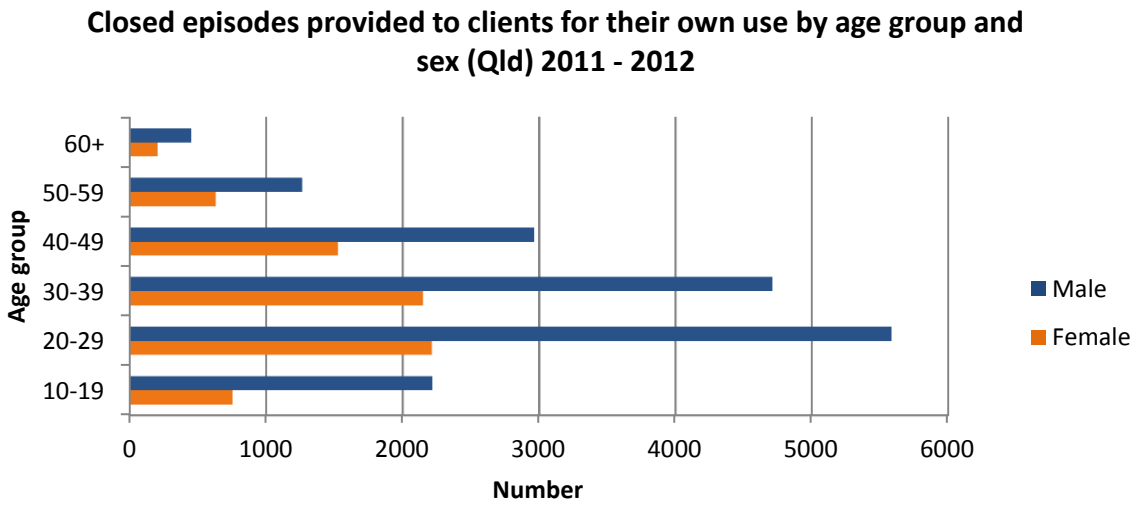
Data on the amount of specialist alcohol and other drug treatment and support services provided in Queensland is measured through three primary data sets:

- The Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS) collects information on closed treatment episodes provided by publicly funded residential and non-residential treatment services;
- The National Opioid Pharmacotherapy Statistical Annual Data (NOPSAD) collects information on the clients receiving opioid pharmacotherapy on a census date each year; and
- The Queensland Minimum Data Set for Needle and Syringe Programs (QMDS-NSP) collects information on clients as well as equipment and interventions provided across Qld.

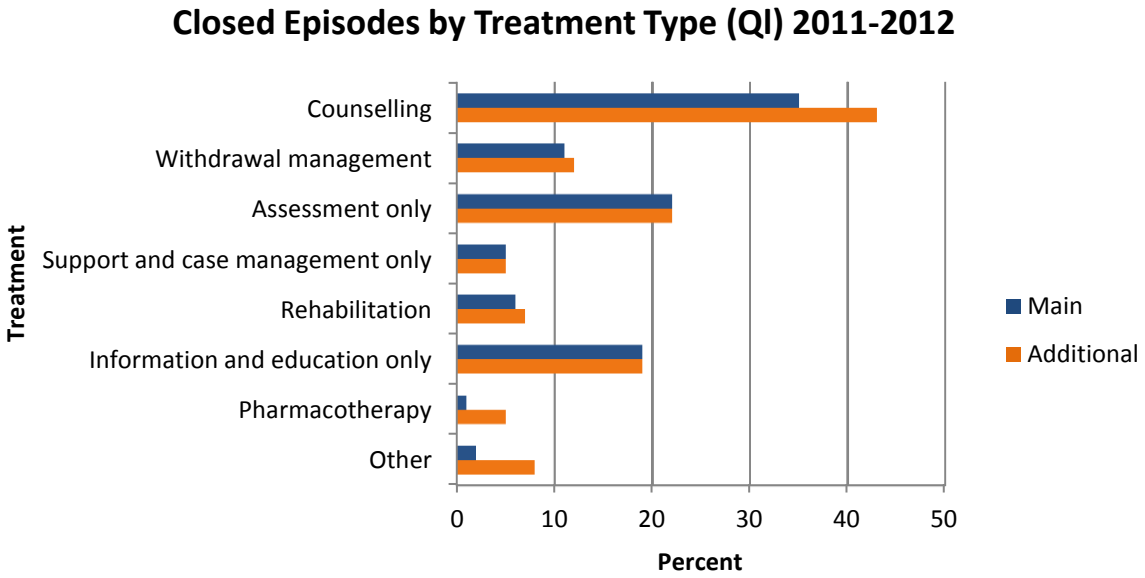
The most recent data from each of these collections is presented below. This data was provided to delegates at the Convention as an overview of the amount of service provided in Queensland.

2.3.1 The Alcohol and other Drug Treatment Services National Minimum Data Set

The most recent data available from the AODTS-NMDS was for the 2011 – 2012 financial year. Delegates were provided with an overview of the age and gender of clients, as well as the treatment types provided and principal drugs of concern identified by clients.

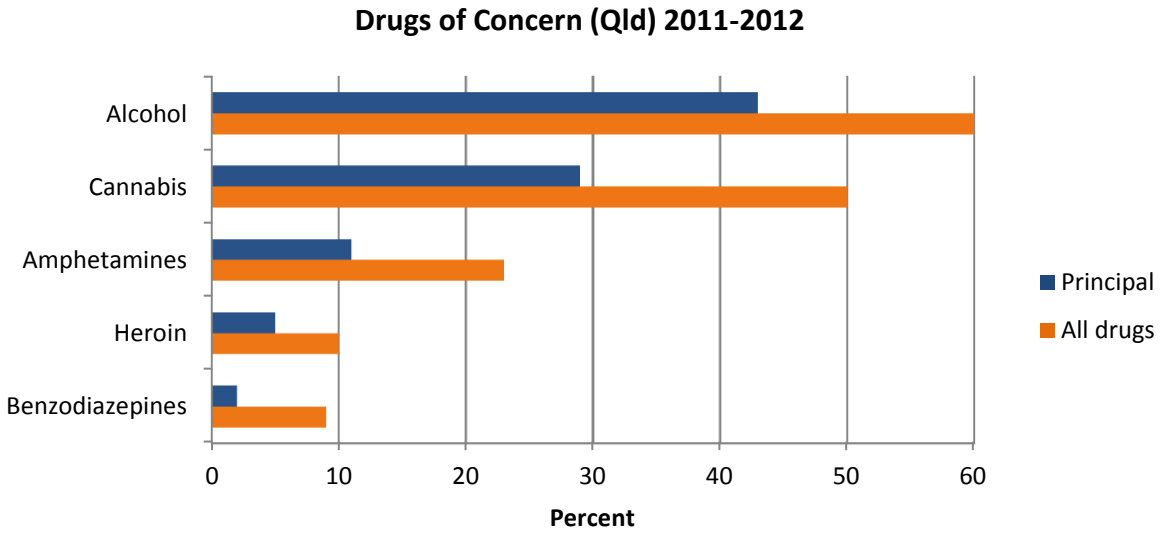


Graph 1 shows the majority of episodes in 2011-12 were provided to males aged 20 – 39.



Graph 2 shows the main treatment type provided was counselling (35%), followed by assessment only (22%), information and education only (19%) and withdrawal management (11%), with a similar pattern followed for additional treatment types[1].

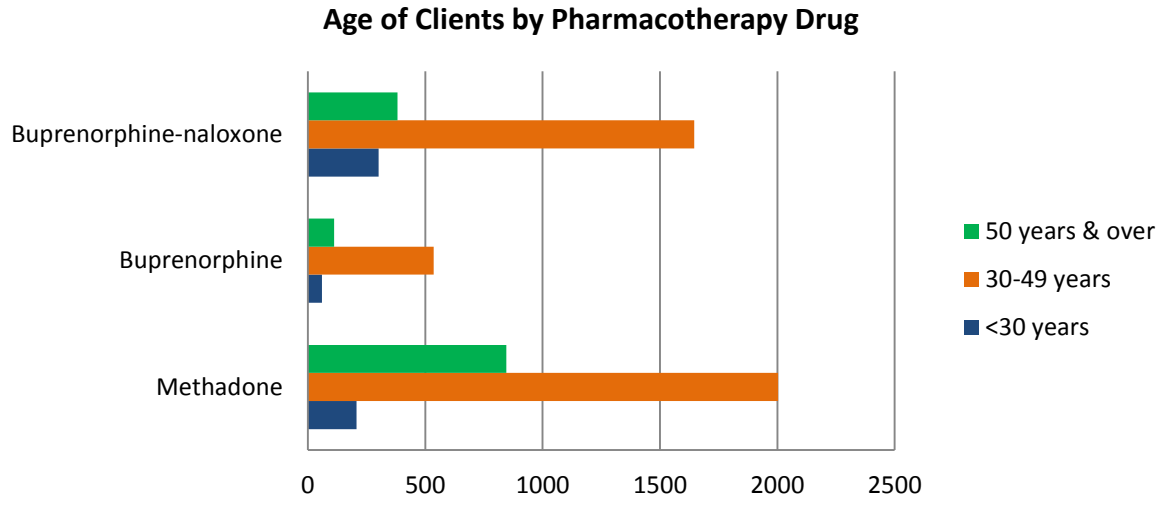
[1] Queensland provides a higher proportion of information and education only treatment episodes than the national average (19% compared with 4% nationally). This is caused by the volume of referrals from Police and Court Diversion programs.



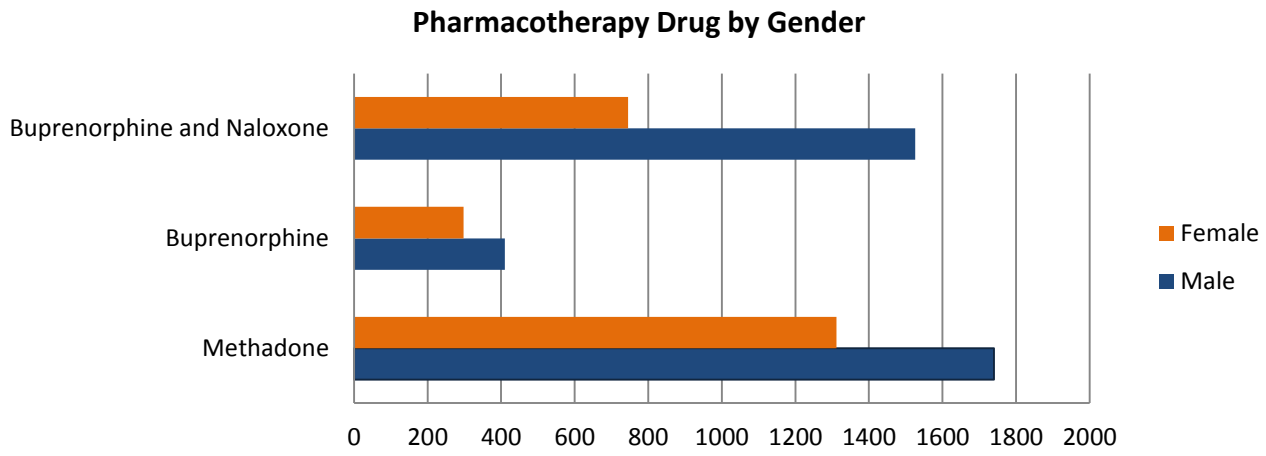
Graph 3 shows the most often reported principal drug of concern was alcohol (43%), followed by cannabis (29%) and amphetamines (11%), with a similar pattern identified for all drugs of concern identified by clients.

2.3.2 National Opioid Pharmacotherapy Statistical Annual Data

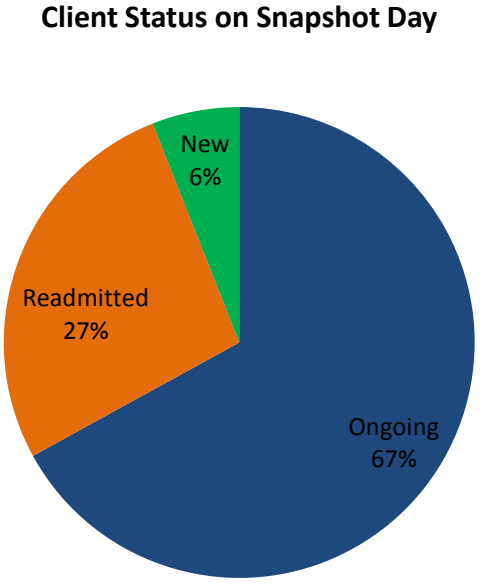
The most recent data available from the NOPSAD collection was for 2013. Delegates were provided with an overview of the age and gender of clients by pharmacotherapy drug, as well as the status of clients.



Graph 4 shows the majority of clients for all pharmacotherapy drug types were aged 30 – 49 years.



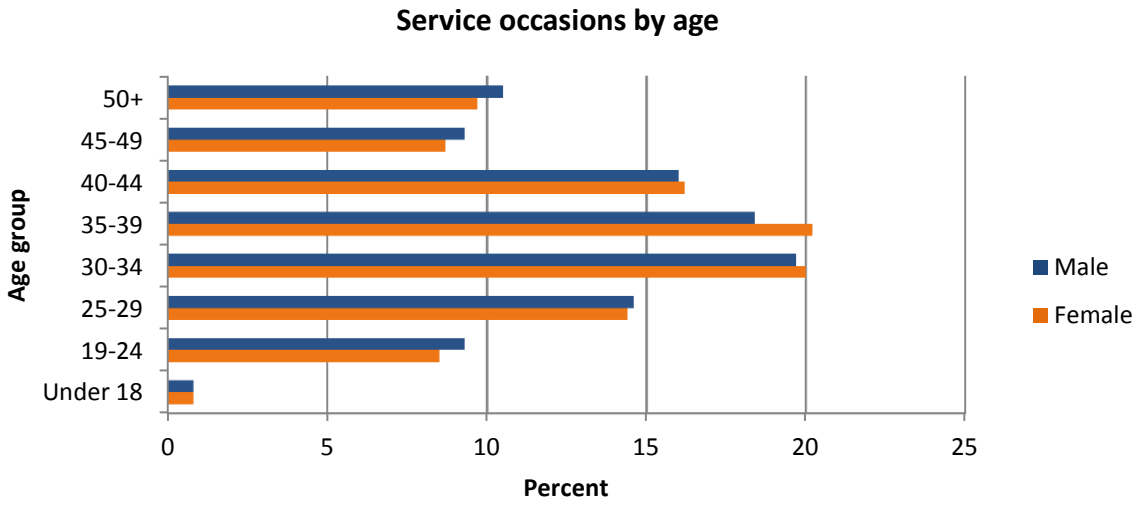
Graph 5 shows the majority of clients across all pharmacotherapy drug types were male.



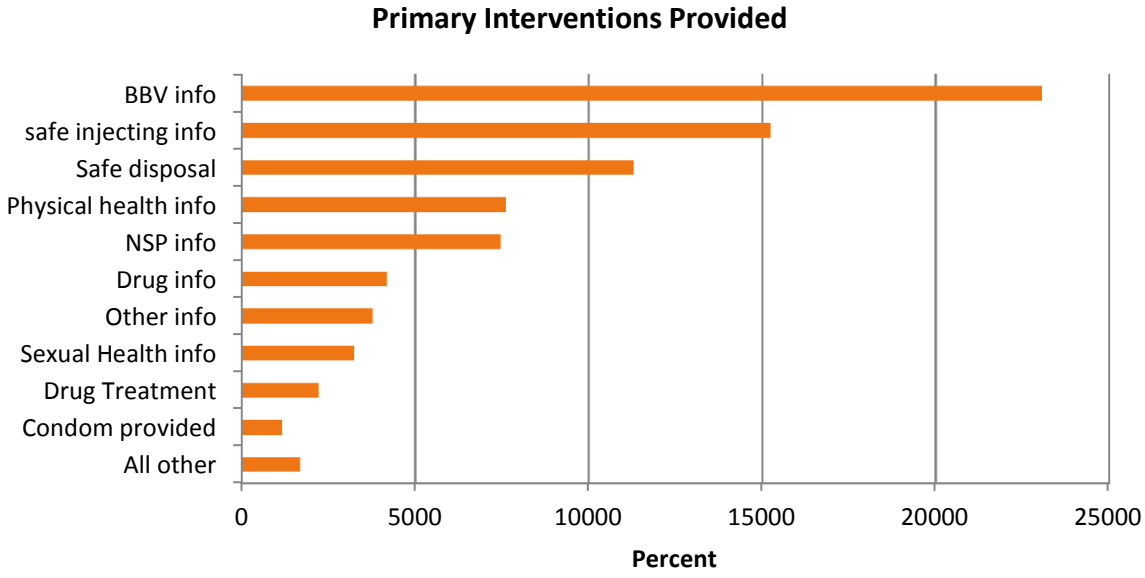
Graph 6 shows the majority of clients on the census day were ongoing clients (67%), followed by readmitted clients (27%) and new clients (6%).

2.3.3 Queensland Minimum Data Set for Needle and Syringe Programs

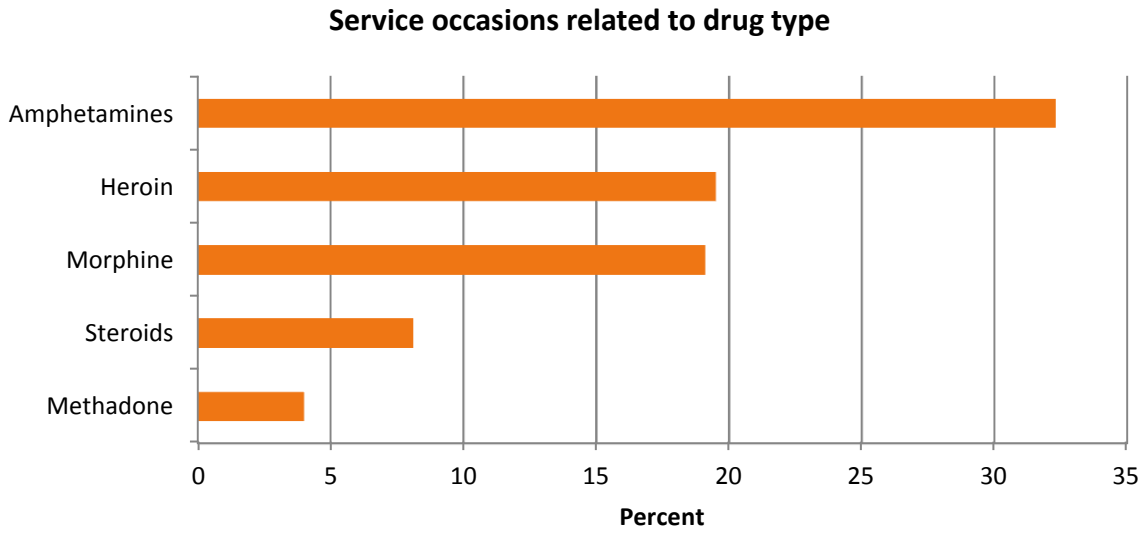
The most recent data available from the QMDS-NSP collection was for 2013. Delegates were provided with an overview of the age of clients, primary interventions provided and drug types reported by clients.



Graph 7 shows the majority of clients were females or males aged 30-39 (40.2% and 38.1% respectively).



Graph 8 shows the most common intervention provided by needle and syringe programs was the provision of information on blood borne viruses, followed by the provision of safe injecting information and safe disposal information.



Graph 9 shows the majority of clients attending needle and syringe programs reported they intended to use the equipment provided to administer amphetamines (32.3%), followed by heroin (19.5%) and morphine (19.1%).

3. Convention Topics

The topics for discussion were organised into seven sessions, as outlined below.

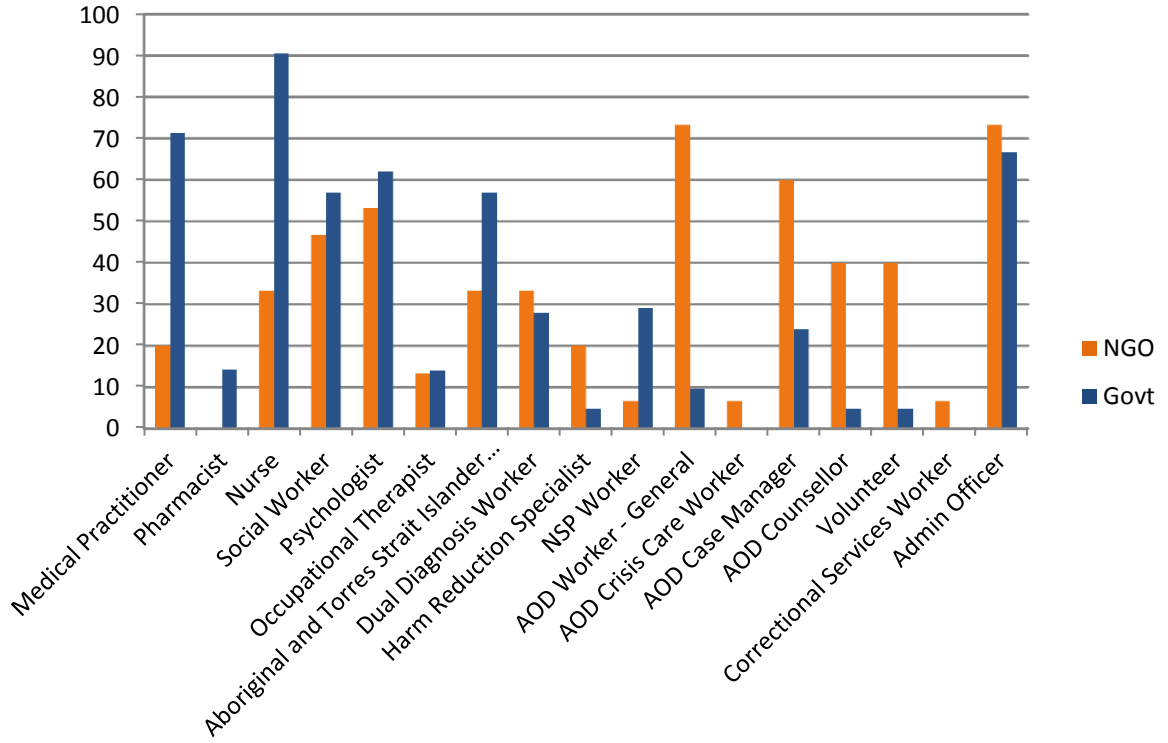
Session 1:	Service Spectrum Sector Values Sector Mission Statement
Session 2:	Intake, Screening and Assessment Treatment Approaches Casework, Case Management and Outreach
Session 3:	Treatment Planning and Referral Case Coordination and Service Integration
Session 4:	Working with Specific Populations Working with Aboriginal and Torres Strait Islander communities
Session 5:	Engaging and Involving Service Users Aftercare and Exit
Session 6:	Measuring Client Outcomes Service Effectiveness
Session 7:	Workforce and Sector Development Convention Resolutions

This section summarises the survey responses and delegate discussions at the Convention.

3.1 Identifying the AOD Sector

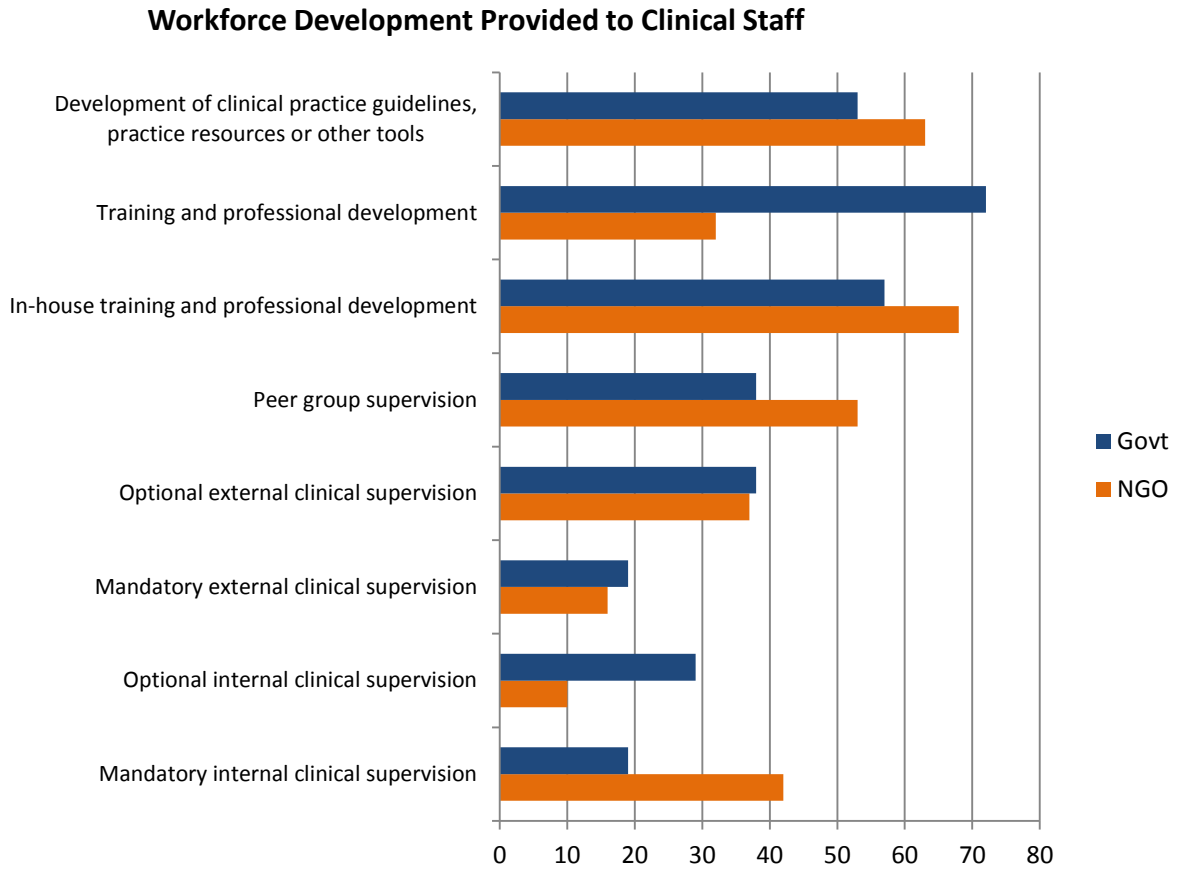
In order to provide delegates with a sense of the breadth and diversity of services provided in the alcohol and other drug treatment and prevention sector, the first session of the Convention focussed on the types of services offered, the professional background of the AOD workforce and sought to identify a mission statement for the sector.

3.1.1 Professional Disciplines Employed in Services



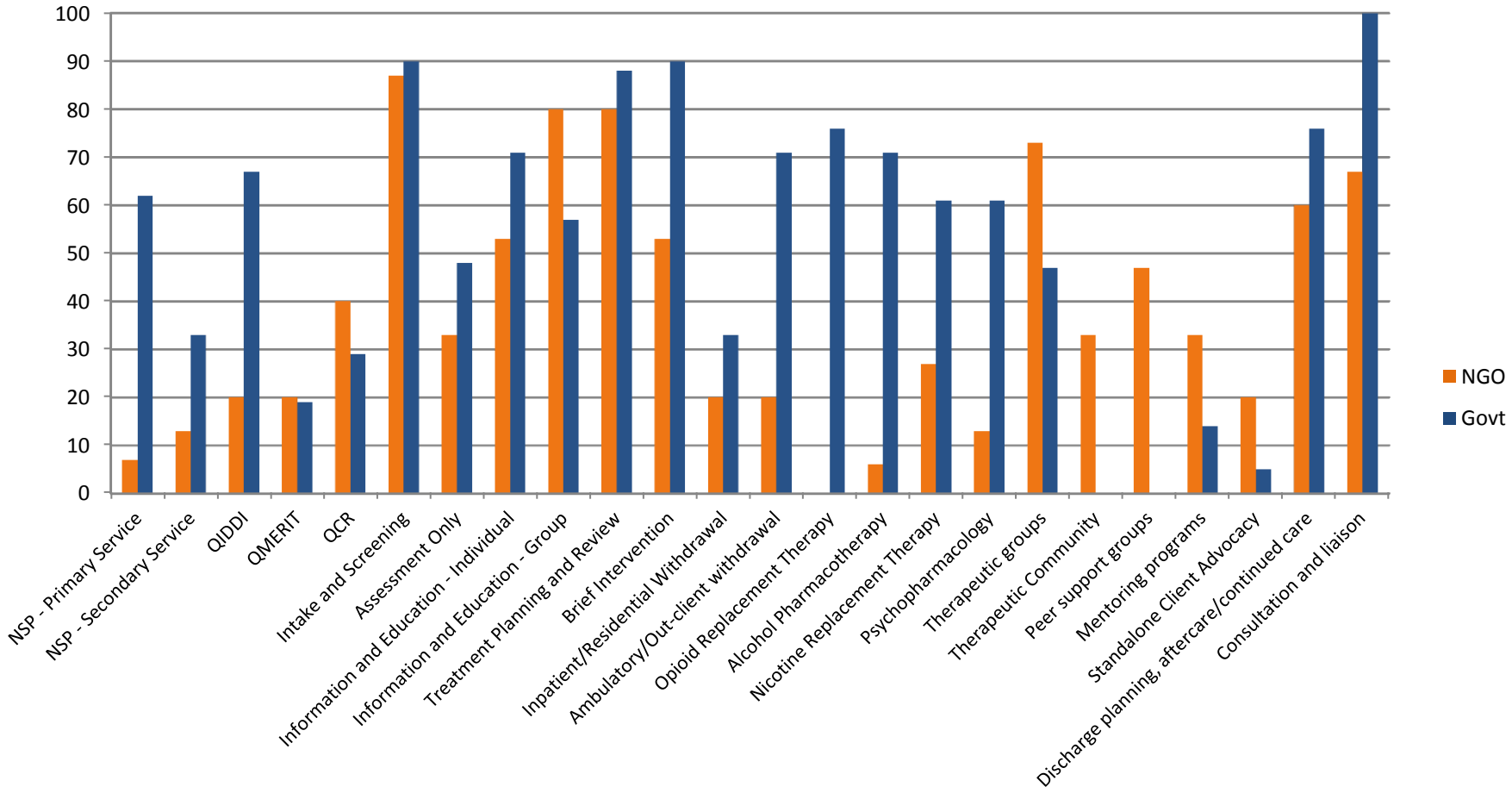
Graph 10 shows that the primary disciplines employed by government alcohol and other drug treatment services (excluding administration officers) is nurses, followed by medical practitioners, psychologists and social workers. The primary disciplines employed by non-government alcohol and other drug treatment services is AOD worker – general, followed by AOD Case Manager, psychologists and social workers.

3.1.2 Workforce Development Activities



Graph 11 shows the range of workforce development activities offered to clinical staff across government and non-government services. Excluding the development of clinical practice guidelines, practice resources or other tools, clinical staff in government services were most likely to access training and professional development (72%), followed by in-house training and professional development (57%) and peer group or optional external clinical supervision (38% each). Clinical staff in non-government services were most likely to access in-house training and professional development (68%), followed by peer group supervision (53%) and mandatory internal clinical supervision (42%).

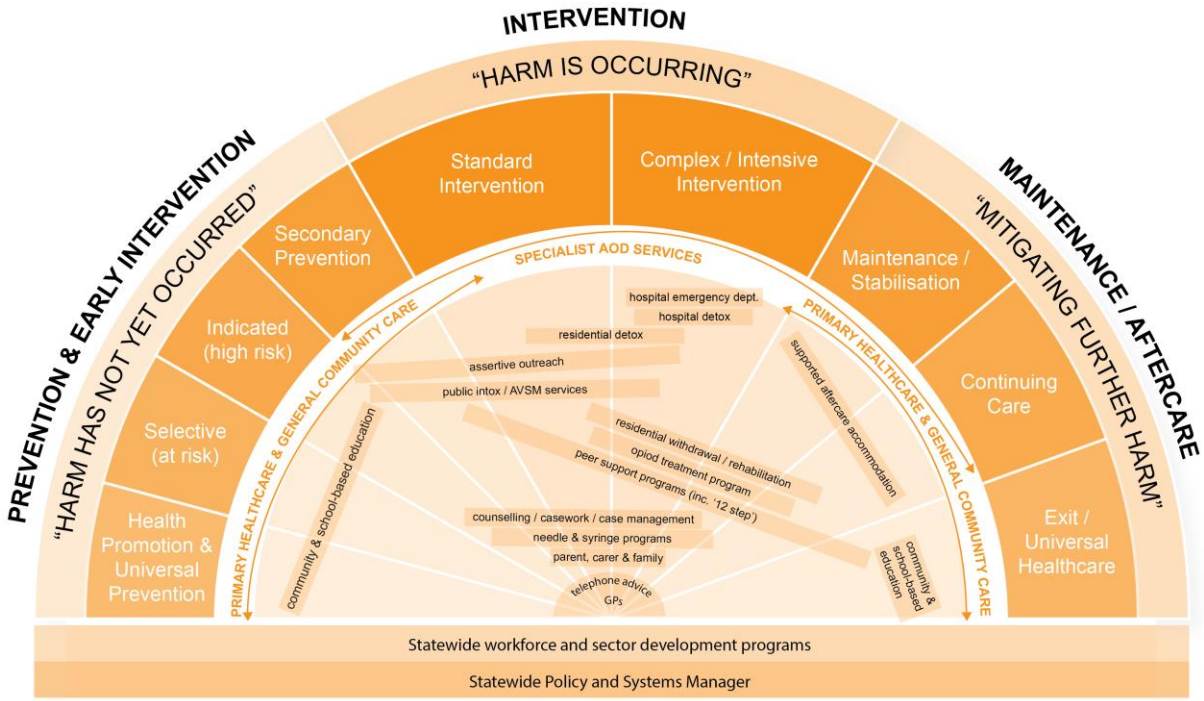
3.1.3 Treatment Types



Graph 12 shows the range of treatment types offered across government and non-government services in Queensland.

3.1.4 Service Spectrum

Delegates were provided with an incomplete version of the diagram below and asked to locate each service type on the spectrum, according to how they corresponded to levels of alcohol and other drug related harm for individuals.



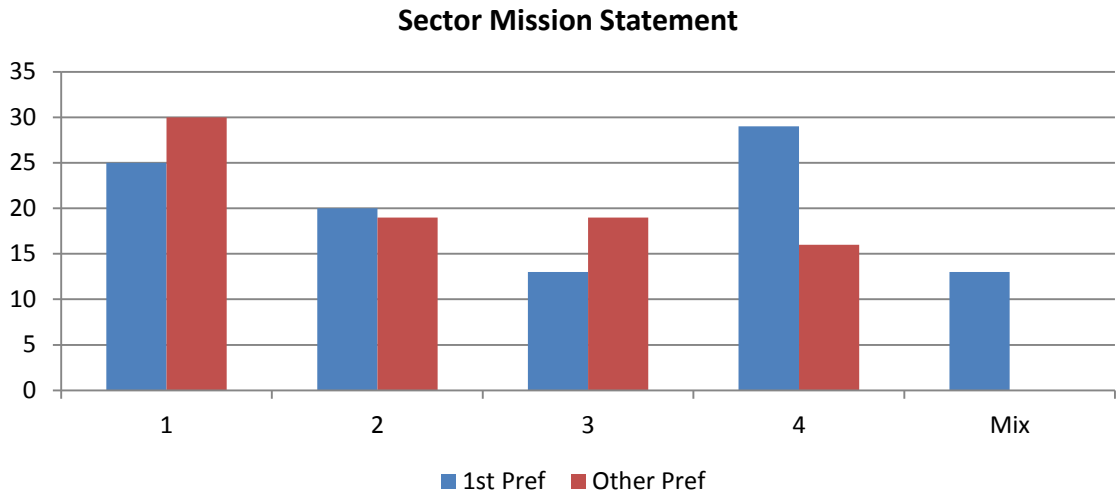
Participants' suggestions as to where each service type was located along the spectrum in relation to client's experience of harm have been aggregated and incorporated into the image above.

It is noted there was a degree of variation in the way participants' responded to the spectrum above, meaning the spectrum is indicative only. Individual organisations and programs may consider themselves fitting across other "wedges" than those presented here. Nevertheless, the intent of this exercise was to consider the role and function of different intervention types in relation to clients' needs and the inter-relationship between these program areas as part of the sector's attempt to establish a continuum of care (or clinical pathway) for various types of clients – or trajectories - through treatment.

3.1.5 Sector Mission Statement

Delegates were asked to consider the following suggested mission statements:

1. To reduce levels of AOD related harm experienced across Queensland;
2. To increase the overall health and wellbeing of individuals, families and communities across Queensland;
3. Safe, healthy, resilient individuals, families and communities across Queensland; or
4. A Queensland community with the lowest possible levels of alcohol, tobacco and other drug related harm , as a result of the alcohol, tobacco and other drug sector's evidence-informed prevention, treatment and harm reduction policies and services.



Graph 13 shows that when first preferences only are considered, statement 4 was most preferred (29%), followed by statement 1 (25%), statement 2 (20%) and statement 3 (13%). When all preferences were counted and excluding blanks, 32.4% of participants preferred statement 1, 26.8% preferred statement 4, 22.8% preferred statement 3 and 18.4% preferred statement 3.

Of the participants who expressed a preference for statements 1 and/or 4, the following statements provide an overview of the comments provided:

- *4 is comprehensive but complicated whereas 1 is succinct but remains open to interpretation. Just the first section of the 4th statement.*
- *I like 1 as it is specific to AOD - perhaps combine with 3 to name the community benefit.*
- *Modified version of 4 - A Qld community with the lowest possible levels of alcohol, tobacco and other drug-related harm, as a result of evidence-informed prevention, treatment and harm reduction policies and services. Or a modified version of 1 - To minimise levels of AOD related harm experienced across Queensland through evidence-informed prevention, treatment and harm reduction policies and services.*

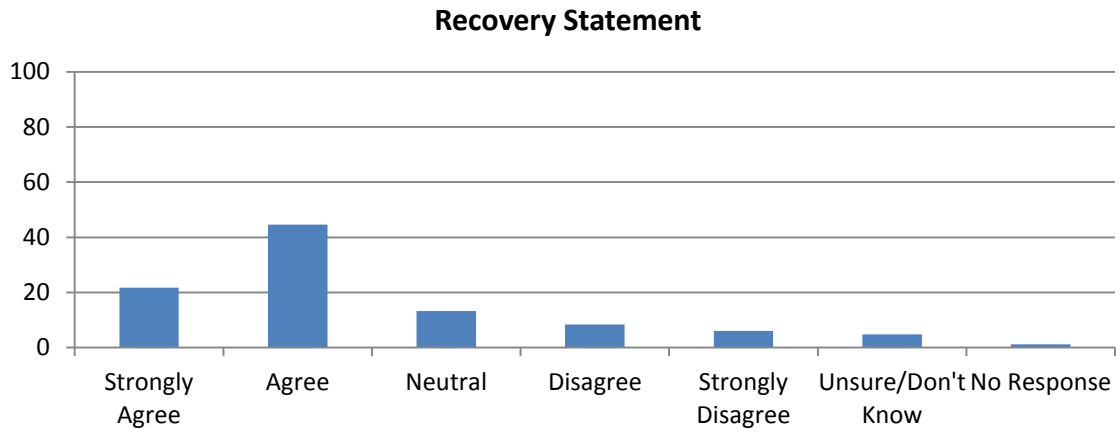
A full list of the comments provided by respondents is included at Appendix 3.

3.1.6 Defining Recovery in an Alcohol and Other Drug Treatment Context

Participants were provided with the following proposed definition of 'recovery' in the alcohol and other drug prevention and treatment context:

> *Recovery, in the AOD treatment setting, can be conceptualised as describing services that seek to work with an individual experiencing problems related to their substance use to identify and achieve realistic goals, which may include reduced use, abstinence, or safer using practices.*

Participants were asked to indicate their level of agreement with this proposed definition and provided with the opportunity to suggest an alternative definition or to otherwise comment on the proposed definition.



Graph 14 shows 66.3% of respondents agreed or strongly agreed with the proposed recovery statement, 19.1% of respondents were neutral or unsure and 14.4% disagreed or strongly disagreed.

The following comments provide an overview of the issues raised by those participants who agreed or strongly agreed with the proposed definition:

- *Must include acknowledgement of individuals own determination of what is 'recovery' for them - what their meaningful goals are. Also must accept that 'recovery' is not necessarily linear, steady or uninterrupted. Recovery may not conform to workers or community expectations.*
- *Recovery oriented AOD treatment services are those that work with individuals experiencing problems…(as above). Just think that recovery oriented is what we're describing, not recovery (and the recovery word alone is part of the problem - which is largely semantic).*
- *Not all drug users need to 'recover' and can manage their use healthily and without the need for services/support. It links drug users to being unproductive and ostracised community members until they stop using. We need to be careful with this word.*

The following comments provide an overview of the issues raised by those participants who disagreed or strongly disagreed with the proposed definition:

- *Recovery, in the AOD treatment setting, can be conceptualised as describing models that seek to work with an individual to identify goals which may include a range of options.*
- *Recovery is a process whereby an individual returns to (and can improve on) previous levels of health, functional living that may include reduced use, abstinence or safer using practices.*
- *I disagree with the use of recovery in the AOD sector. It places a mental health label on AOD, it pushes the sector under MH control, philosophy.*

A full list of the comments provided by respondents is included at Appendix 4.

3.2 Intake, Screening and Assessment

The survey of both the government and non government treatment services included the identification of intake, screening and assessment tools in use. Participants at the convention were provided with the list of the ten most commonly used tools across government and non government services:

Government		Non-government	
1	Alcohol Use Disorders Identification Test (AUDIT)	1	DASS 21
2	Mental State Examination	2	Self Harming/Suicidal Ideation
3	DASS 21	3	Indigenous Risk Impact Screen (IRIS)
4	Severity of Dependence Scale	4	K10
5	Self Harming/Suicidal Ideation	5	Alcohol Use Disorders Identification Test (AUDIT)
6	Indigenous Risk Impact Screen (IRIS)	6	Severity of Dependence Scale
7	Aggressive/Homicidal Ideation	7	Psycheck
8	DSM Dependence Rating	8	Substance and Choices Scale
9	Fagerstrom Nicotine Tolerance Questionnaire	9	DSM Dependence Rating
10	K10	10	Aggressive/Homicidal Ideation

Delegates were asked to discuss two questions related to intake and assessment processes:

1. In your opinion, what are the key principles underpinning a 'good' intake?
2. What principles should underpin an effective and responsive waiting list management process?

Ninety-seven responses were provided to question one, which could be grouped into the following themes:

- Client centred
- Thorough
- Non judgemental
- Builds the therapeutic alliance
- Appropriate (eg culturally, age)
- Manages expectations
- Promotes informed consent
- Reliable and valid
- Promotes treatment matching
- Includes feedback to referral source
- Safe
- Accessible, timely and responsive

Fifty-eight responses were provided to question two, which could be grouped into the following themes:

- Transparent
- Fair and equitable
- Includes referral for those who can't be seen within a reasonable timeframe

- Prioritised by need
- Regular contact with clients to check if circumstances have changed

3.3 Treatment Approaches

3.3.1 Treatment Interventions

Delegates were provided with a list of common treatment interventions available in Queensland, together with a proposed definition for each intervention in their Delegate Information Pack and asked to provide feedback to any member of the Organising Committee if they identified any issues or additional interventions that should be included in the Statewide framework. No feedback was received.

ACTIVITY	DEFINITION
Needle and Syringe Program – Primary Service	Provision of a full range of sterile injecting equipment alongside harm reduction interventions such as BBV info, vein care, safe disposal information and referral
Needle and Syringe Program – Secondary Service	Provision of basic sterile injecting equipment only, distributed by non-NSP staff or through vending machines
Police Diversion and Illicit Drug Court Diversion Services (previously QIDDI) - Drug Assessment and Education Sessions	Provision of a one-off 1-2 hour assessment and brief intervention session for clients referred for diversion from Queensland Police or a Queensland Magistrates Court
Queensland Magistrates Early Referral Into Treatment Program (QMERIT)	A bail-based diversion program for defendants with illicit drug use issues operating in the Maroochydore and Redcliffe Magistrates Courts.
Queensland Court Referral	A bail-based program that enables defendants to engage with government agencies and non-government organisations to address the causes of offending behaviour by identifying those defendants who come into contact with the criminal justice system as a result of: • drug and/or alcohol dependency • mental illness • intellectual disability • cognitive impairment • homeless people or those at risk of homelessness.
Intake and screening	A process to determine if engagement with a client is appropriate based on their needs, what treatment and support options are available in the service system, whether the client is voluntary or coerced and whether the client has additional needs related to their cultural background.

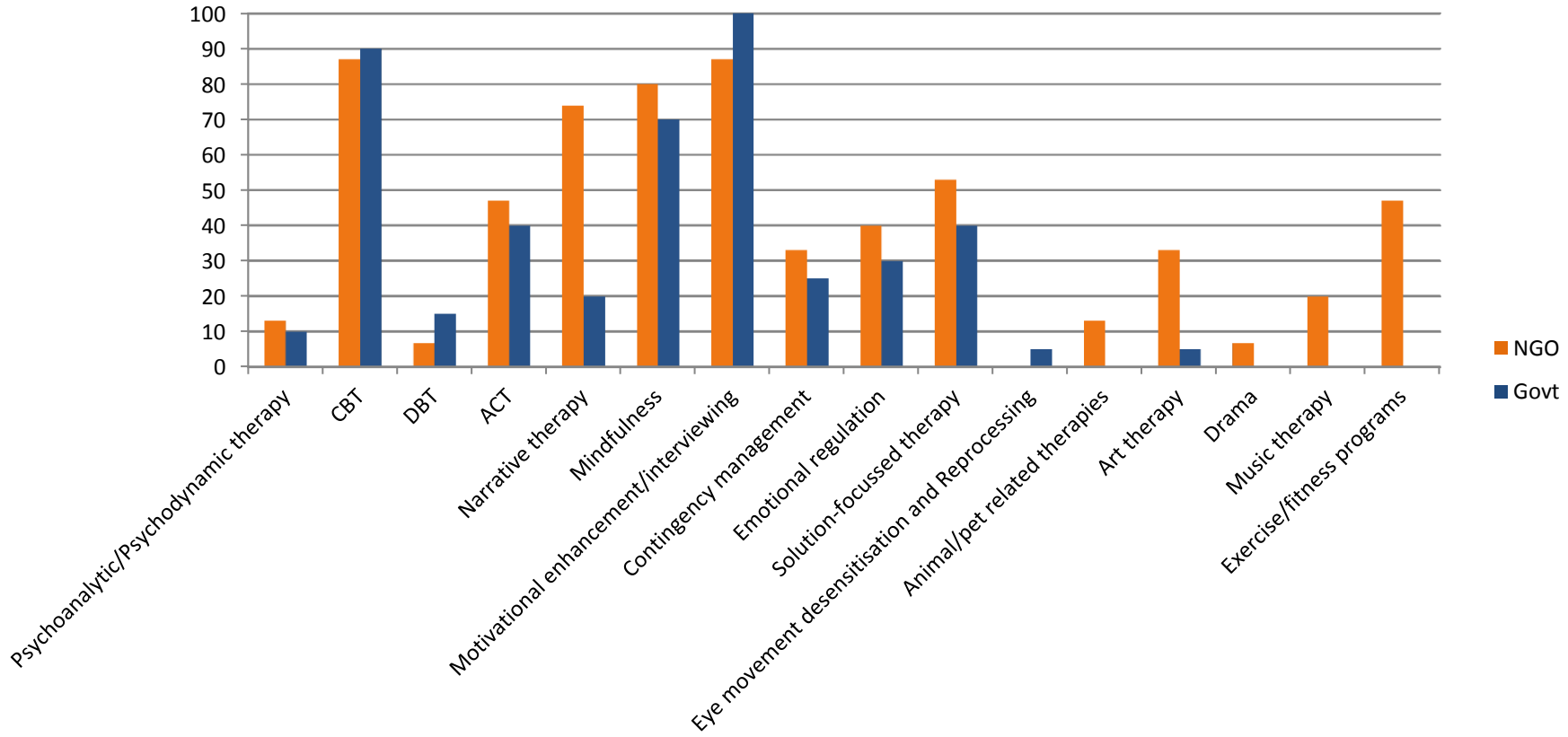
ACTIVITY	DEFINITION
Assessment only	Undertaking a stand-alone AOD assessment with the understanding that there will be no subsequent treatment phase (ie upon request by other professions / practitioners for court, for external treatment planning or for clients referred by a GP or hospital for an assessment for therapeutic use of prescription opiates)
Information and education only for *clients individually*	No treatment provided to the client other than information and education. It is noted that, in general, service contacts would include a component of information and education.
Information and education only for *clients in groups*	No treatment provided to a number of clients in a group setting other than information and education. It is noted that, in general, service contacts would include a component of information and education.
Treatment Planning and review	A process of identifying and documenting a client's goals in relation to their alcohol and drug use to be used to guide their interaction with a treatment service, as well as the periodic review (at least every 90 days) of these goals to ensure continuing relevance of the treatment approach.
Brief Intervention	A one-off structured intervention between 5 and 60 mins in length which involves a brief or basic assessment and provision of information and feedback.
Inpatient / Residential withdrawal management and support (detoxification)	The provision of a "very high" (hospital setting or withdrawal unit) or "moderately high" (residential settings) level of medically assisted care for clients undertaking an alcohol or other drugs withdrawal process. It is the preferred treatment setting for those assessed as having a risk of complex or severe withdrawal symptoms.
Ambulatory / Out-client / Home-based withdrawal management and support (detoxification),	The provision of short term management or support to people who do not require, or no longer require, inpatient withdrawal management. Suitable for low level, withdrawal with low predicted withdrawal complexity, though in some cases, withdrawal pharmacotherapies may be clinically indicated.
Opioid Replacement Therapy	Clinically supervised replacement of the drug of dependence with a legally obtained, longer-lasting opioid that is administered to reduce or eliminate withdrawal symptoms and drug cravings.
Alcohol Pharmacotherapy	The use of medication to reduce heavy drinking and support an increase in days of abstinence for individuals with alcohol dependence.
Nicotine Replacement / Smoking Cessation Therapy	The administration of either nicotine or a nicotine-receptor-agonist via means other than tobacco to reduce or eliminate withdrawal symptoms and nicotine cravings.
Medical Interventions	The provision of a range of AOD related medical interventions, inclusive of but not limited to: BBV screening; Hepatitis vaccination; and medical assessment, intervention and referral for a range of physical and psychological conditions.

ACTIVITY	DEFINITION
Therapeutic groups	Structured, closed groups for individuals seeking help with their AOD use, facilitated by a clinician to create a safe environment in which to experiment with getting and giving feedback and exploring new behaviours in a social context.
Peer support groups	Voluntary, self help groups open to individuals seeking to address their AOD use, or to maintain abstinence (including AA, NA, SMART Recovery). These groups may also support the family and friends of people with AOD issues (egAlanon).
Mentoring programs	Non-clinical, personalised support programs that involve matching volunteer mentors with client 'mentorees' for life-skill or interest-based interactions, including cultural men's and women's groups.
Therapeutic Community	A residential treatment program which utilises the 'Community as method' approach, incorporating distinct stages of treatment (generally covering assessment/orientation, treatment, transition and re-entry).
Standalone Client Advocacy	Provision of direct support to a client in navigating a service system.
Discharge planning, aftercare/continued care	A process of identifying and documenting a client's needs post treatment, generally including relapse prevention and harm reduction information. May include the provision of supported accommodation during the initial transition stage from residential withdrawal or treatment.
Consultation and liaison	Provision of advice and support to clients and health professionals at the interface between the AOD sector and the broader health sector, usually in hospital or community health settings.

This list of activities and their definitions will be included in the Statewide framework.

3.3.2 Counselling Approaches

The survey of both the government and non government treatment services included the identification of counselling approaches commonly used across the sector. The following graph shows the range of approaches utilised by the government and non-government treatment services.

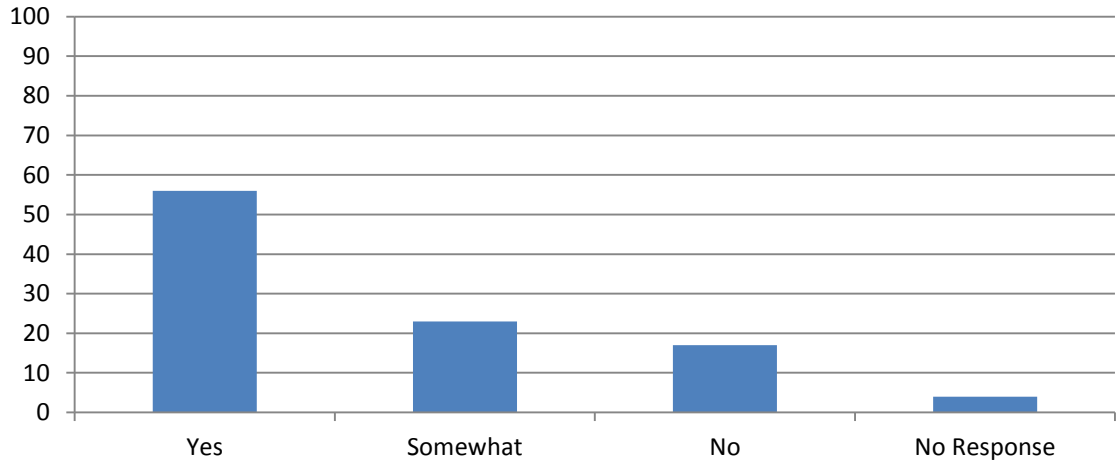


Graph 15 shows that the most commonly used counselling approaches were Motivational Interviewing, Cognitive Behavioural Therapy (CBT), Mindfulness and Acceptance and Commitment Therapy (ACT). The range of counselling approaches utilised across government and non-government treatment services will be acknowledged in the Statewide framework.

3.3.3 Case Management and Case Work

Delegates were asked to consider the following proposed differentiation between Case Management and Casework:

> *Case Management is the planning and brokering of services; whereas Casework is the implementation or actual doing of that plan*



Graph 16 shows that 56% of delegates agreed with the proposed distinction between case management and case work, a further 23% partially agreed and 17% disagreed.

The following comments provide an overview of the issues raised by those participants who responded 'yes':

- *Agree that this is what it should be defined as across the sector. Difficult to ensure that these definitions translate to established meanings ingrained within services.*
- *Add "coordinating and monitoring" to the definition of case-management.*
- *I do agree with the statement, but it is probably too simplistic. I think case management encompasses casework, but includes the planning and brokering of services.*

The following comments provide an overview of the issues raised by those delegates who responded 'somewhat':

- *Case management is supervision of the planning and brokering of services as well the support of the practitioners. Casework is what the practitioner does with the client on behalf of the client. Case management is agency driven. Casework is practitioner and client driven.*
- *A case manager can do casework and vice versa.*
- *Somewhat, however both names aren't that client friendly.*

The following comments provide an overview of the issues raised by those delegates who responded 'no':

- *Disagree. Case management is in my view managing your client's case, that is from whoa to go. Case Manager is a term used on ATODS-IS as well to indicate the clinician managing the client's treatment*

- *I think case management also relates to attribution of responsibility for the individual's case plan and levels of responsibility. I like the Turning Point definitions and descriptions of case management (see Turning Point resources. These describe the forms and intensity of service provision)*
- *No differentiation. I could not separate them, unless clear it is a brokerage case management model, which I would not support.*

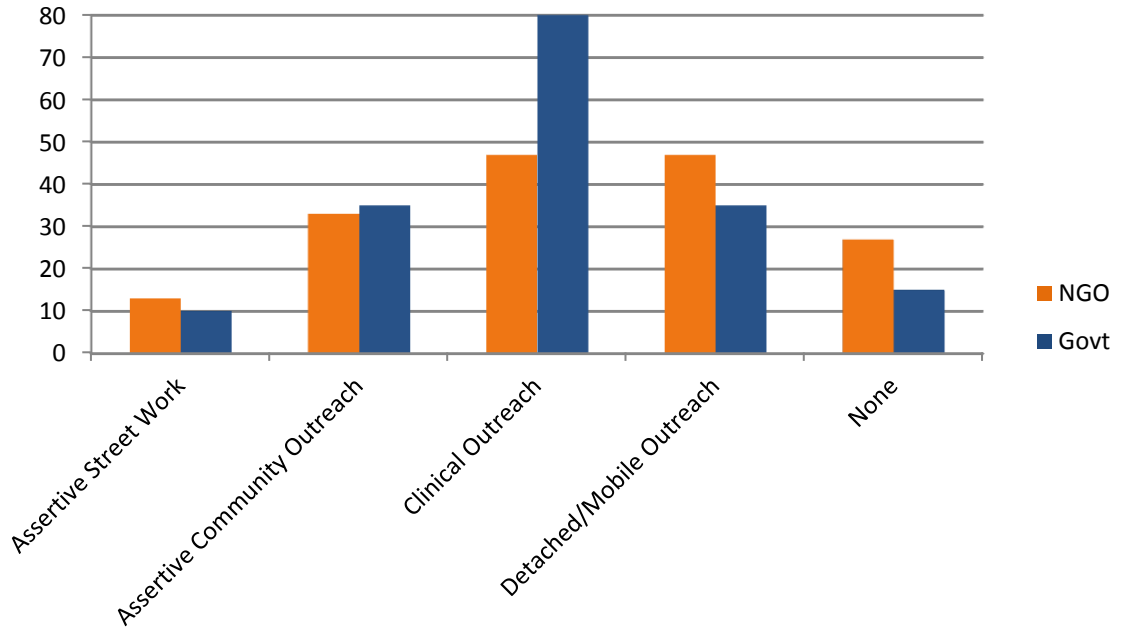
The following comments provide an overview of the issues raised by those delegates who did not respond:

- *Case management as used in one service is: the implementation or actual doing of that plan; the person responsible for the coordination of care, the main contact for the client. Even though case management is the term used there is no brokering of services and the planning of care is primarily internal and as well external agencies it is mainly a one-to-one referral.*
- *I see them as the same and use case management rather than casework.*

A full list of comments provided can be found at Appendix 5.

3.3.4 Outreach

The survey of both the government and non government treatment services included the identification of outreach approaches used across the sector.



Graph 17 shows that the most common form of outreach for both government and non government services was clinical outreach (80% and 47% respectively), followed by detached/mobile outreach (35%/47%) and assertive community outreach (35%/33%).

Participants were provided with the following proposed definitions for the types of outreach commonly used across the sector in the Delegate Information Pack and were asked to provide

feedback to any member of the Organising Committee if they wished to suggest changes. No feedback was received.

Assertive Street Work	Actively looking for individuals who are not currently in AOD treatment in public space locations such as the streets, malls, parks, shopping centres etc, sometimes after hours.
Assertive Community Outreach	Actively looking for individuals who are not currently in AOD treatment at other health, social and accommodation service settings, such as hospital EDs, Centrelink offices, boarding houses etc.
Clinical Outreach	Structured, planned work with clients in another health or support service's venue, such as a hospital, health service, community centre or youth service
Detached / Mobile Outreach	Structured, planned work with clients in their own homes, workplaces or other agreed settings.

3.4 Treatment Planning and Referral

3.4.1 Treatment Planning

Delegates were asked to discuss two questions related to Treatment Planning processes:

1. In your experience, what are the key elements of a 'good' treatment plan?
2. What might be the triggers to review a treatment plan?

Eighty-two responses were provided to question one, which could be grouped into the following themes:

- Client centred
- Focussed on individual needs
- Achievable
- Strengths-based
- Fluid and flexible with capacity to adopt different case planning models to suit client needs
- Negotiated between the worker and the client
- Purposeful
- Includes short, medium and long term goals
- Regularly reviewed
- Culturally appropriate and sensitive
- Outcomes focussed

Fifty nine responses were provided to question two, which could be grouped into the following themes:

- Change in client circumstances
- Standard part of the service eg every three months
- Client request
- Stagnation of process

- New information
- Change in setting or treatment type

3.4.2 Referral

Delegates were asked to discuss two questions related to referral practices:

1. What might be important for our clients when assisting them to be referred to other services?
2. What might a best practice referral look like?

Eighty responses were provided to question 1, which could be grouped into the following themes:

- Informed consent – share assessment information where possible to reduce the need for the client to retell their story
- Clinician understanding of services offered by other agencies
- Supportive
- Followed up with client and service to see how it went
- Process explained to client
- Documented
- Culturally secure
- Integrated with the treatment plan

Fifty-four responses were provided to question 2, which could be grouped into the following themes:

- Seamless
- Active
- Include a discharge summary for the referring service (where applicable)
- Followed up
- Good consent/confidentiality processes
- Getting feedback from clients on the referral process
- Clarity regarding continuing responsibility and lead agency supporting client

3.5 Case Coordination and Service Integration

Case Coordination and service integration are acknowledged across social services as important in addressing the needs of clients with multiple and complex needs (eg housing, mental health, employment, education, etc). What is less clear is the extent to which case coordination and service integration activities are employed by government and non-government treatment services and formally documented in the client's treatment plan.

Participants were asked to break into small groups to discuss four scenarios to identify:

1. Which services (or people) might you need to coordinate efforts with in your scenario?
2. What tools, templates or resources would you need to do this effectively?
3. What are some core principles of good case coordination?
4. How can we balance the need to preserve client confidentiality and privacy with the need to share information and coordinate our efforts with other service providers?

The following sections outline the four scenarios and provide an overview of the responses of delegates.

3.5.1 Lucy

Lucy is a 14 year old Pacific Islander girl who lives in the outer suburbs of a regional town in Queensland. Since her parents split up 12 months ago, Lucy has become increasingly disinterested in school and now frequently truants. She spends most evenings and all weekend hanging out with other transient/homeless young people in the local park and shopping centre, where she regularly uses inhalants. She is known to police, child safety and youth justice after being busted repeatedly for stealing deodorant from the local supermarket. She has started accessing the local youth service which employs a Youth AOD Worker who is assigned her case.

Three groups considered Lucy's case scenario. Delegates identified the following services that might assist in coordinating support for Lucy:

- Youth AOD Services
- Alternative Education Services
- Intoxication Management Services (VSM services)
- Emergency Accommodation service

Delegates identified the following tools, templates and resources that might assist in supporting Lucy:

- Big Sister Program
- Shared care and crisis management plans
- Family meetings
- Shared assessment

Delegates identified the following core principles for coordinating support for Lucy:

- Culturally appropriate family engagement
- Communication
- Age appropriate support services

Delegates identified the following strategies to balance issues around confidentiality when providing support to Lucy:

- Lead agency ensures competent case management
- Informed consent of Lucy and family for coordinated care
- Adequate risk of harm assessment

3.5.2 Charlie

Charlie is a 38 year old single father of 2 children for whom he has full custody. Charlie has been out of work for 3 years since injuring his back on a construction site. He was prescribed Oxycontin to deal with his chronic back pain from one doctor and has also secured a steady supply of benzodiazepines from another. He now has a significant prescription opioid dependence and is using approximately 400mg/day alongside 10mg Xanax, as well as alcohol. One day a worker from child safety knocks on his door following a notification from his children's school. The teachers there are concerned about their welfare at home. He comes seeking your help as he doesn't want to lose his kids.

Delegates identified the following services that might assist in coordinating support for Charlie:

- Family Support / Parents Under Pressure / support from friends
- Withdrawal Support (HADS?) / Rehab / AA or NA??
- ATODS Medical review / OTP?
- GP for pain management issues
- Child Safety support
- Education
- ICYS / Centrelink / ACT for Kids / KIF / RAI / Drug Arm

Delegates identified the following tools, templates and resources that might assist in supporting Charlie:

- Initial biopsychosocial assessment (eg DASS21)
- Appropriately skilled staff
- Uniformity of tools where possible
- Good careplan

Delegates identified the following core principles for coordinating support for Charlie:

- Focus on identifying his priorities and goals
- Safety for all
- Not excluding family and friends
- Client focused, Strengths-based, Non-judgmental, Empathy

Delegates identified the following strategies to balance issues around confidentiality when providing support to Charlie:

- Service Level Agreements between agencies
- Explained, signed and witnessed client consent forms

3.5.3 Molly

Molly is a 50 year old Aboriginal woman who has an acquired brain injury following a car accident she was involved in 5 years ago. Since the accident she has lost significant cognitive function and experiences regular memory loss, has been unable to find work, keep friendships or maintain independent living. Since the accident Molly has become increasingly alcohol dependent, drinking between 30 and 40 standard drinks per day. She is on the DSP and lives in a boarding house style accommodation program where she receives some, albeit very limited help from an external support person. One Monday, this support person brings Molly into your service as Molly has been in a major fight (again) and is also suspected of having been sexually assaulted. Molly is really shaken up and says she wants to go to detox and rehab.

Delegates identified the following services that might assist in coordinating support for Molly:

- Detox services
- GP review / health centre
- Sexual health check
- Rehab service
- Contact / Referral / Intake with AOD Service

Delegates identified the following tools, templates and resources that might assist in supporting Molly:

- Assessment and referral
- People resources ie Indigenous services, domestic violence resources, sexual assault services
- Increase external supports
- Capacity issues to consider

Delegates identified the following core principles for coordinating support for Molly:

- Information sharing
- Effective and clear communication
- Cultural Safety
- Central identified case manager
- Regular / ongoing monitoring and review
- Prioritise crisis intervention / plan
- Consider Molly's involvement and inclusiveness
- Query acquired brain injury and its impact on Molly's decision making capacity

Delegates identified the following strategies to balance issues around confidentiality when providing support to Molly:

- Consent from Molly
- Who takes on guardianship??

3.5.4 Harry

Harry is a white, 23 year old kitchen hand from Brisbane who still lives at home. He likes to work hard and party hard. He believes he is homosexual and has had a small number of sexual encounters with males, although he has kept this a secret from everyone else, including his parents, who he knows are homophobic. Whilst he has always been a moderately heavy drinker, pot smoker and occasional ecstasy user, a new work colleague has introduced him to crystal methamphetamine and seems to have a constant, good quality supply. Over the past 6 months, Harry's use has become increasingly frequent to the extent that he is now using almost every day and he recently initiated into injecting. Last week he lost his job and his parents know he is using and have threatened to kick him out if he doesn't stop, however he is too scared of the comedown to stop. He is starting to look very thin, constantly feels anxious and paranoid and is losing friends fast. The other day he thought he may have even heard voices, and the NSP worker recommends that he see a counsellor.

One group considered Harry's case. Delegates identified the following services that might assist in coordinating support for Harry:

- Alcohol and other drugs counselling
- Sexual health
- Withdrawal management
- LGBTI support
- Mental health

Delegates identified the following tools, templates and resources that might assist in supporting Harry:

- BBV testing
- Sexual health check
- Mental State Examination
- Severity of Dependence Scale

Delegates identified the following core principles for coordinating support for Harry:

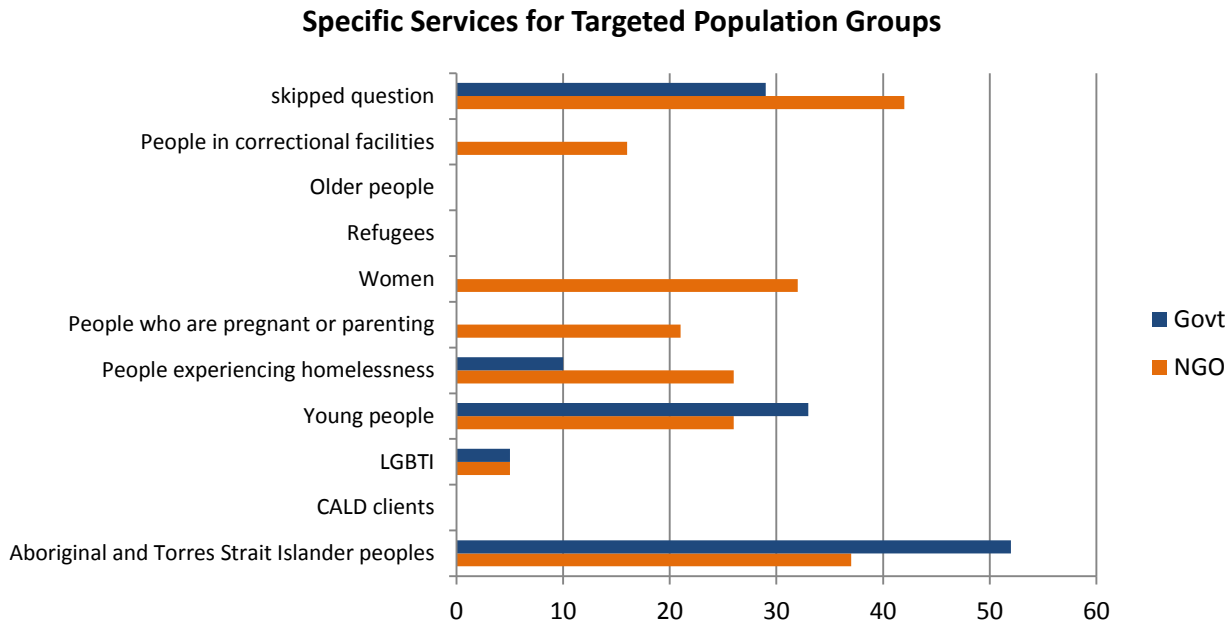
- Respect
- Confidentiality
- Harm reduction

Delegates identified the following strategies to balance issues around confidentiality when providing support to Harry:

- Informed consent
- Patient controlled e-health record

3.6 Work with Specific Populations

The surveys conducted prior to the Convention indicated that government and non government treatment services offered a range of specialised services to specific population groups, as indicated in the graph below.



Graph 18 shows a clear gap in specialist services for CALD clients, refugees and older people, with no current treatment services providing specialised alcohol and other drug services to these groups.

Based on this information, delegates at the Convention were asked to organise themselves into small groups to consider the practice principles of working with a range of specific population groups, with the principles identified outlined by population group below.

3.6.1 Intoxicated Clients

Participants identified the following as essential elements in working with intoxication:

- Effective risk management (to client and staff)
- Provision of safe areas for sobering up (quiet, calm, food and drink available), as an alternative to using Emergency Departments or Watch houses
- Access to basic first aid and links with tertiary centres where client deteriorates

3.6.2 Criminal Justice Clients

Delegates identified the following as essential elements in working with criminal justice clients:

- Risks associated with substance use in correctional facilities (eg increased risk of BBV transmission through needle sharing)
- Support transition from correctional facility to community (relapse risk)
- Understand behavioural issues as related to survival whilst incarcerated and may be difficult to make the transition to living in the community

- Engagement barriers for mandated clients

3.6.3 Culturally and Linguistically Diverse Clients

Delegates identified the following as essential elements in working with clients from Culturally and Linguistically Diverse backgrounds:

- Language barriers
- Seek to understand cultural values of client
- Potential effects of trans-generational trauma
- Modifying assessments/language to be relevant for the client

3.6.4 Pregnant Women and Parents

Delegates identified the following as essential elements in working with pregnant women and parents:

- Understand that the fear of child safety intervention may prove a barrier to engagement in treatment and establish clear agreement with client to address this
- Seek to understand the dynamics of family relationships (partner, grandparents, siblings, etc)

3.6.5 Refugees

Delegates identified the following as essential elements in working with refugees:

- Understanding how trauma impacts on substance use
- Link mainstream services with culturally appropriate support
- Engage refugee organisations to support cultural understanding of staff
- Additional resource costs for interpreters

3.6.6 People Living in Rural and Remote Areas

Delegates identified the following as essential elements in working with people living in rural and remote areas:

- Flexible service delivery (after hours, outreach, telehealth, upskilling community members)
- Links with GPs
- Ensure support systems for workforce to avoid burnout
- Understand issues around confidentiality and the perceived stigma of AOD issues and related services

3.6.7 Young People

Delegates identified the following as essential elements in working with young people:

- Services and advice must be age appropriate
- Involve young people in decision making
- Importance of harm minimisation approach

- Understanding the stage of use the young person is at (from experimenting to habitual use)
- Importance of holistic approach
- Importance of assertive outreach services

3.6.8 Lesbian, Gay, Bisexual, Transgender and Intersex People

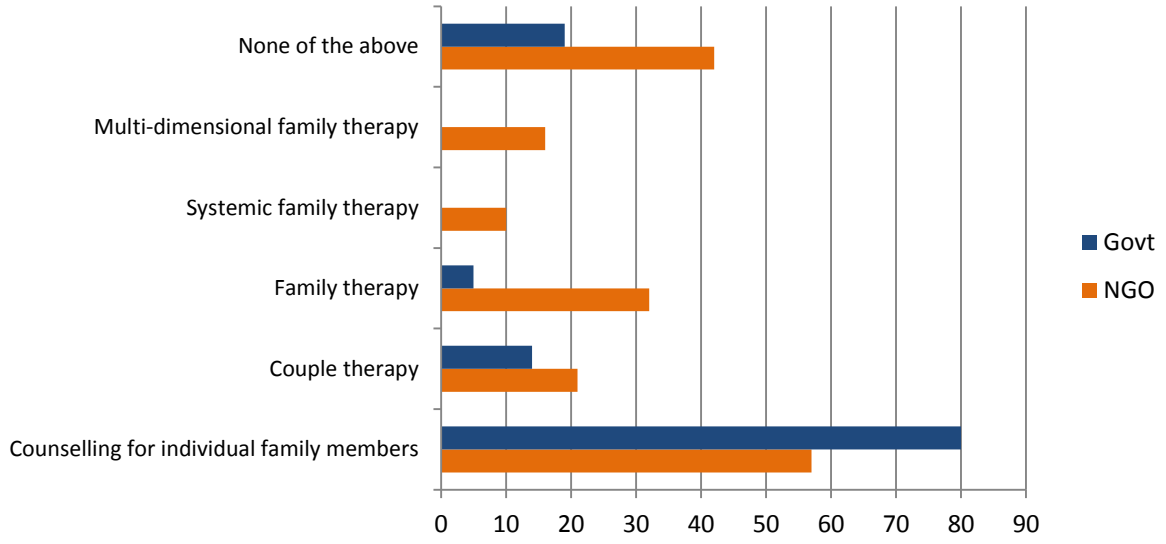
Delegates identified the following as essential elements in working with clients who identify as lesbian, gay, bisexual, transgender or Intersex:

- Understand the limits of practitioner expertise
- Remember that sexuality is not the presenting issue
- Respect and acceptance
- Consider age (competence)

3.6.9 Family and Significant Others

As part of the pre-convention surveys, delegates were asked if their service provided specific services for family and significant others of people experiencing problematic alcohol and other drug use.

Services Proivded to Family and Significant Others



Graph 19 shows the majority of both government and non-government services offered counselling for individual family members (80% and 57% respectively).

Delegates identified the following as essential elements in working with family and significant others of drug users:

- Identifying functional versus dysfunctional family involvement
- Teach ownership of choices and decisions
- Understanding who is involved in the family unit
- Inclusion

3.6.10 People Who Inject

Delegates identified the following as essential elements in working with clients who inject drugs:

- Issues around providing needle and syringe exchange and treatment services aimed at cessation of use in the one service
- Injecting related injuries
- BBV risk screening
- Broad based approach that responds to physical and mental health issues

3.7 Working with Aboriginal and Torres Strait Islander Communities

The surveys identified the most frequently serviced specific population group was Aboriginal and Torres Strait Islanders.

Delegates were asked to discuss two questions related to working with Aboriginal and Torres Strait Islander communities:

1. What are the key principles underpinning culturally secure practice within Aboriginal and Torres Strait Islander clients and communities?
2. How can the Qld AOD sector better support the work of community controlled AOD services?

Eighty responses were provided to question 1, which could be grouped into the following themes:

- Respect and appreciate the diversity within Aboriginal and Torres Strait Islander cultures
- Establish links with the community and elders
- Watch all elements of communication from clients (body language, verbal language, etc)
- Understand and acknowledge the impact of colonisation
- Engagement of Indigenous staff
- Important to understand the impact of inter-generational trauma

Forty-seven responses were provided to question 2, which could be grouped into the following themes:

- Genuine collaboration and partnerships
- Employ Aboriginal and Torres Strait Islander staff
- Learning from each other – between NGO and government, through cross agency placements
- Flexible referral pathways
- Culturally appropriate resources for NGOs

3.8 Engaging and Involving Service Users

Delegates were asked to discuss two questions related to engaging and involving service users:

1. In what ways does your service engage with/and or seek input or feedback from your clients?

2. How can we better engage with users within our services?

Forty-seven responses were provided to question 1, which could be grouped into the following themes:

- Feedback forms, surveys, questionnaires and suggestion boxes
- Client meetings, focus groups, consultations
- Exit interviews
- Peer support
- Resourcing and reimbursement for client participation

Forty-seven responses were provided to question 2, which could be grouped into the following themes:

- Use of social media/technology
- Advocacy training for clients
- Independent support mechanisms for client engagement
- Peer support workers

3.9 Aftercare and Exit

Delegates were asked to discuss the key principles underpinning effective aftercare.

Thirty-eight responses were provided to the question, which could be grouped into the following themes:

- Commence planning for exit at the start of service (this was also articulated as movement towards independence, not closure)
- Flexible, achievable
- Client-focussed, client-driven
- Planned follow-up
- Acknowledgment that continuing care/aftercare is as important than the treatment

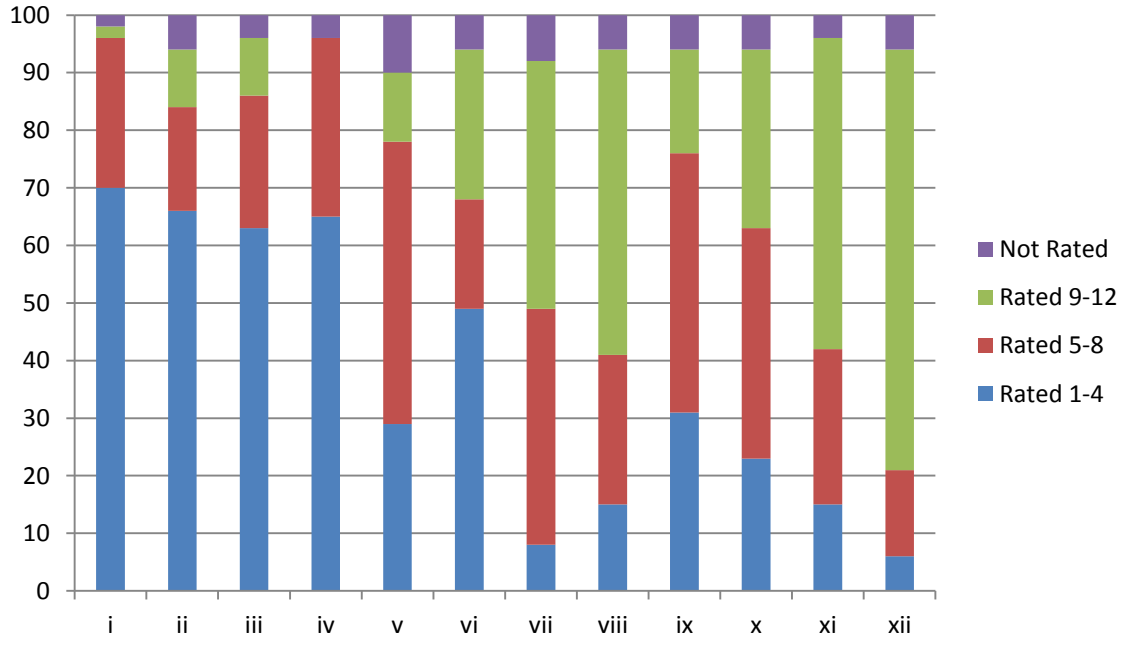
4. Measuring Client Outcomes and Service Effectiveness

There is an increasing awareness of the need to better articulate how the investment in health and community services impacts on individuals, families and communities. Initial efforts to identify client outcomes have noted how difficult it is to correlate the proportion of client outcomes associated with treatment and support provided by the AOD sector and the proportion associated with other factors in the client's life. However, a number of domains have been identified that experts agree can be reasonably expected to be influenced by treatment and support services and a range of instruments have been developed that seek to measure outcomes. As the pre-convention surveys identified that most services in Queensland are not currently working with an outcome measure, the Organising Committee considered it important to gather delegate opinions on the domains most relevant to their service setting.

4.1 Measuring Client Outcomes

The purpose of measuring treatment outcomes for clients is to better develop our understanding the extent to which particular interventions impact a client's ability to live a meaningful life and in so doing seek to deliver those interventions that are most likely to produce the impact we are seeking. Delegate discussions at the Convention concluded that clients of alcohol and other drug services often have multiple and complex needs, so it is not the case that the same outcomes would be sought for every client. The Organising Committee identified 12 possible outcome 'domains'. Delegates were asked rank these domains by importance and relevance to their work:

i. Changes in amount/frequency of alcohol and/or other drug use;
ii. Changes in risky behaviour;
iii. Changes in physical health;
iv. Changes in mental health;
v. Changes in self-esteem;
vi. Increase in client's knowledge of health and AOD risks/harms;
vii. Changes in housing/accommodation;
viii. Changes to participation in education/training/work;
ix. Increase in client's life skills;
x. Changes in client's relationships with partners, family and friends;
xi. Changes in criminal/offending behaviour; and
xii. Ability to comply with legal or statutory directives.



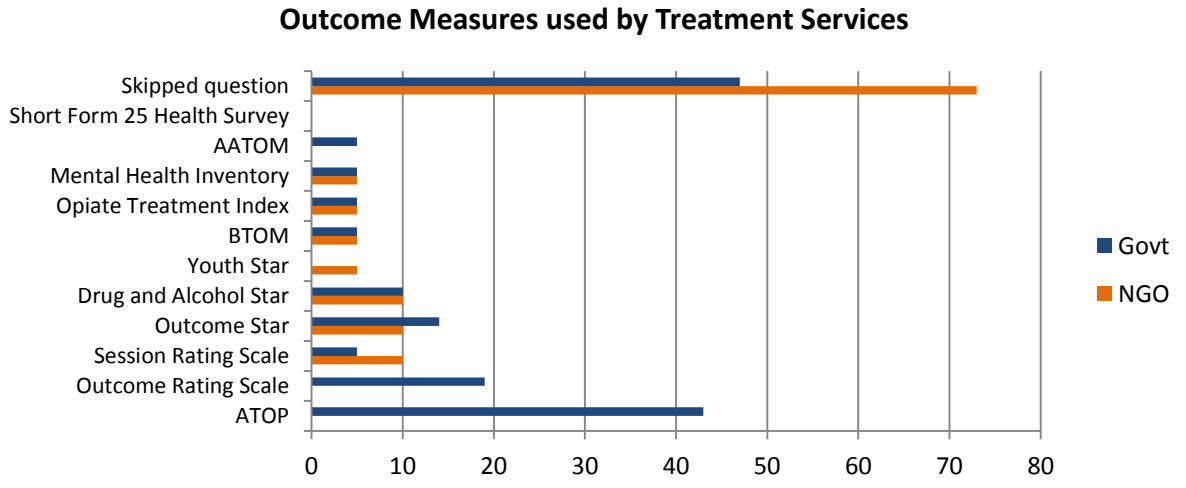
Graph 20 shows that more than 50% of respondents considered domains i, ii, iii and iv as the top four domains that could be influenced by AOD treatment services. More than 40% of respondents considered domains vii, viii, xi and xii as domains less likely to be influenced by AOD treatment services.

Many delegates commented on the difficultly of this exercise, as they considered desired treatment outcomes to be contextually specific to the individual (which is consistent with the principles of client-centred care). A number of delegates also commented that only some of the domains (eg changes in amount/frequency of alcohol and/or other drug use, changes in risky behaviour and increase in knowledge of health and AOD risks/harms) could be reasonably attributed as 'outcomes' of treatment, while others (eg changes in housing/accommodation, changes in participation in education/training/work) were more likely to be impacted by factors beyond treatment (though delegates acknowledged treatment might have some indirect impact).

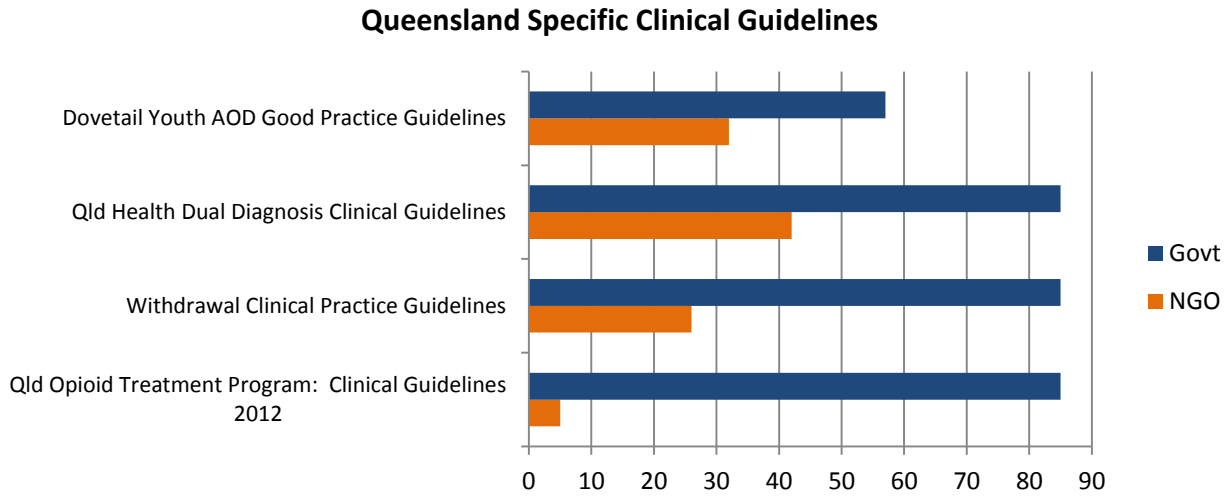
In any case, establishing a hierarchy of need or 'order' of priority domains is an important initial step the process of identifying or developing outcomes measurement tools that could apply across the majority of treatment settings.

4.2 Measuring Service Effectiveness

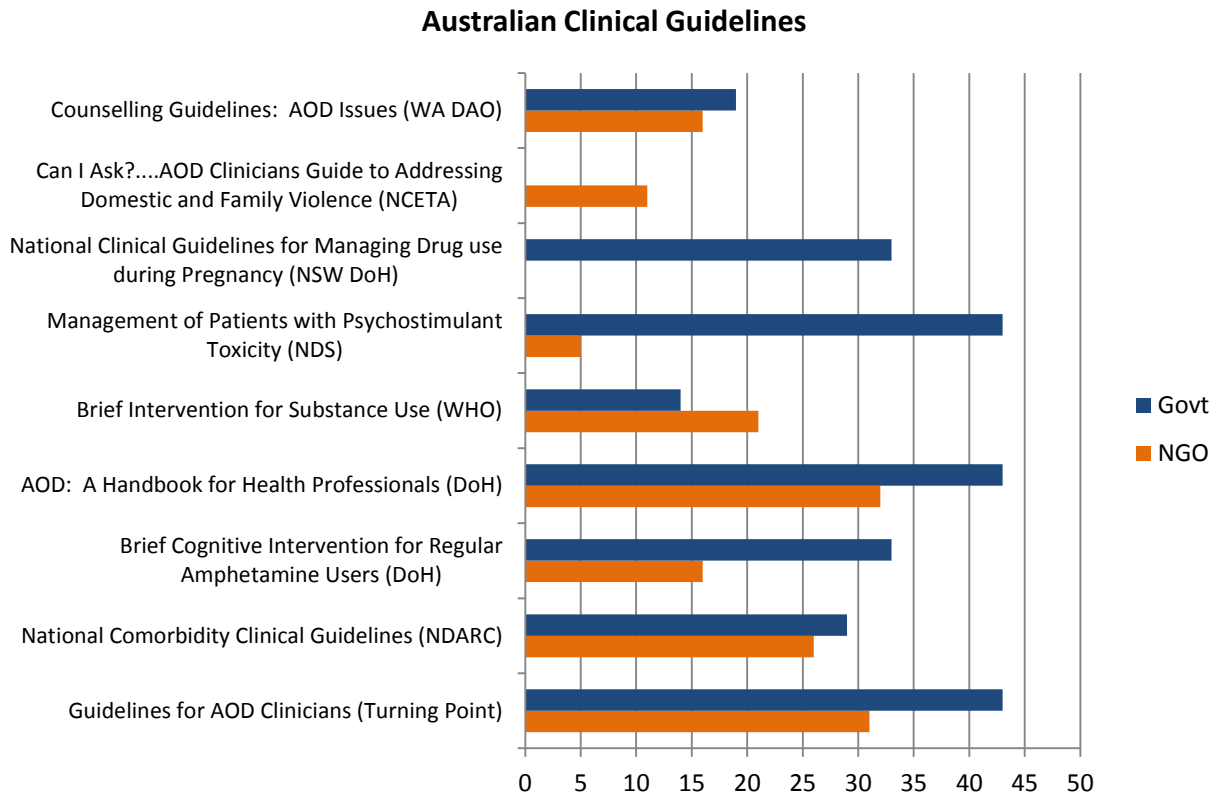
While there are a range of outcome measures available for use by AOD treatment services, the pre-Convention survey's indicated there was no one tool that was commonly used across services. Indeed, the majority of both government and non-government services skipped the question altogether. Anecdotal advice indicates that those services who are working with an outcome measure have only recently adopted it and that there is something of a disconnect between the outcome domains they wished to measure and the availability of tools to measure these domains (eg changes in use, changes in risky behaviour, social and emotional wellbeing, etc). Some tools are freely available on the internet, while others require providers to subscribe to a database in order to collate and analyse results. There is a high degree of consensus around the value of measuring service effectiveness and a willingness to do so, but there remains a degree of uncertainty around how to progress to the next step.



Graph 21 shows the majority of treatment services are not currently using any of the outcome measurement tools identified as appropriate for alcohol and other drug treatment services.



Graph 22 shows the Queensland specific clinical guidelines used by government and non-government services.



Graph 23 shows the Australian clinical guidelines used by government and non-government services.

5. Sector and Workforce Development

The National Drug Strategy 2010 – 2015 includes a commitment to workforce development, on the basis that "an appropriately skilled and qualified workforce is critical to achieving and sustaining effective responses to drug use" (p20, NDS 2010-2015). The Intergovernmental Committee on Drugs (IGCD) has endorsed the following definition of workforce and sector development articulated by the National Centre for Education and Training on Addiction (NCETA): "a multi-faceted approach which addresses the range of factors impacting on the ability of the workforce to function with maximum effectiveness in responding to alcohol and other drug related problems. Workforce development should have a systems focus. Unlike traditional approaches, this is broad and comprehensive, targeting individual, organisational and structural factors, rather than just addressing education and training of individual mainstream workers" (www.nceta.flinders.edu.au)

Delegates were asked to discuss the sector and workforce development needs of the Qld AOD sector. Fifty-five responses were provided to the question, which could be grouped into the following themes:

- Development of a model of care for the sector
- Improved access to training for frontline workers
- Stigma reduction for alcohol and other drug clients in the community and the health system
- Resourcing accreditation support similar to the work of WANADA
- Opportunities for professional development in rural areas
- Mandatory clinical supervision that is separate to line supervision
- Placements in other AOD services to enhance skills and collaboration
- User friendly web based guide on servicing AOD in rural hospital settings for doctors new to the area, etc

6. Convention Resolutions

The final session of the Convention consisted of a large group discussion with delegates endorsing the following resolutions:

Supporting services

Delegates insist we should not conflate the budgets for alcohol and other drug and mental health work – integration of services should not equal integration of budgets.

Delegates support the need for a robust and well supported Community Controlled alcohol and other drug sector.

Delegates advocate for a statewide service to provide clinical support to rural and remote health services (eg telehealth advice on detox and withdrawal).

Delegates highlight the need for more sector development activities to be undertaken in regional areas.

Supporting clients

Delegates support the need for discussions with clients (past and present) across services to identify better ways to engage with and support clients.

Delegates call for the development tools and resources to support organisations to better engage clients (past and present), ensuring a feedback loop to check on improvement.

Delegates call for the implementation of strategies to reduce stigma towards alcohol and other drug service clients from other parts of the health system.

Delegates support the development of an e-health record for alcohol and other drug service clients to support seamless delivery of services.

Supporting people who use substances

Delegates support the need for a campaign aimed at reducing stigma in the community for people with AOD issues.

General

Delegates support the need to conduct an annual Qld AOD Sector Convention

Delegates support the need for consultation to clarify where alcohol and other drug and mental health treatment and prevention services should be integrated and where there is a place for separate and distinct services.

Delegates reaffirm the need for and relevance of a stand-alone alcohol and other drug treatment and prevention sector.

Delegates acknowledge the causal effect of the social determinants of health on problematic substance use and call on governments to invest in population based prevention strategies and interventions, including those that focus on place-based strategies.

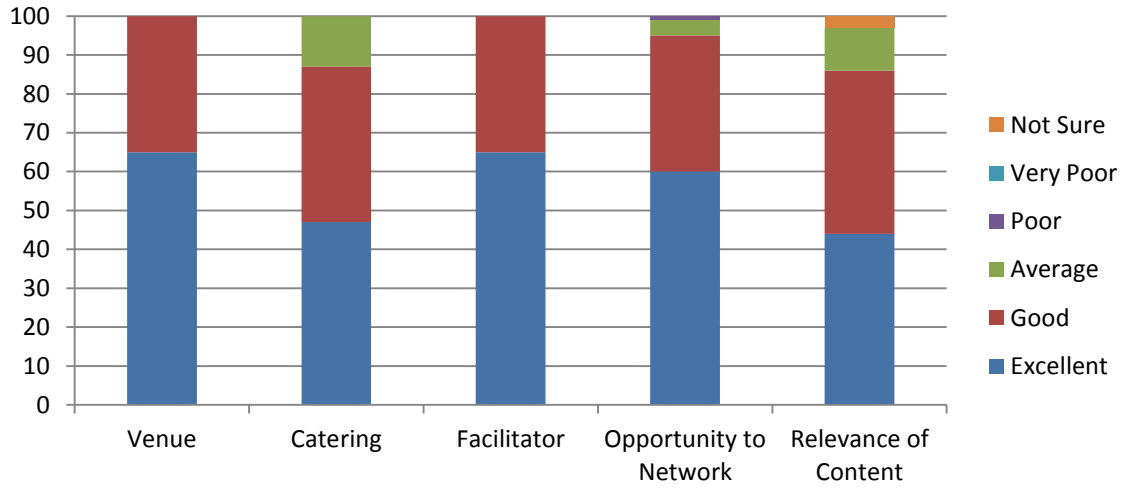
Delegates call on governments to ensure alcohol and other drug issues are on the primary health agenda.

QNADA, Dovetail, QAIHC and QISMC work with the State Government to continue to build connections and partnerships across the alcohol and other drug sector.

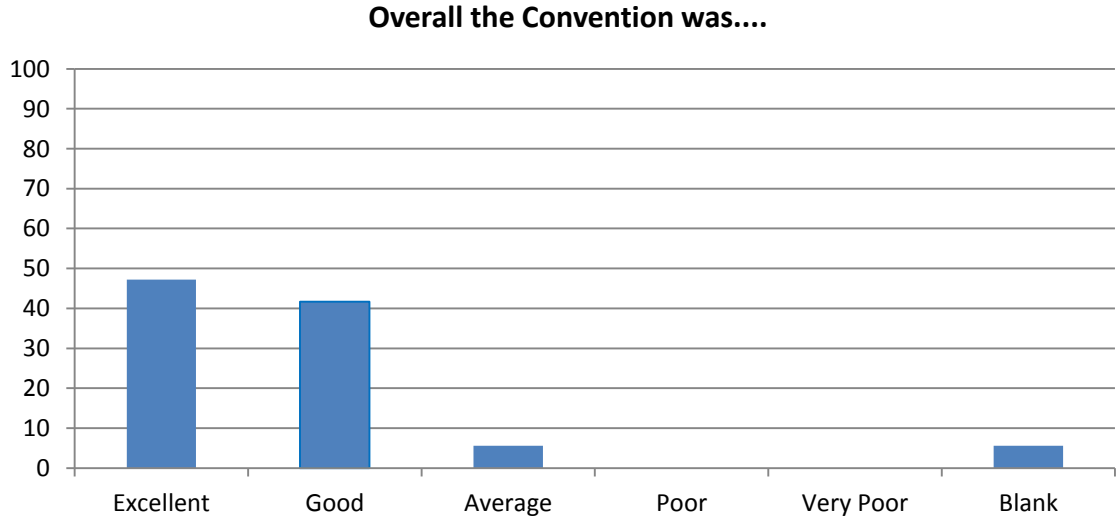
Delegates were also provided with space to offer general comments, ideas and suggestions in their workbooks. A full list of these comments is provided at Appendix 6.

7. Evaluation

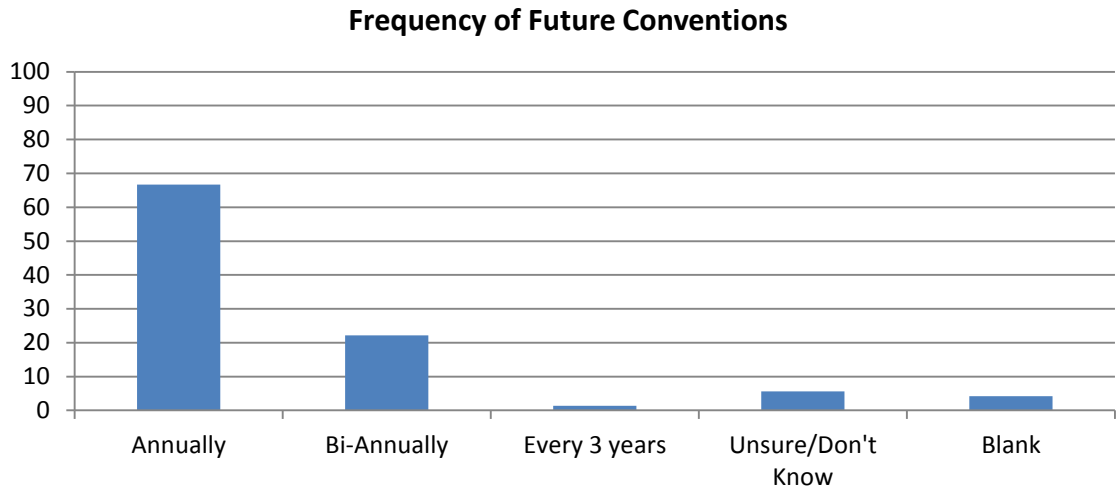
Delegates were asked to provide feedback on the Convention. Seventy-two of the 107 delegates completed the evaluation form. The following graphs illustrate the collated responses.



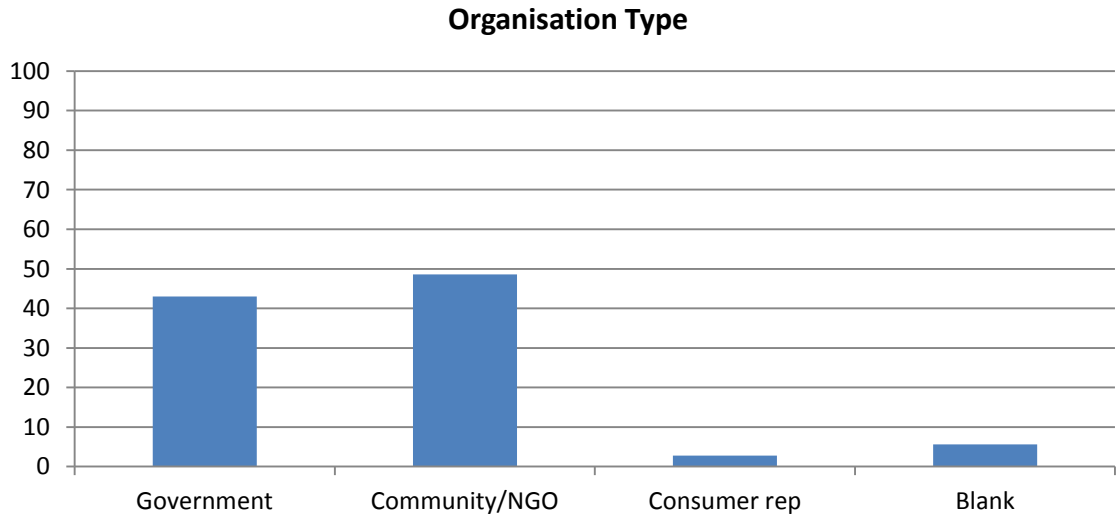
Graph 24 shows that 100% of participants rated the venue and the facilitator as either 'excellent' or 'good', 95% rated the opportunity to network as either 'excellent' or 'good', 87% rated the catering as either 'excellent' or 'good' and 86% rated the relevance of the content as either 'excellent' or 'good'. One percent of participants rated the opportunity to network as 'poor'. No participants rated any of the items as 'very poor'.



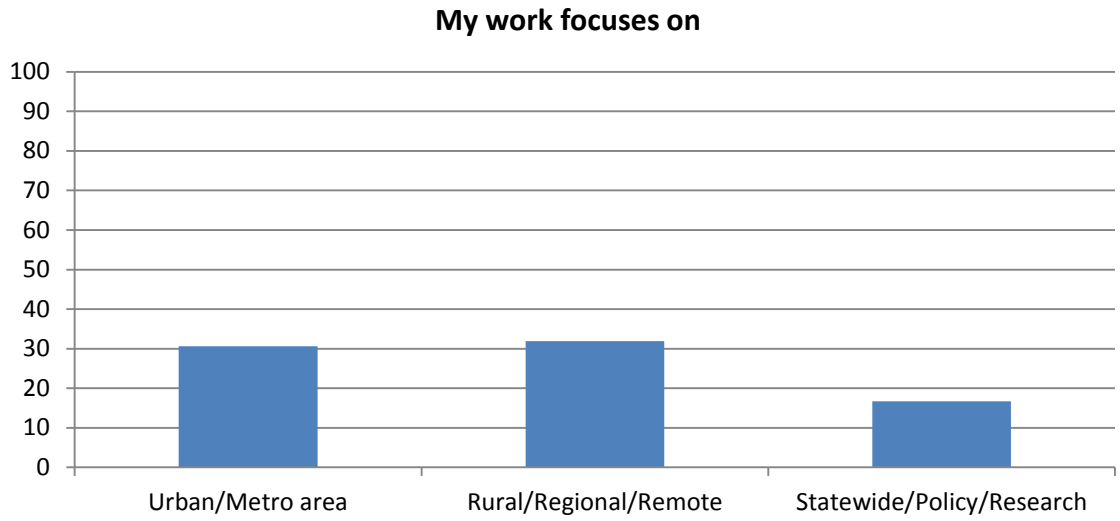
Graph 25 shows 88.9% of participants rated the Convention as Good or Excellent. 5.6% of participants rated the Convention as average or did not respond.



Graph 26 shows 66.7% of participants thought future Conventions should be held annually, 22.2% bi-annually and 1.4% every three years.



Graph 27 shows 48.6% of participants were from Community or non-government organisations, 43% were from government, 2.8% identified as consumer representatives and 5.6% did not respond.



Graph 28 shows 31.9% of participants work is focussed on rural/regional/remote, 30.6% on urban/metro areas and 16.7% statewide/policy/research.

8. Conclusions

The 2014 Queensland AOD Sector Convention brought together sector leaders from across the state, who were able to report on the application of good practice approaches in frontline service delivery. There was roughly equal representation from urban/metropolitan services and rural/regional/remote services, as well as representatives from statewide/policy/research organisations.

The level of engagement from sector leaders was high, with many delegates commenting that they valued the opportunity to meet colleagues from across the state as much as they valued the opportunity to reflect on and discuss the elements of good practice in service delivery. 95% of delegates rated the opportunity to network as either excellent or good.

There was a high degree of consensus amongst delegates on appropriate screening and assessment and counselling approaches, as well as good practice approaches to waiting list management, treatment planning and referral and working with clients with multiple and complex needs suggesting a high degree of consistency of approach in the way services are delivered across the state.

There was less clarity around good practice approaches to outcome measurement, with many services indicating they do not currently work with an outcome measure. This result was not surprising, given the relatively recent focus on this area by both the sector and funders. It seems reasonable to conclude there would be benefit in supporting the sector to develop good practice approaches in this area to ensure the same consistency of approach across the state. Discussions on the day highlighted the need for outcome measures to be flexible enough to be individualised and informed by the client's treatment plan and goals.

Delegates indicated an interest in making the Convention a regular event, with 66.7% preferring an annual event and 22.2% favouring a bi-annual event.

Appendix 1: List of Convention Delegates

Name	Organisation	Name	Organisation
Adrian Kelly	Centre for Youth Substance Abuse Research	**Charlene Thompson**	NPA Women's Shelter
Ailsa Lively	Gindaja Treatment and Healing Indigenous Corporation	**Charlie Blatch**	Goldbridge Rehabilitation Services
Alan Gude	Brisbane South Metro HHS	**Cheri Yavu-Kama-Harathunian**	Indigenous Wellbeing Centre
Alvin Hava	Young People Ahead	**Christine Tamsett**	Salvation Army Recovery Services
Amanda Tilse	Mater Health Services	**Colleen Besgrove**	Darling Downs HHS
Angela Martin	AOD Homeless Outreach Team	**Dallas Leon**	Gidgee Healing
Angela Driscoll	Chill Out Zone	**Dallas Hure**	Qld Drug and Alcohol Council
Annemaree Callander	Brisbane Youth Service	**Daphne Tapim**	Townsville Aboriginal and Islander Health Service
Ara Harathunian	Indigenous Wellbeing Centre	**Dave Warby**	Qld Drug and Alcohol Council
Aubrey Anderson	Youth Substance Misuse Service	**David Pinchin**	Gold Coast HHS
Ben Dougherty	Dovetail	**David Twivey**	Salvation Army Recovery Services
Ben Norris	Qld Department of Health	**David Kaczmarek**	West Moreton HHS
Bernice Smith	Goldbridge Rehabilitation Services	**Dennis Young**	Drug Arm
Bill Kingswell	Qld Department of Health	**Diana Beere**	Queensland Mental Health Commission
Bindi Diamond	Youth Empowered Towards Independence	**Dom Shelley**	Family Drug Support
Brendan Pont	Qld Network of Alcohol and other Drug Agencies	**Don Spencer**	Sunshine Coast HHS
Brett McDermott	Mater Health Services	**Donna Leary**	Mackay HHS
Brian O'Neill	Lives Lived Well	**Eddie Fewings**	Qld Aboriginal and Islander Health Council
Cameron Francis	Dovetail	**Elizabeth Leitch**	Qld Centre for Mental Health Research
Carcia Nullajar	Ferdy's Haven	**Genevieve Sinclair**	Youth Empowered Towards Independence
Carla Schlesinger	InSight Clinical Support Services	**Geoff Manu**	Qld Injectors Health Network
Carmel Ybarlucea	Qld Mental Health Commission	**Gerard Byrne**	Salvation Army Recovery Services

Name	Organisation	Name	Organisation
Grant Robin	Lives Lived Well	**Kath Anderson**	Ferdy's Haven
Greg Fourmile	Gindaja Treatment and Healing Indigenous Corporation	**Kathryn Williams**	Torres and Cape HHS
Hayley Baldwin	Department of Child Safety, Communities and Disability Services	**Kevin McNamara**	Gold Coast HHS
Helen Taylor	Qld Department of Health	**Kevin Fjeldsoe**	Qld Centre for Mental Health Research
Helena Holdaway	Ozcare	**Kylie Read**	Gillies House
Jade De Bruyn	Cape and Torres HHS	**Leigh Beresford**	Dovetail
Jake Najman	Qld Alcohol and Drug Research and Education Centre	**Linda Hipper**	Brisbane South Metro HHS
James Finn	Department of Child Safety, Communities and Disability Services	**Liz Pearson**	Pormpuur Paanth Aboriginal Corporation
Janelle Test	Indigenous Wellbeing Centre	**Liz Toeke**	Young People Ahead
Janet Martin	Qld Department of Health	**Louise Davis**	Boystown
Jeff Buckley	Dovetail	**Mal McCullough**	Ozcare
Jeremy Hayllar	Brisbane North Metro HHS	**Maria Mene**	Cairns and Hinterland HHS
Joanne Brown	Cairns and Hinterland HHS	**Marie Kelly**	Qld Department of Health
Joanne Stitt	Townsville HHS	**Mark Fairbairn**	Brisbane North Metro HHS
Jody Wright	Drug Arm	**Mark Warcon**	Gumbi Gumbi
Joe Conway	Stagpole Street Drug and Alcohol Rehab	**Mark Daglish**	Metro North Brisbane HHS
John Bartlett	Fresh Hope	**Mark West**	Qld Department of Health
John Kelly	Brisbane North Metro HHS	**Mark Ferry**	Ted Noffs Foundation
John Reilly	Townsville HHS	**Mary Anne Collier**	Boystown
Jude Saldanha	Indigenous Youth Health Service	**Matt Noffs**	Ted Noffs Foundation
Judi Krause	Children's Health Qld	**Meredith Harris**	Qld Centre for Mental Health Research
Julie Dignan	Lives Lived Well	**Merrissa Jose**	Youth Substance Misuse Service
Karen Rolfe	Townsville Aboriginal and Islander Health Service	**Michael Stubley**	Drug Arm
Kate Podevin	Qld Department of Health	**Mitchell Giles**	Lives Lived Well

Name	Organisation	Name	Organisation
Nichole Meyers	Consumer Representative	**Sandy Clancy**	West Moreton HHS
Nicola Hayes	Qld Injectors Health Network	**Scott James**	Qld Department of Health
Niki Parry	Qld Intravenous Aids Association	**Sean Popovich**	Youth and Family Services Logan
Paul Letters	Childrens Health Qld	**Sharon Sarah**	Bridges Health and Community Care
Paul Woodward	Ozcare	**Sonia Oleksyn**	South West HHS
Pele Bennet	Qld Aboriginal and Islander Health Council	**Steve Leicester**	headspace
Peter Lehman	North West HHS	**Suzi Morris**	Lives Lived Well
Phil Smith	Brisbane Youth Service	**Trevor Hallewell**	We Help Ourselves
Rebecca MacBean	Qld Network of Alcohol and other Drug Agencies	**Uheina McDonald**	Indigenous Youth Health Service
Rob Rolls	Central Qld HHS	**Vanda Wieczorkowski**	Lives Lived Well
Robert Kemp	Qld Needle and Syringe Program	**Vic May**	Ozcare
Robin Pullen	Salvation Army Recovery Services	**Wayne Mulvany**	Indigenous Wellbeing Centre
Ruth Fjeldsoe	Qld Department of Health	**Will Curtis**	Fresh Hope
Sally Schembri	Ozcare – Mackay	**Yigezu Ergetu**	Qld Aboriginal Islander Alcoholic Services
Sandra Kennedy	Central West HHS		

Appendix 2: Pre-Convention Survey Questions

1. Your name
2. Your position title
3. Your HHS
4. Your service name
5. Your email address
6. Your street address
7. What is the youngest aged client you service provides treatment to?
8. What is the oldest aged client your service provides treatment to? If there is no upper age limit, just type 'no limit'.
9. Are there any other specific eligibility criteria for your service?
10. What professional disciplines are currently employed in your service?
11. Please read the following treatment types and select the one/s which your service currently delivers (mark as many as appropriate):
    a. Needle and syringe program – primary service;
    b. Needle and syringe program – secondary service;
    c. Qld Illicit Drug Diversion assessment and education sessions;
    d. Qld Magistrates Early Referral into Treatment Program (QMERIT);
    e. Qld Court Referral;
    f. Intake and screening;
    g. Assessment only;
    h. Information and education only for individual clients;
    i. Information and education only groups;
    j. Treatment planning and review;
    k. Brief intervention;
    l. Inpatient/residential withdrawal management and support (detoxification);
    m. Ambulatory/outclient withdrawal management and support (detoxification);
    n. Opioid replacement therapy;
    o. Alcohol pharmacotherapy;
    p. Nicotine replacement therapy;
    q. Psychopharmacology for co-occurring mental health conditions;
    r. Therapeutic groups;
    s. Peer support groups;
    t. Mentoring programs;
    u. Therapeutic community;
    v. Standalone client advocacy;
    w. Discharge planning/aftercare/continuing care;
    x. Consultation and liaison.
12. Which specific counselling approaches does your service provide (please note, only mark those approaches that you would promote publicly, for example to other services or on a service brochure. Do not list if you are simply referring to the fact that staff in your team may have been trained in this approach previously:
    a. Psychoanalytic/Psychodynamic therapy;
    b. Cognitive Behavioural Therapy (CBT);

c. Dialectical Behaviour Therapy (DBT);
d. Acceptance and Commitment Therapy (ACT);
e. Narrative Therapy;
f. Mindfulness;
g. Motivational enhancement/interviewing;
h. Contingency Management;
i. Emotional regulation;
j. Solution-focussed therapy;
k. Eye Movement Desensitisation and Reprocessing (EMDR);
l. Animal/Pet related therapy;
m. Art Therapy;
n. Drama;
o. Music Therapy;
p. Exercise/Fitness programs.

13. Does your service provide any outreach services as described below?
    a. Assertive street work;
    b. Assertive community outreach;
    c. Clinical outreach;
    d. Detached/mobile outreach;
    e. No, we don't provide outreach services.
14. Does your service provide casework and/or case management services?
15. Does your organisation provide any of the following residential services:
    a. No we don't provide any residential services;
    b. Short term (less than 3 months in duration);
    c. Medium to long term (longer than 3 months duration);
    d. Supported accommodation – short term (less than 3 months);
    e. Supported accommodation – medium to long term (longer than 3 months duration).
16. If you selected any of the residential options above, please describe the model briefly and the average length of stay.
17. Does your service provide any of the following primary healthcare services:
    a. BBV testing;
    b. Hep B vaccinations;
    c. Hep C related interventions;
    d. LFT level testing.
18. Does your service provide any of the following counselling and support to other people in a client's life, such as partners, family members or significant others:
    a. Counselling for individual family members (eg parents, partners);
    b. Couple therapy;
    c. Family therapy;
    d. Systemic family therapy;
    e. Multi-dimensional family therapy;
    f. No, none of the above.
19. Does your organisation provide a service established specifically for any of the following target groups? Please note, only mark options where you have a stated, dedicated program in place:
    a. Aboriginal and Torres Strait Islander people;

b. Culturally and linguistically diverse people;
c. Lesbian, gay, bisexual, transgender or intersex people;
d. Young people aged between 10 and 25 years;
e. People experiencing homelessness;
f. People who are pregnant or parenting;
g. Women;
h. Refugees;
i. Older people aged over 65 years;
j. People in correctional facilities.

20. Does your organisation provide any other services established specifically for a target group or community not listed above? If yes, please describe.
21. What psychometric assessment or screening instruments do your treatment staff use?
22. Has your service developed or do you use your own assessment tool/s? If yes, what are they?
23. Does your service provide any of the following workforce development activities:
    a. Mandatory internal clinical supervision;
    b. Optional internal clinical supervision;
    c. Mandatory external clinical supervision;
    d. Optional external clinical supervision;
    e. Peer group supervision;
    f. In-house training and professional development for internal staff only;
    g. Training and professional development for both internal and external staff;
    h. Development of clinical practice guidelines, practice resources or other tools.
24. Are there any other training, professional development, sector or workforce development activities that your service delivers? If yes, please provide details.
25. Does your service hold quality accreditation (eg ISO, QIC, etc)?
26. Which of the following Qld specific standards and guidelines do you use or refer to in your work? Please list others you might use or refer to:
    a. The Qld Opioid Treatment Program: Clinical Guidelines 2012;
    b. Withdrawal Clinical Practice Guidelines;
    c. Qld Health Dual Diagnosis Clinical Guidelines;
    d. Dovetail Youth AOD Good Practice Guidelines.
27. Which of the following non-Qld specific standards and guidelines do you use or refer to in your work? Please list others you might use or refer to:
    a. Guidelines for Alcohol and Drug Clinicians;
    b. National Comorbidity Clinical Guidelines;
    c. A Brief Cognitive Behavioural Intervention for Regular Amphetamine Users – a Treatment Guide;
    d. Alcohol and Drugs: A Handbook for Health Professionals;
    e. Brief Intervention for Substance Use: A Manual for Use in Primary Care;
    f. Management of Patients with Psychostimulant Toxicity: Guidelines for Emergency Departments;
    g. National Clinical Guidelines for the Management of Drug Use During Pregnancy, Birth and the Early Development Years of the Newborn;
    h. Can I Ask? An alcohol and drug clinicians guide to addressing domestic and family violence;

i. Counselling Guidelines: Alcohol and other drug issues.

28. How does your service collect and/or store client records?
29. How does your service collect and/or store treatment plans?
30. How does your service collect and/or store the National Minimum Data Set?
31. Does your service use any other client, record or case management database? If so, what is it and why do you choose to use this particular database/system?
32. Does your service use any of the following outcome measurement tools:
    a. ATOPS;
    b. Outcome Rating Scale;
    c. Session Rating Scale;
    d. Outcomes Star;
    e. Drug and Alcohol Star;
    f. Youth Star;
    g. Brief Treatment Outcome Measure (BTOM);
    h. Opiate Treatment Index (OTI)
    i. Mental Health Inventory;
    j. Australian Alcohol Treatment Outcome Measure (AATOM);
    k. Short-Form 25 Health Survey.
33. Are there any other outcome measurement tools that you use or know of? If yes, please list.

Appendix 3: Delegate Comments on the Proposed Mission Statements

4 is comprehensive but complicated whereas 1 is succinct but remains open to interpretation. Just the first section of the 4th statement

I think methodology has to fit with restorative justice principals

Remove the tobacco from the second sentence in 4 - most ATODS are now AODS with the co-joining with Mental health ie MH&AOD

It is fundamental that we know whether services are effective, that is whether they make any difference. The major problem for the sector is the absence of an evidence base and its use in service delivery

To reduce levels of AOD related harm experienced by individuals, families and communities across Queensland

In addition to 4, add a statement referring to coordination/partnerships with other services/sectors

Combination of 1 &2 - To increase the overall health and wellbeing of individuals, families and communities across Queensland by limiting AOD related harm

Risk in mission statement being too broad

The term 'recovery' needs to be intertwined within the statement

To increase the overall health and wellbeing of individuals, families and communities across Queensland by reducing AOD related harm

I like 1 as it is specific to AOD - perhaps combine with 3 to name the community benefit

Need to ensure harm minimisation and prevention are part of our mission statement (AOD specific - 3 and 4 too broad)

1 relates to all areas across the spectrum from prevention to maintenance. It is clear, concise, message can't be lost that the focus is AOD (unlike 2 and 3). 4 is too wordy and repetitive

Reducing harms associated with issues related to AOD use - eg MH, quality of life, offending, violence, relationships, employment, etc. Might be part of some above, but I think to be made explicit as AOD related harm may mean many different direct and indirect things

1 is succinct and clear. I like how it clearly states AOD related harm. 2 and 3 as a mission statement are too broad in my opinion

Add 1 to the end of 2

Modified version of 4 - A qld community with the lowest possible levels of alcohol, tobacco and other drug-related harm, as a result of evidence-informed prevention, treatment and harm reduction policies and services. Or a modified version of 1 - To minimise levels of AOD related harm experienced across Queensland through evidence-informed prevention, treatment and harm reduction policies and services

2 is broad and general although I would like to see 'of people who use drugs and alcohol' written in there so it narrows it down

Perhaps 2 - empowering as a term in the mission statement

To increase the overall health and wellbeing of individuals, families and communities by promoting harm minimisation and prevention strategies that builds on resilience and 'mepower' techniques

Stating it's for health resilience, wellbeing for families communities and individuals is key for inclusiveness throughout the community

To reduce AOD related harm though the provision of evidence informed prevention, treatment, harm reduction and health promotion services and activities

I'd like to add responsive and accessible services

Reworded - A Queensland community with the lowest possible levels of alcohol, tobacco and other drug related harm

1 & 2 linked together with ATODS rather than just AOD - we must remember to include tobacco because it causes the most harm that could be prevented

Would like to see 1 &2 linked together including tobacco

1 and 4 are very similar with 4 being more descriptive

Combine 1 and 2 - get rid of AOD - substitute Alcohol, Tobacco and other drug for those who don't follow

1 and 2 could be combined

1 and 2 could be combined

To increase community awareness of AOD related harms and reduce stigma for those affected by AOD issues

I like 1 and 2

4 is a fantastic vision but not a 'mission' hence why I'm choosing 2 as a mission

Children, youth, families, community

1 Need a prevention focus - To reduce and prevent. 2 Empowering/training community coalitions

Through a range of government and non government initiatives

Combine 1 and 2

Incorporate first part of 1 with all of 3 - To reduce levels of AOD harm for safe, healthy and resilient individuals, families and communities across Queensland

4, but maybe shorter

Appendix 4: Delegate Comments on the Proposed Recovery Statement

Substitute 'services' for models. Substitute 'realistic' for 'reach client identified achievable goals' - realistic for who? (opens to potential for judgemental position). 'which may include a range of outcomes according to client goals)

Recovery, in the AOD treatment setting, can be conceptualised as describing models that seek to work with an individual to identify goals which may include a range of options.

Too many words and recovery and achiving realistic goals is not a logical link. In sum, seems word not helpful, seems imposition from other concept.

Recovery is being substance free

Thinking that recovery should focus on the individual, not the service. So it should start 'recovery services'

Convoluted statement

Recovery doesn't describe the service but rather the client - living well through the identification and achievement of goals etc

If practice is client-centred then the concept/definition of 'recovery' should be client centred ie what is 'recovery' or 'recovered' to that person (ie: not necessarily abstinence)

Must include acknowledgement of individuals own determination of what is 'recovery' for them - what their meaningful goals are. Also must accept that 'recovery' is not necessarily linear, steady or uninterrupted. Recovery may not conform to workers or community expectations

Suggest more of an 'outcome' focus that focuses on functional gains or life lived not behavioural changes (eg reduced use). Look at the mantra of the national mental health commissions re living the life you want/quality of life issues

I think it fails to look at recovery in a bigger picture sense regarding recovery within community, family, life aspects, etc

may include AOD goals, but also psycho-social goals related to relationships, employment and education, legal, health, mental health, quality of life and safety. The above statement also doesn't say enough about the general outcomes and improvements that would mean recovery

I do agree, but recovery also entails education and counselling around drug use

Don't use emotive words such as 'problems'

Culturally: economically assessed per client

As well as other life goals - educational, work or whatever is important to the person

Recovery, in the AOD treatment setting, can be conceptualised as describing services who seek to ***enable*** *an individual experiencing problems related to their substance use to identify and* ***problem solve*** *realistic goals, which may include reduced use, abstinence, or safer using practices.*

Good one!

Recovery oriented AOD treatment services are those that work with individuals experiencing problems…(as above)
Just think that recovery oriented is what we're describing, not recovery (and the recovery word alone is part of the problem - which is largely semantic)

Reduced use may work for some but most will escalate use long term

But still don't like the use of the word recovery - it is not applicable in an AOD treatment setting. Rebecca!! You know this!

Recovery oriented practice in the AOD sector is a process of working with individuals based on their own identified goals

remove conceptualised and use a different word

Not all drug users need to 'recover' and can manage their use healthily and without the need for services/support. It links drug users to being unproductive and ostracized community members until they stop using. We need to be careful with this word

Agree - however our service (resi rehab) must maintain an abstinence approach. However, in aftercare we respect each individuals right to determine their own life and will meet them and work with them where they choose to be

Yes, I think we should link with the recovery oriented mental health definitions, if necessary simply adding a reference re applicability to people with AOD problems (though I don't think necessary)

Recovery is individual. I might be old school but I still like the word holistic (even better 'wholistic')

Recovery is a process whereby an individual returns to (and can improve on) previous levels of health, functional living that may include reduced use, abstinence or safer using practices.

Recovery is an individual concept - we as services are agents of change for the individual to overcome their specific barriers or apprehension.

Recovery belongs to the client, not the service. Therefore a service can be 'recovery oriented', but not a 'recovery service'

Recovery is owned by the client. The AOD treatment assists and supports the client taking responsibility to return to wellbeing and wellness so as to achieve a healthy lifestyle where realistic goals turn into action and safe use practices can be achieved.

Where is the client centred perspective? How does recovery describe a service - a recovery focus is an attribute of a service and there are degrees and levels of recovery possible

change 'realistic' to 'personal' goals

Congruent with what services aim to do. But maybe should say 'recovery-oriented' services is a term to describe… Recovery is an aim, not a service type

I disagree with the use of recovery in the AOD sector. It places a mental health label on AOD, it pushes the sector under MH control, philosophy

So long - can it be condensed? eg Recovery, in the AOD treatment setting, involves working with an individual to identify and achieve realistic goals in regards to their substance use.

Wordy - is there a simpler word (than conceptualised). Is this for clients?

Means different things for different services/consumers is an individual thing. Hard to define as above as trying to encompass everything and says little.

Yes! Harm reduction must be involved. Recovery is a client goal, not a service type. As it is a client goal, it needs to incorporate the whole spectrum of harm minimisation - eg harm reduction

Recovery is a personal goal not service centred. My definition: Recovery is the change of condition an addict strives to achieve when endeavouring to recommit to a more meaningful life. This could be goals aimed at around harm reduction, social inclusion, general and mental health

Also include social integration, psychosocial functioning and social role functioning. Recovery is a personal goal not a service.

Recovery, in the AOD setting, relates to an individual experiencing problems related to their substance use to identify and achieve their own realistic goals, which may include reduced use, abstinence or safer using practices.

Very important that this does not funnel everyone to the same outcome eg abstinence. Important to keep to harm minimisation because if we meet clients where they are at they are more likely to return for help if they want to make more changes. Recovery is very much a mental health term. If you are an alcoholic chances are you will never be able to drink in a controlled way, so how can this be called recovery?

Along with this, minimise associated problems and/or focus on underlying issues.

Re - ongoing outreach services attached to any exiting clients.

Doesn't really make sense to me. Recovery = outcome or process, but is it a service?

I don't believe there is a one size fits all definition to recovery as a concept in the AOD sector

Is this an uncleared base statement - are we able to gather the recovery paradigms that are in the AOD literature and use or note on one of these a reference to the above statement.

Need to add something about achieving your potential despite having a SUD

Recovery focus is the individual consumer, not the service. Focus on individuals achieving a stable, valued and meaningful life in the context of AOD use which may include reduced use, abstinence or safer using practices.

Add all of life situations - recovery is for all of life not just AOD

Appendix 5: Delegate Comments on the Proposed Case Management and Casework Definitions

This is good way to define the distinct differences of the two concepts
Yes, I agree, but don't like the word "case" or "client"
Yes, but it's not really that important
They are different but in most cases it is the same person doing the work
If you're a case manager you are doing case management and casework. They are not mutually exclusive, nor do or should the individual doing case management be 2 different individuals assigned to a client
Although lots of confusion when there are multiple "case managers" managing. Indicates need for shared support plans
I do agree with the statement, but it is probably too simplistic. I think case management encompasses casework, but includes the planning and brokering of services
Case management is the planning, brokering and management of services for a client and their families across the service spectrum. Casework is the operationalising of the case management plan
Add "coordinating and monitoring" to the definition of case-management
Agree that this is what it should be defined as across the sector. Difficult to ensure that these definitions translate to established meanings ingrained within services
I hadn't differentiated between the two previously but the definition works ok for me if it is needed. not sure we aren't into semantics???
It's hard to understand what casework is in this definition - how it differs from the service elements (counselling / rehab etc) that are identified in the case management plan. Shouldn't the case management include the implementation?
Understanding that case management should encompass all facets of planning, brokerage and implementation and actually doing the work
At ATODS we see ourselves as Case Managers - or at least that is what we call ourselves. We do the work, we manage the entire case. We don't broker it out
Case management is supervision of the planning and brokering of services as well the support of the practitioners. Casework is what the practitioner does with the client on behalf of the client. Case management is agency driven. Casework is practitioner and client driven
Or case coordinator?
Case manager VS case worker, Case management does not equal casework. Somehow build in individual clinicians as CMs with responsibility for patient / client
Case management is a contextual concept that is utilised differently depending on service, resources, structure, philosophy etc
A case manager can do casework and vice versa

This is often the same person - it is in my organisation. Hence the name or term means nothing - a waste of time discussing it.
Depends on staff. There is a tendency towards multi-disciplinary approach. This is also translated now into Degree Courses
Case management yes, however casework could be a broader term to incorporate both. I prefer care coordination to incorporate both definitions / roles
Somewhat, however both names aren't that client friendly
Case management is managing and identifying the client's needs and monitoring and reviewing of case plan (and adjusting to meet client's needs). Casework is identifying client's needs, itemising what client's goals are (prioritise) - identifying the services / programs that helps support's client's case plans
We have the terms case management and case managers and they do all of the above statement. We tend to use the term 'support plan' in lieu of case plan but the work done is completely case management. When we work with clients we call it a support plan. Calling it a case plan seems loaded eg they're a case, rather than an individual (semantics!)

Appendix 6: General Comments, Ideas and Suggestions from Delegates

We need the ability to develop new innovations and get them funded. Or at least a vehicle to get a hearing for new ideas.

We need a sector wide strategic plan that unifies the sector: 1 pager in keeping with the HIV or immunisation strategies, signed off by the Minister with buy-in from the top down. Need to consider fundamental realignment between public, NGO and primary care sectors. The bulk of people experiencing A+D issues should be managed at the primary care level through use of various schemes such as chronic disease management, psychological prescription. NGOs should be dealing with a more marginal, ingrained, complex population with public services responsible for managing the most complex of clients – dual diagnosis / criminal behaviour etc.

Need a youth rehabilitation centre in NQ – with mandatory attendance.

Need a shared strategic plan for the sector and shared resources so that we can collectively get the job done.

Need updated information about new substances and effects. We need a higher professional profile. Too long been the poor relation in terms of funding, status… Many of the problems we are working with are not individual problems. It would be good if we were a part of a whole of government approach to wellbeing. Need more work in the regional areas – so under-resourced!

Need wage parity to employ quality / trained staff – current staff are underpaid. Need funding increases to employ quality staff and better baseline training.

Need an RTO for regions, specialist skill based identified positions, ongoing support and education for skills and certified worker, a database for training programs and standard benchmarks for NGOs.

Need a communication platform for policy makers and practitioners to exchange, innovation grants for models of practice and network dating (ie speed dating for organisations).

I would like to endorse Eddie Fewings' proposal to strongly support the growth of Aboriginal and Torres Strait Islander Community Controlled Services. This is a statement of support for self-determination. If we can strengthen individuals / families in community through Community Controlled Organisations then it is essential that is what we do. Thanks for a great and productive day.

Professionalisation of AODS medical workforce – should not be paid as specialists if they aren't actually fellows of a specialist college. Employ training registers so that there's a future medical workforce. Can the MHAOD Branch please make it clear that they have responsibility for acute medical conditions in D&A clients.

Need common tools and a common language.

All inclusive sharing of services across public and private sector. All inclusive program database for all sectors. Equal services for public and private sectors, common programs and funding for all services across public and private sectors. Tailored services for different communities / rural areas. Individualised programs instead of guideline practice. Informative discussions with consumers over effectiveness of services, both current and past clients. Informative forums open to public for community input instead of just organisational meetings / forums / discussions. Anti-stigma

campaign for people with AOD issues. From a consumer point of view (I'm) very pleased with the informative day and would like to be invited to more.

All inclusive shared client database for all. All inclusive program database. Shared information clients / programs. Funds accessibility (if you can pay, then pay). Needs-based rehab beds. Supports established for all clients on list; in rehab and previous clients. Culturally (out of the box) alternative help (ie Aboriginal elders used for guidance with Aboriginal clients). Ministers / religious leaders used for guidance. Job secured in sectors for client regularity. Centralised client and program, database. Let's do it again – loved it!

Specialised AOD training in remote communities. Secure funding… hehehe! Standardised tools – the rest has been zinged!

InSight in great. Like some more practice type / roleplay training to develop competence and confidence. Consumer framework. Thank you very much for today – it's great that we're thinking about AOD consumers.

Key internet resource for guidelines / training / issue-updates / news.

AOD workforce plan / credentialed training / credentialed workforce KPI. AOD provider KPI.

Unification! Common vision and loss of territorialism. Then the sector could influence funding, rather than the other way around. Strategic level direction for the sector at a statewide level. This would enable the AOD sector as a whole to move forward as one, regardless of govt / NGO. Could this go onto SIG agenda for discussion please? May be an action plan for SIG which is developmental and is in line with current government directions.

Consistent terminology across sector. Funding for training in rural areas.

I have concerns about the discussion around the issue of a separate or integrated sector. These are: community controlled sector; youth sector; AOD sector; mental health sector; health sector; human services sector; residential sector; primary care sector; NGO sector; government sector, and it goes on. A focus more on the range of service required to meet the needs of clients would be more constructive. Promotes an unhelpful "us" and "them" approach. Depends on how the term 'sector' is used. As something "distinct and separate" or as a "shared interest" – I heard both today.

Face to face education to rural doctors in hospitals. Many are locums isolated and have limited knowledge on clients admitted with AOD issues. Often AWS isn't written up other than as a PRN eg (diazepam 5mg – 10mg). There is a high changeover of doctors so there needs to be an easy link to treatment options. I've recently been involved in Medicare Locals (Chlamydia mapping) concept whereby a series of drop-down boxes has information and direction on what to prescribe, what blood tests to order, services / referrals to contact – with Chlamydia other things include types of swabs to test with etc. Could this be transferred to AOD for doctors in medical centres and doctors in rural / regional hospitals to use. The link is a web database they can sign into and this is also allocated to staff in AOD etc.

Agreement on terminology / shared language. Build capacity and capability to work in partnership. Ongoing training and professional development with support for smaller organisations to share costs (eg collaboration between orgs, scholarships, exchanges, secondments). Genuine career paths, not limited to within the organisation. Professional networks / circles of practice. More focus on developing and maintaining a peer workforce. Develop capability to evaluate and report on

effectiveness and to undertake continuous improvement – in part for the sake of better services and better client outcomes, abut also to support funding applications to government and elsewhere.

Overarching strategic plan for AOD.

AOD education in Queensland Health facility, GPs.

Consistent terminology. Career paths.

Consistent terminology.

Collaboration across state.

Specific training for the sector for all AOD workers. More statistics nationally for VSM. Increased training for frontline workers – increased access for rural and remote communities.

Increased financial resources, able to pay our staff at more then basic award rate.

Security of roles / strategic direction / plan for state. How will AOD be maintained when integrated into mental health teams. Happy to have teams and happy to change, but concerned that AOD focus and strategic direction will be lost to mental health.

Clinical supervision. Good training opportunities. Some sort of sign of where ATODS is going. A lot of staff in the sector are frightened of losing their job and are looking for jobs elsewhere.

Partnerships, ongoing development / innovation grants, seminars, capacity-building opportunities. Regular catch-ups and a charter?

Champions in different areas. Consistency of practice. Assessment. Treatment Plans. Outcome measures. Statewide database (used by all). Trained workforce.

Where does public intoxication fit in, in terms of AOD vs Mental Health argument? We need solidarity or unity and protection as we are currently on the peripheral and would be gone soon without much discussion – About our worth to our clients.

Central direction. Common goals. HHS's are increasing the communication gap – let's fill it in. Better consumer info database.

Interagency support plan (collaborative approach).

Sector – strong network. Knowledge / links / working together. Evidence based practice with competency based training.

Flexibility with servicer agreements – consultation with frontline workers when writing policy – more consultation. Work together – stop putting ownership on service favouritism. Community-focussed engagement / forums / networking in our local community. Surveys. Better paid services. Value community / cultural acknowledgement. Group activity.

Expectation that <u>all</u> workers are members of a registered AOD association.