QUEENSLAND NETWORK OF ALCOHOL AND OTHER DRUG AGENCIES LTD.

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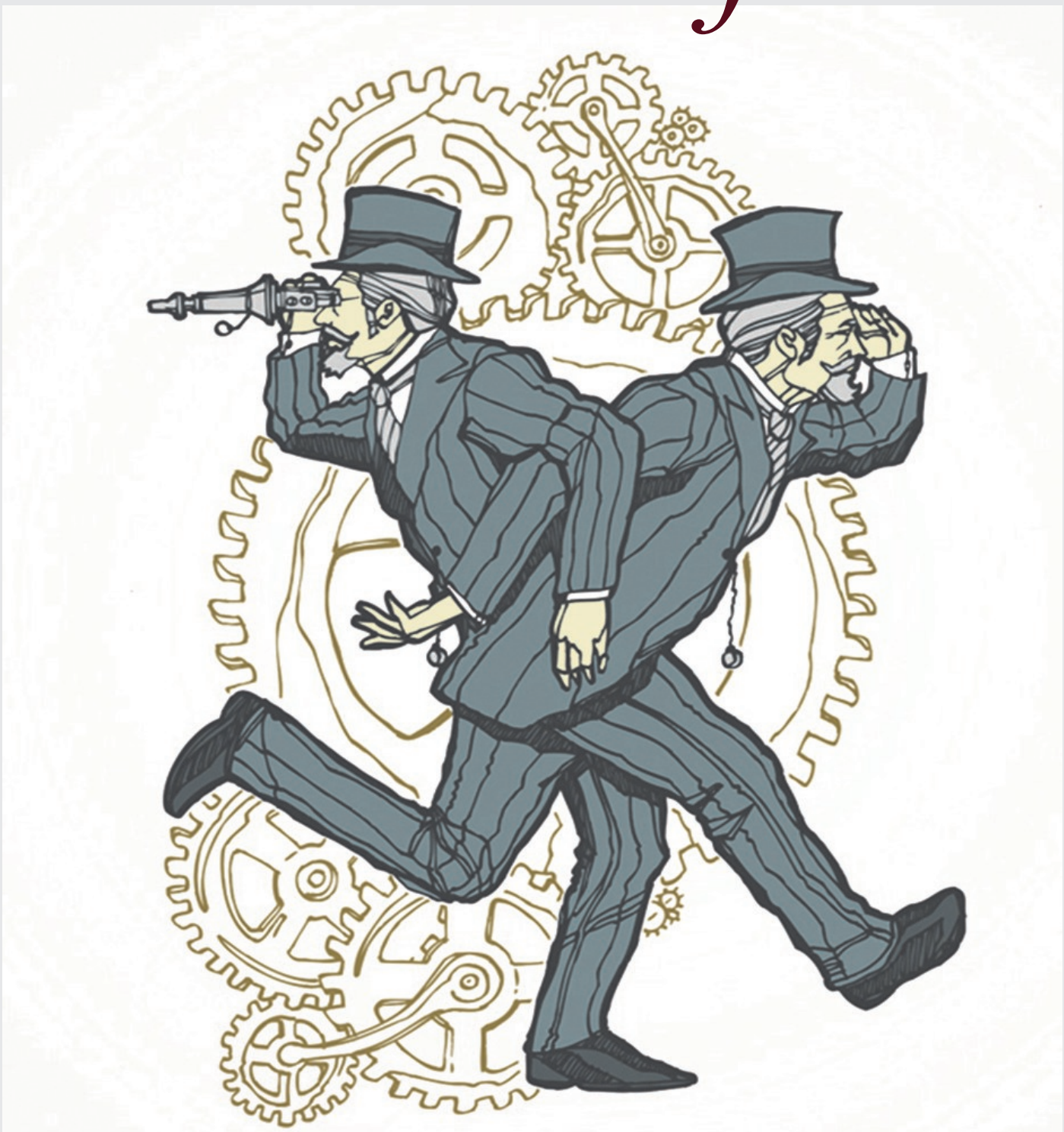
QNADA *focus*



From the iPEN of the Executive Officer

It is with much pleasure that I welcome you to the fourth QNADA newsletter, timed to coincide with the 25th Australian Winter School and the QNADA Annual Breakfast.

I look forward to catching up with you all at our breakfast on Wednesday 6 June and take this opportunity to thank our key presenters — Geoff Manu, Niki Parry, Dennis Young and John Bartlett.

I'd also like to take this opportunity to thank Peter Prendergast for his dedication and service to QNADA, as he will be leaving us at the end of this month. Peter has been an asset to QNADA, both as an extremely capable Business Manager and for recently holding the fort, performing the role of Acting Executive Officer prior to my appointment.

This month, we're also a bit sad that we have to farewell a member of the QNADA family, Mary Alcorn. As many of you would know, Mary has dedicated more than 25 years to the AOD sector, most significantly with the Gold Coast Drug Council. Mary has also served our members and worked tirelessly to advance the AOD sector, both in her local community, across the State and as a member of the QNADA board. Mary was one of the first people from the AOD Sector I met (a few years back now) and I have to say her passion and commitment (and that of others like her) was a significant factor in drawing me into this role. On behalf of the AOD sector, we wish you all the best Mary and know that you've left the sector in a stronger position than when you commenced.

I hope and trust you all find this year's Winter School (and our special edition newsletter) to be thought provoking and informative!

Rebecca

A send off to a special lady

On the 11th of May 2012, over 200 guests gathered at Gold Coast Drug Council's West Burleigh campus to farewell GCDC's Executive Director, Mary Alcorn. During the high tea, there were several moving stories of hope and success from those who have passed through the doors of the Gold Coast Drug Council. All shared a consistent theme of Mary's dedication to supporting them through a tough journey, with compassion and empathy (one gentleman wished Mary a happy Mother's Day and we are sure that there are countless more who would also have done so). Whilst, it was a sad occasion (with more than a few tears), there were also a few cheeky moments and much laughter!

Mary has devoted her life to improving drug and alcohol treatment, with particular emphasis on addressing associated mental health disorders. We acknowledge her passion for improving the quality and safety of AOD services, and the pivotal role she has played in fostering community engagement and partnerships on the Gold Coast. It's not surprising that Mary nominates her career highlight the success of clients in turning around their lives, which she also cites as a driving force for her to continue on.

The Gold Coast Drug Council had its beginnings as a voluntary organisation – the Drug Referral Centre. It was established in 1971 as the first alcohol and drug service on the Gold Coast. As Executive Director, Mary has led the growth of the Gold Coast Drug Council, into a dynamic and innovative organisation, developing a wide range of new services over the last 20 years.

Since taking over the reins in 1987, Mary's vision and drive has seen the service grow to where it is today. The Gold Coast Drug Council is now recognised as one of south east Queensland's premier services offering specialist support for young people, particularly those with co-existing substance misuse and mental health concerns.

Mary also served on the Gold Coast District Health Council for 13 years and chaired for a term. In her spare time (!), she was instrumental in the formation of QNADA and has served as a Director since our establishment in 2007.

Throughout her career, Mary has been formally recognised on a number of occasions for her commitment and excellence. In 2009, she was the Queensland winner of the Pride of Australia Medal in the Care and Compassion category for her dedication to Gold Coast Drug Council.

In addition to that, she received a Centenary Medal from then Prime Minister John Howard for distinguished service as a Director of a Drug Rehabilitation Centre and an Australia Day Achievement Medallion from the Alcohol and Other Drugs Council of Australia in 2002. She was also nominated for Australian of the Year in 2003 (Gold Coast Local Hero).

Mary has not yet effectively 'retired' – she has headed north for the winter to Cairns to assist ADFQ with the establishment of a therapeutic community and somehow we have the suspicion that this will not be the last we see or hear of Mary (at least we hope not)!

There's much more we could say but for now we'll keep it short and sweet – from all of us in the AOD sector:

Thank you Mary

Do you know someone who's dedication to the AOD sector should be recognised?

Mary is only one (but very unique) person dedicating herself to ensure that clients of the AOD sector are given every opportunity to recover, to reduce stigma in the community and to improve outcomes for individuals with innovative approaches (often building the evidence base to support treatment approaches). As a sector, we should take the time to recognise these tireless efforts in others. This monthly newsletter presents a great opportunity to do so. Take a minute to look around for that special person your service or another that you work closely with (often they are the person working quietly away) and contact us to dob them in!

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Meet the QNADA Board

Dr Dennis Young (President) is one of Australia's leading advocates for the AOD sector. As the Executive Director of Drug Arm Australasia for the past 20 years, Dennis has been at the forefront of the awareness, prevention and rehabilitation agenda Australia-wide. Dennis, a former police officer and Qld MP, has delivered leadership and management to the expansive Drug Arm network throughout Australia.

Dennis's commitment and involvement with the AOD sector is exemplified through his on-going contributions to a range of state and national organisations including: QNADA, the Australian National Council on Drugs and the Mental Health Association of Queensland, of which he is Company Secretary.

Trevor Hallewell (Vice President) has been involved in the community-based not-for-profit field for over 20 years. Trevor has extensive experience in governance issues for community-based organisations. In 2005, whilst program manager at We Help Ourselves, he was instrumental in the establishment of a new 20-bed therapeutic community on the Sunshine Coast, which he has managed ever since.

He has also had extensive experience in the corporate sector including in implementing corporate infrastructure, establishing Incorporated Associations and developing risk management policies and procedures.

Ara Harathunian (Treasurer) has been CEO of the Indigenous Wellbeing Centre (IWC) in Bundaberg for eight years.

IWC operates as a "one stop shop" model, providing a range of primary health and community care services to the community.

The programs run by IWC include a number of alcohol and drug programs which aim to encourage the use of a variety of primary prevention activities that are related to alcohol and other drug use, while at the same time, promoting social and emotional health and wellbeing to the community.

Ara is also a member of various advisory health groups in the Wide Bay region and has a wide range of management experience with community, indigenous and health organisations.

Mitchell Giles (**Secretary)** is the CEO of the Alcohol and Drug Foundation Queensland (ADFQ). Mitchell is a Registered Nurse, and also holds a Bachelor of Business and a Master of Health Science (majoring in Mental Health).
Mitchel started work in the AOD sector as a nurse at an inpatient Detox Unit. He then went on to manage another hospital based Drug and Alcohol Service for 12 years. Mitchell has worked in a variety of other positions including as the Deputy Director of Clinical Services and as a State Manager for a HIV services program.

Geoff Manu (Director) is the General Manager of Queensland Injectors Health Network (QuIHN). He is from a non-English speaking background and values his connections to his cultural heritage as a South Pacific Islander. Geoff has a professional and personal commitment to the development of disadvantaged communities and to the improvement of social inclusion for such communities. Through his roles for government departments and within the not for profit community sector, Geoff has acquired a vast amount of experience in health, social inclusion and equity issues among a diverse range of populations, including: prisoners, drug users, people with mental health concerns, the intellectually impaired, the homeless, Indigenous communities, young people, and the aged.

John Bartlett (Director) co-founded Fresh Hope in 1999 with his partner Karen Bartlett and has been a Co-Director ever since.
Fresh Hope is a non-profit community based organisation with a family-orientated rehabilitation program designed for mothers and their children who have become dependent on drugs and alcohol.
John has a degree in Ministry, and he is also a qualified Justice of the Peace and a Civil Marriage Celebrant.

Gerard Byrne (Director) has spent the past two decades working with The Salvation Army Recovery Services. He is currently the Clinical Director for Recovery Services, which is comprised of eight Residential Therapeutic Communities, four Detoxification Services and three out-client Services.
Gerard has also worked in the private and government sectors , providing a range of alcohol, gambling and other drug services. Gerard holds qualifications in Social Sciences, Alcohol and Other Drug Work, Psychotherapy, Clinical Supervision and Business Management.

Advancing the AOD sector

- we're hatching a strategy

Calling all members

Have your say on a number of current and emerging issues. Return to the QNADA Members Only page regularly as we'll be posting updates, with your feedback and comments informing policy positions and future directions for advancing the NGO AOD sector.

Member organisations should have recently received a new log on and password to the Members Only section. If you haven't, or have issues logging on, please contact; Gunnar on (07) 3010 6504.

Here's a few items to get you started:

CHANGES TO QH SERVICE AGREEMENTS

Queensland Health (QH) has recently commenced a review of the Service Agreements for the provision of NGO AOD services. These clauses should be minor amendments to your current contracts and are intended to come into effect from 1 July 2012.

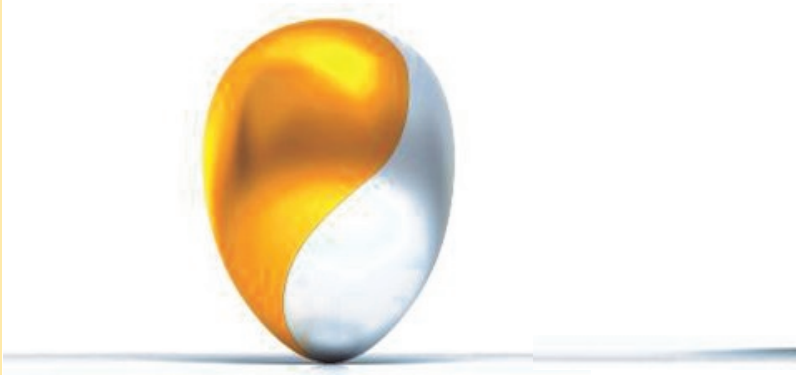
QNADA INFORMATION AND TECHNOLOGY SURVEY

QNADA is committed to a cycle of continuous improvement in the assistance and support we provide to our member services. We've developed a survey to allow our member services to provide feedback on CADDS. Please take the time to tell us what you think.

CURRENT AND EMERGING ISSUES – AUSTRALIA21 REPORT AND A NEW DEFINITION OF RECOVERY

QNADA is seeking feedback from members on the recently released Australia21 Report and the Anex discussion paper: *Australian Drug Policy: harm reduction and 'new recovery'*. In the Members Only section of our website, discussion papers have been prepared to assist you in considering these reports. We strongly encourage you to have a look, discuss the papers around your office and provide feedback to us.

Majority & minority voices are equally important parts to any discussion!



In the coming year we will be adding a number of new services, such as offering

support and advice
to members

in engaging with quality accreditation processes

and exploring opportunities to support members with

workforce development
and
networking.

Improved Services Initiative - Building sector capacity

QNADA is looking forward to continuing the momentum created through the ISI program to support all member services with ongoing service and system improvements. In this second round of ISI, QNADA will be focusing on supporting services through the achievement of four key objectives— strategic partnerships and linkages, service improvement and support, workforce development and the development and dissemination of information and resources.

In mid-June, QNADA will be hosting a forum with those member services recently who were re-funded to continue programs leading to the outcomes of co-ordinated services, particularly for those experiencing co-morbidity. Marguerite would love to hear how QNADA can assist your service.

Dual Diagnosis (Mental Health and Substance Misuse) Training on the Gold Coast 2012

Workshops were created in response to a need determined by the Gold Coast Heads Up Consortia Dual Diagnosis Sub-committee. This Sub-Committee has been meeting regularly since 2010 and many of its founding aims have been met. Queensland Health (Gold Coast District) has been doing a lot of work integrating mental health and addiction services. The Sub-Committee felt many of the remaining aims could be met through education.

The current Chair of the Sub-Committee (The Gold Coast Drug Council Dual Diagnosis Coordinator) with the Queensland Health Dual Diagnosis Coordinator and ATODS Educator were tasked with creating a rolling education program that would be local, free and open to Workers from all sectors, aiming to increase Worker capability in assessing and treating dual diagnosis.

Together, they developed a series of six workshops. The content of the workshops is based on the Queensland Dual Diagnosis Guidelines (2010) and aims to introduce workers to:

- Mental health assessment and referral
- AOD Group Intervention
- Mental health Interventions
- AOD Education
- AOD Brief Interventions
- Working with Dual Diagnosis

Workshops are advertised as widely as possible - through primary care networks, professional bodies such as the Australian Psychological Society (Gold Coast Branch), the Heads Up Consortia and Dual Diagnosis Sub-Committee service members, mental health and youth service networks and within Queensland Health. One of the overarching aims of the series of workshops is to improve collaboration between services.

The first and second workshops were fully booked within days. Staff from Queensland Health mental health attended as did employment agency and indigenous health service staff. There was representatives from the Department of Child Safety representation, as well as other NGO staff. There was the full range of professionals – from social workers to psychologists and nurses, to youth and other support workers.

A basic satisfaction survey is conducted for all workshops. For the first workshop 100% of attendees found the training very relevant/ relevant, very professionally/ professionally delivered, with content easy to understand. Initially 72% had rated themselves with some knowledge and 23% felt they had good knowledge. A full 90% rated themselves as having achieved greater understanding by the end of the day. Analysis of some pre and post testing indicated a consistent trend of improvement – but not statistically significant. This may be attributable to the substantial experience in the group. We plan to complete this series of workshops and if all evaluate as well as the first one, we will repeat them in the second half of the year. In the future, we would like to get the content accredited so workers can use the training for formal 'continuing professional development' points.

Some of the great work being achieved

Author: Contact Kim Wood, Dual Diagnosis Coordinator, Gold Coast Drug Council on (07) 55 354 302 for further information.

figuring out the facts

Libby Topp

Around Australia, data is collected on topics that affect the alcohol and other drug sector. Why does this data matter and hat are some of the issues involved with collecting and analysing it?

Types and purposes of data

Across Australia, data is collected to monitor alcohol and other drug-related issues and trends. From hospital emergency departments and secondary schools, to therapeutic communities and police stations, this data forms the 'evidence' that helps policy makers decide on program directions and funding allocations. This evidence is vital to our sector because of its sensitive issues; with solid data, policies to address these issues can be developed more objectively. Alcohol and other drug (AOD) 'datasets' are managed by a range of agencies, primarily government departments and research institutions.

In terms of quality and comprehensiveness, Australia's drug information systems are among the world's best. There are many examples of how data collections inform AOD policy responses, and document their outcomes. For example, the removal of Temazepam gel capsules from the market in 2004 was a direct result of data from the Illicit Drug Reporting System and other research indicating that injection of this formulation, and the substantial associated harm, were prevalent among people who inject drugs.

Indicators and reliability

Among the important data sources for policy activity are 'outcome indicators', or measures of the achievement of the major objectives of a policy or program (Degenhardt & Dietze 2005). Ideally, outcome indicators allow for comparison of the situation before a policy or
program is implemented, and again sometime later, to measure progress. For example, Australia's *2004-2009 National Drug Strategy* aimed to 'reduce drug-related harm for individuals, families and communities'.

One indicator used to measure this objective is the number of drug related deaths. Likewise, a treatment program may state the objective 'a reduction in illicit drug use'. One indicator of the program's outcomes might be a client's number of drug-free urine samples in a given time frame.

Data sources vary in the extent to which they can be considered reliable and valid. For example, self-report survey data is often criticised because participants' reports cannot be verified (interestingly, authoritative literature reviews have demonstrated the reliability of drug users' self-reports); and difficulties also exist around accessing representative samples of participants.

On the other hand, surveys are considered an efficient and cost-effective means of collecting specific and detailed information that is up-to-date and, when collected using consistent methods, is comparable and sensitive to trends.

Some data sources provide information that when used in conjunction with other datasets can provide interesting indicators. etc. alcohol sales data provides a measure of the volume of alcohol sold in Australia; while it cannot tell us who drinks it, nor what consequences are experienced as a result of consumption, when used alongside other data, such as assaults in venues, it can give policy makers valuable guidance.

Consequently, there is great value in having available many different data sources that can be compared against each other. Many factors influence data quality and usefulness, and each data source has limitations. When all limitations are considered and multiple data sources point to the same finding, the evidence becomes stronger, allowing more confident conclusions.

Levels of data collection

Different levels of data collection also contribute to a complete understanding of the patterns and consequences of AOD use in Australia. For example, data can be collected at the level of an individual service for the purposes of quality assurance; at the state/territory level to monitor the outcomes of decisions around resource allocation; or at the national level to estimate rates of illicit drug use in the general population.

Likewise, depending on the purpose for which data is collected, the unit of measurement might be an individual, a family or an entire community. Although all such data sources are essential to serve their individual purposes, no single level of data will serve all stakeholders' needs.

National level data on overdoses or general population rates of drug use are of limited use to a local service provider seeking accreditation through a quality assurance process. In addition, the usefulness of many data sources collected at the state/territory level is constrained by the different collection methods used in different jurisdictions, which prevent these data being collated into a meaningful overall picture (see pages 10 -11).

Data collected across other related sectors can all contribute to a knowledge base around drug use and related harms; for example, mental health, criminal justice, education, employment, housing, town planning, and child and family health can all contribute useful data that can have an impact on AOD policies. The challenges in synthesising such cross-sectoral information, are, however, substantial. Indeed, Australia is praised internationally for efforts to underpin drug policies with evidence from just the health and law enforcement sectors.

SOME KEY AUSTRALIAN AOD DATASETS

National Drug Strategy Household Survey: Australian Institute of Health and welfare (AIHW)

- Monitors general population prevalence of drug use
- Triennial surveys of large (25 000+) national samples of Australians aged 14+ years about their attitudes towards and use of licit and illicit drugs
- Limited utility for drugs with low prevalence of use due to small subsample sizes
- Household-based sampling excludes high risk groups (e.g., homeless people, prisoners); criticised for low response rates (<50%) and their potential impact on validity of results.

Australian Secondary School Alcohol and Drug Survey: victorian Cancer Council

- Monitors licit and illicit drug use among high school students
- Triennial national surveys of large (30 000+) random samples of students in years 7-12
- Limited utility for drugs with low prevalence of use due to small subsample sizes; school-based sampling framework excludes risky adolescents due to truancy or dropout.

Causes of Death: Australian Bureau of Statistics (ABS)

- Monitors drug-related deaths
- Computerised database of information drawn from state/ territory registries of births, deaths and marriages and coronial services classifying causes of all deaths in Australia
- Standard ABS presentation provides limited information because most drug-related deaths are not coded as such due to factors including the availability of toxicology results and the completeness of death certificates. No organisation is responsible for systematically undertaking the separate research needed to produce a comprehensive picture
- Criticised for delays in the availability of data on both licit and illicit drug-related mortality.

Illicit Drug reporting System/Ecstasy and related Drugs reporting System: National Drug and Alcohol research Centre

- Monitors price, purity, availability, patterns of use and associated harms of major illicit drugs
- Annual 'snapshots' of drug markets based on (i) interviews with large (900+) samples of regular illicit drug users in all capital cities; (ii) key AOD experts; and (iii) indicator data (e.g. overdose deaths, treatment episodes)
- Constrained by convenience sampling methods and changes in recruiters and recruitment methods between annual studies.

Drug Use Monitoring Australia: Australian Institute of Criminology

- Monitors recent drug use among large samples of police arrestees through self-reports and urinalysis
- Conducted quarterly at police watchhouses across six jurisdictions
- Provides evidence base for examining drug-crime relationships
- Restricted by eligibility criteria. (e.g. an arrestee cannot participate if they are deemed too uncooperative).

Alcohol and other Drug Treatment Services – National Minimum Dataset: AIHW

- Monitors the type, utilisation and availability of treatment services
- Collates data on treatment episodes completed by publicly funded government and non-government specialist AOD services in all states/ territories, (e.g. referral sources, drugs of concern, services provided)
- Excludes agencies whose sole activity is prescribing or dispensing opioid pharmacotherapy; or whose main function is accommodation (including so bering-up shelters) or health promotion (e.g. needle and syringe programs).

CHALLENGES OF THE DATA

Gaps in the data

Although research evidence is vital to informing policy making, relevant or good quality evidence is not always available. Sometimes, scientific evidence is not seen as sufficient, appropriate or desirable in making policy decisions. Political pressures or the need for prompt responses to allay public concerns may lead to governments implementing interventions that are not consistent with the evidence.

Lack of synthesis of data sources

Despite Australia's comprehensive, high quality AOD data collections, the potential of these data is yet to be fully realised because there is no formal system for analysing and synthesising the data and other information into policy relevant forms.

Commendable steps to overcome this problem are included in the *National Drug Strategy 2010-2015* document, under which an expert working group will be established to develop a National Drug Research and Data Strategy. There is a huge difference between having data available from separate data collections, and using them – strategically and in combination – to inform policy making. Important gaps in drug information still exist, and there are significant delays in producing policy-relevant findings from some key data collections.

Mining a wide range of data sources

Many workers and services in the AOD and related sectors collect data as part of their daily job, recording things like number of clients admitted, number of syringes provided, number of opioid overdoses attended. Services collate these data primarily for funding purposes – to apply for funding, to use it in the most effective way possible, and to justify how it is spent. At the individual service level, these data serve their funding purpose, but they also have the potential to be collated and used on a wider scale. A challenge for the new Standing Committee on Data and Research will be to find ways of bringing together small datasets like these more efficiently and effectively. A good example of this is prisoner health data; a huge amount of information is collected on every prisoner when they first enter custody, but so far this data has not been collated in a way that helps build an evidence base.

Jurisdictional differences in data collection

Much data informing AOD monitoring and policy making is collected at the state/territory level. The methods used by individual states often vary in terms of data definitions, time frames, database formats etc.

For example, many consider purity the best single indicator of illicit drug availability. The Australian Crime Commission (ACC) obtains data from the Australian Federal Police (AFP) and state/territory police services on the purity of their drug seizures, but the lack of common data standards means the ACC cannot provide a national overview of drug purity. Purity figures are not estimated from all seizures, only those that have been analysed at a forensic laboratory, and different state/territory police services have different criteria for which seizures are analysed. In some states/territories, figures represent drugs that were seized during the relevant period, and in others, figures are from drugs received at the laboratory during the period. The time between when a drug is seized and when it is analysed can vary from a few days to several months. There is no way to adjust for double counting of some seizures resulting from joint operations between the AFP and state/territory police services; and in the Northern Territory, seizures are not routinely analysed at all. A consistent and coherent national system for monitoring the purity of illicit drugs would be a significant advance.

MENTAL HEALTH, CRIMINAL JUSTICE, EDUCATION, EMPLOYMENT, HOUSING, TOWN PLANNING, AND CHILD AND FAMILY HEALTH CAN ALL CONTRIBUTE USEFUL DATA THAT CAN HAVE AN IMPACT ON DRUG POLICIES.

QNADA wishes to thank *Of Substance* for their permission to publish this article (vol 10 no 1 of 2012). For a full list of references used in this article please email editor@ancd.org.au.

PRACTICAL USE OF DATA IN A THERAPEUTIC COMMUNITY

James Pitts

James Pitts, CEO of odyssey House, provides an outline of the types of data collected by an AOD service, as an example of the wealth of information collected at a grassroots level. All AOD services who receive funding from state and federal governments are required to collect client and other data. How that data is utilised can enhance the quality of interventions offered by a service. Here are some examples of how Odyssey House uses the data we collect:

- Our Admissions Centre collects client demographic data that tells us about who is accessing the different program services, their ages, problem drug(s), mental health status, gender etc. This information helps us make adjustments to our services. A recent example of this has been the need to enhance our interventions for alcohol-dependent clients, who make up over 30% of our residential population.

- When clients enter the initial stage of the residential program, information is collected on educational achievements to determine tuition needs at our school learning centre. A vocational history helps determine appropriate job placements for clients while they are undergoing treatment. A psychiatric mental status evaluation is also conducted which helps staff to identify issues that may need to be addressed urgently.

- Given the increasing frequency of comorbidity within our client population, we administer a number of clinical surveys to clients at various stages of their treatment. These include the Personality Assessment Inventory and the General Health Questionnaire. These surveys assist in the formulation of individualised treatment plans that are adjusted and updated as clients progress through their program.

- Other data is collected through surveys on consumer satisfaction; program interventions; and environmental factors. Odyssey is required to supply data on a number of activities/ interventions we provide as part of our overall service delivery.

We receive funding from both governments (state and federal) and private sources. We are required to provide data which supports the original submission depending on what that maybe. Categories of data collection include: number of participants in a particular project; pre- and post-test questionnaire results; statistical data; and evaluations of the overall effectiveness of a particular project. The data collection required is usually commensurate with the amount of funding that is given for a particular project; larger grants require more detailed reporting on a more frequent basis; smaller grants, usually from trusts and foundations, require less reporting, such as once per year.

How can your organisation contribute to growing the evidence base in Queensland?

QNADA is committed to a cycle of continuous improvement in the assistance and support we provide to our member services and is currently undertaking an Information and Technology Survey allow member services to provide feedback on the Collector of Alcohol and Other Drug Data Set system (CADDS).

CADDS is QNADA'S client management system (previously known as the QNADA Datanet Gateway – NMDS Database). CADDS can be utilised in the following ways -

CADDS
Collector of Alcohol and other Drug Data Set

- Client management database for AOD clients
- Document management for internal and client records
- One click reporting to government, Boards and Management
- Contributing to qualitative justification for improved funding for the NGO AOD sector
- CADDs is also a handy mechanism for reporting data to contribute to the Alcohol and Other Drug Treatment Services National Minimum Data Set (NMDS). Currently only 67 NGO AOD services nationally contribute to the NMDS.

The survey is available at www.qnada.org.au and the results will inform proposals for system improvements and form the basis of a discussion on how CADDS can be of benefit to your service.

if you have any questions or need assistance with completing this survey please don't hesitate to contact Gunnar on (07) 3010 6504 or via email at gunnar.kristiansen@qnada.org.au.

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