

It's not a one way street

Project Gauge alcohol and other drug client engagement and participation discussion paper

July 2016

It's not a one way street: Project Gauge alcohol and other drug client engagement and participation discussion paper
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Project Gauge is funded by the Mental Health Alcohol and Other Drugs Statewide Clinical Network. The project aims to support public health AOD services in Queensland to begin the process of embedding good client engagement and participation. Project Gauge is built upon foundational work already being undertaken by Metro North Mental Health-Alcohol and Drug Service and the work of the *Mental Health Alcohol and Other Drugs Consumer and Carer Partnership Project* undertaken by West Morton Hospital and Health Service (2015).

About the authors

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Executive summary

This discussion paper provides an outline of the current research, legislation, frameworks and principles of client engagement and participation (CEP), and more specifically within the alcohol and other drugs (AOD) sector. The paper will identify and explore existing recommendations established in a series of key and readily available sources that may be adapted to meet the unique needs of AOD clients. Final recommendations will be made specific to Queensland public health AOD services on the basis of this evidence following consultation and finalisation of Project Gauge.

CEP refers to active client involvement in all aspects of delivering healthcare services. This ranges from individual treatment planning to policy development. It is an essential and legislated requirement in the health field that services meet minimum standards of CEP which can be achieved through a number of mechanisms. Current evidence suggests the AOD sector in Australia is not progressing CEP at the rate of other health services. The evidence also suggests this lack of progression may be due to the specific context of AOD service provision and unique barriers experienced by the client group.

The discussion paper identifies:

- The benefits of AOD CEP and utilising client expert knowledge to improve the quality of service provision, including
 - more responsive and improved services
 - client empowerment and wellbeing
 - increased client skills and confidence in multiple domains
 - increased service satisfaction leading to treatment retention
- The unique and specific barriers to engagement experienced by the AOD client group, including
 - a lack of adequate opportunities to engage
 - perceptions of a lack of interest or ability in the client group
 - time of entry into an AOD treatment / support service and associated vulnerabilities
 - fear of perceived repercussions (e.g. opiate treatment program clients)
 - marginalisation, isolation and stigmatising of AOD clients in ways that other health consumers do not experience
 - moralistic views of drug use and associated behaviours
 - the illicit nature of some substance use as a defining barrier to engagement (e.g. while no-one chooses substance dependence or mental illness, living with mental illness is not an illicit activity)
- The complexity of the AOD client group and the various levels where they may present for treatment and / or support
- The resulting importance of avoiding a 'one size fits all' approach
- Elements required to facilitate CEP in the AOD sector.

Greater involvement of Queensland public health AOD service clients in all levels of participation is essential to fulfilling *National Safety and Quality Health Service Standard 2: Partnering with Consumers*, as well as meeting the strategic objectives set out in the *Department of Health Strategic Plan 2014 – 2019*. Service providers also have an ethical obligation to fulfil as CEP is a clearly articulated right of all individuals accessing health services. In short, it is a right of people who use drugs to be able to participate in all levels of decision making related to their health care regardless of the legal status of the substances used.

Project Gauge is undertaking 6 key activities over its funded 3 month period to raise the status of CEP within Queensland public health AOD services. These activities are based upon recommendations from key documents referred to through this paper - the *Mental Health Alcohol and Other Drugs Consumer and Carer Partnership Project*, *Consumer Participation in the Australian Alcohol and Other Drug Sector* and *Voices on Choices: Working towards consumer-led alcohol and drug treatment*.

1. The development and distribution of this discussion paper
2. Establishing a statewide network of AOD client engagement champions (representative of these services) to ensure those that may be affected by the initiative have opportunities to collaborate and guide its undertaking
3. Establishing a network of critical friends to Project Gauge ensuring the project deliverables are reviewed by a range of experienced parties both internal and external to the project
4. Creation of a package of client feedback and engagement tools and resources for sharing across Queensland that is to be co-reviewed with AOD client engagement champions, clients and / or client representatives and critical friends
5. Delivery of two free statewide webinars on best practice AOD CEP to provide opportunities to engage with the material in support of the above mentioned activities
6. Establishing a website to include the above mentioned webinar videos, tools, information and resources to give project longevity and ready accessibility to easy to use information and templates that can be modified to different AOD specific service contexts.

While Project Gauge is a starting point for services to harness and improve upon current practices, embedding CEP requires long term resourcing. Key barriers must be addressed with adequate collaboration and commitment from policy makers, AOD services, and workers to ensure that Queensland's public health AOD services are able to improve the quality of care for AOD clients and meet the requirements of *National Safety and Quality Health Service Standard 2: Partnering with Consumers*.

Rationale

Examination of current CEP in Queensland public health AOD services is essential to assess how well these services are performing in relation to national and international standards. Although CEP has progressed internationally in relation to AOD, such as in the United Kingdom, efforts appear to be less advanced in Australia. This is in contrast to mental health consumer participation which has progressed as a result of reform within the sector. Notably, supporting structures are generally well established within mental health while AOD services are commonly under-resourced to deliver meaningful CEP activities. The Australian National Advisory Council on Alcohol and Drugs (ANACAD [formerly the ANCD]) notes that, 'increasingly people in the AOD sector are observing, and expressing concern about, what they see as this sector falling behind in the area of participation' and 'point to other sectors, particularly disability services and mental health, as being more advanced' (McDonald, 2014, p. 29). In addition, the current national focus has been to amalgamate mental health and AOD services which has highlighted 'the inconsistencies in the approaches in the two sectors' (p. 29).

In Queensland, the amalgamation of AOD and mental health services provides opportunities for addressing co-morbidity and ensuring client-centred approaches are undertaken. However, CEP in AOD services presents unique issues when compared to mental health consumer participation. While elements of the mental health framework for engagement are applicable, it is crucial to examine and acknowledge the variances amongst the client group and the work that AOD services undertake. In order to progress reform, Queensland public health AOD services and their clients will likely be best served by working towards full engagement of the client group on multiple levels. This will not only ensure clients' legislated rights are met, but that the perspective of the client group informs best-practice, subsequently maximising service quality and responsiveness to the community.

Key definitions

While there has been an increased national and international focus on what is referred to as CEP throughout this document, CEP and its associated concepts are defined differently depending on the context in which it is being employed (Sarrami-Foroushani, Travaglia, Debono & Braithwaite, 2014^a; Clarke & Brindle, 2010). CEP does encompass individual treatment planning however this should not negate, overshadow nor be confused with other important elements of CEP. This document provides a brief, clear representation of CEP for Queensland public health AOD services.

Key terms as they are defined in this document are as follows:

Client - Refers to people who have direct experience of alcohol and other drug use issues and have used or are currently using AOD services.

Patient – Used in the context of medical / clinical discourse to describe a person who is accessing healthcare services and receiving some form of treatment.

Consumer – More broadly refers to those who are currently, have previously accessed or may access healthcare services in future, including family members, carers and support people.

Client Engagement and Participation (CEP) – Refers to a range of activities that may be undertaken to involve service consumers / clients / patients in decision-making with relation to the delivery of healthcare services. CEP is also commonly called Consumer and Community Engagement and Consumer Participation and Collaboration.

Clients who access AOD services are a diverse population including: people of any gender, sexual orientation or gender identity; of various ages; Australia's First Nations People; people from diverse cultural and linguistic backgrounds; people from a range of socio-economic circumstances; people from varied geographical locations; people who present with a wide range of physical and mental health conditions; and people who come into contact with the service with different expectations and needs.

Why is it important?

Good models of CEP ensure that clients are placed at the centre of decision-making. They create a process by which clients have the ability to co-create change and thus ensure good experiences of care. Good experiences of care have been shown to positively correlate with adherence to treatment, and treatment retention which is particularly pertinent for the AOD field. For example, Doyle, Lennox and Bell (2013) conducted a systematic review of the literature that included multiple health contexts and concluded that good care experiences are positively correlated with better health outcomes. Good experiences of care are at the core of strategic decision making in each Queensland Hospital and Health Service (HHS) district. Many HHSs explicitly refer in their strategic planning to 'improving the patient journey' or 'improving patient experience'. Further to this, the Queensland Mental Health Commission's (QMHC) *Mental Health, Drug and Alcohol Strategic Plan 2014-2019 Performance Indicators Outcome 6* is articulated as, 'People living with mental illness and substance use disorders have positive experiences of their support, care and treatment' (p. 36).

There are limited AOD specific 'policy frameworks to support consumer participation in the drug treatment context' (Australian Injecting and Illicit Drug Users League [AIVL], 2011, p. 24). A brief review of Queensland Health specific CEP policy conducted by the authors of this document indicates there is a need for the development of guidelines and resources specific to Queensland public health AOD services in order for CEP to be properly implemented within these services. Any CEP model implemented by services must account for diversity, be delivered in context and have sustained support from all levels of governance to avoid tokenism and band aid solutions – one size does not fit all.

The engagement and participation of people who use alcohol and other drugs is fundamental as 'there are ethical and human rights imperatives that require greater involvement of people who use drugs' (Jürgens, 2008, p. 35). Essentially the involvement of people accessing AOD services is underscored by 'the ethical premise that all people should have the right to be involved in decisions affecting their lives' (p. 35). In support of this, the Canadian HIV/AIDS Legal Network examined the importance of meaningful involvement of people who use drugs in the HIV response internationally. A key recommendation of the *Nothing about us without us* report targets government agencies at a local, regional and national level to involve people who use drugs in consultation processes in decisions regarding their lives. In particular, the report suggested such agencies 'invite people who use drugs to participate in all consultations, committees, or forums where policies, interventions, or services concerning them are planned, discussed, researched, determined, or evaluated' (p. 59).

When CEP has been carefully considered, planned and implemented in the AOD service context, potential benefits as highlighted by the Consumer Focus Collaboration (2001, p. 2), and reiterated by Clarke and Brindle (2010) and Parry (2013) include:

- Active client participation in decision-making in individual care leads to improvements in health outcomes
- Access to quality information facilitates decision-making and supports an active role for clients in managing their own health
- Active client participation leads to more accessible, responsive and effective health services
- Effective client participation via the adoption of a range of methods leads to quality improvement and service development activities
- Effective client participation uses methods that can facilitate participation by those traditionally marginalised by mainstream health services
- Active involvement of clients across the continuum of engagement is known to be integral to the success of developing, implementing and evaluating service strategies and programs.

CEP research is an emerging and understudied area, particularly in relation to clients of AOD services. There are significant opportunities to progress innovative strategies and research with relation to CEP within AOD services across Queensland.

National context

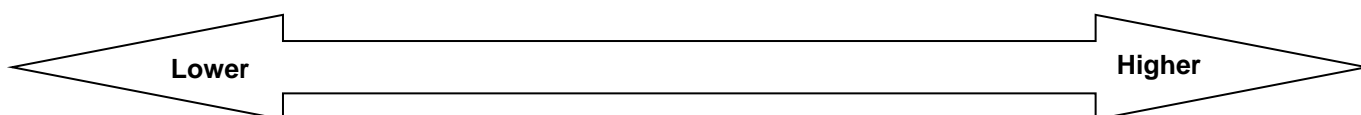
The *Australian Charter of Healthcare Rights* articulates a set of rights, principals and expectations to guide both consumers and services. The fifth element on the charter is 'Participation'. Patients are advised 'I have a right to be included in decisions and choices about my care' and in practice 'I may join in making decisions and choices about my care and about health service planning' (Australian Commission on Safety and Quality in Health Care [ACSQHC], 2008^a, p. 1). Ensuring participation occurs at a system level is an expectation for all health services. In practice, participation means health service organisations need to 'develop and maintain policies which encourage and appropriately support patients, consumers and their families to be involved in the decision making' and facilitate such involvement at multiple levels (ACSQHC, 2008^b, p. 2).

Health services are accountable to the ACSQHC *National Safety and Quality Health Service (NSQHS) Standards* for accreditation purposes. These standards provide the framework for implementation and continuing improvement of safety and quality in healthcare. In order to achieve the NSQHS *Standard 2: Partnering with Consumers*, health service organisations are required to ensure the following are in place (ACSQHC, 2012, p. 8):

- Consumer partnership in service planning
 - Governance structures are in place to form partnerships with consumers and/or carers
- Consumer partnership in designing care
 - Consumers and/or carers are supported by the health service organisation to actively participate in the improvement of the patient experience and patient health outcomes
- Consumer partnership in service measurement and evaluation
 - Consumers and/or carers receive information on the health service organisation's performance and contribute to the ongoing monitoring, measurement and evaluation of performance for continuous quality improvement.

This can be achieved via a number of methods which can be placed along a continuum of practice. There are various models that have been adapted from *Arnstein's Ladder of Participation* originally developed as a participation model in 1969. The following is an excerpt from *NSQHS Standard 2: Partnering with Consumers* (ACSQHC, 2012, p. 9):

	Information	Consultation	Partnership	Delegation	Control
Description	The organisation develops or adopts a policy, plan or program and provides information about this to the consumers and/or carers and the community.	The organisation identifies an issue and proposes a policy, plan or program which responds to the issue. It then provides information to consumers and/or carers and the community on that proposal and seeks views and comments with a view to maximising acceptance.	The organisation identifies an issue and presents a tentative policy, plan or program which responds to the issue. The organisation seeks active involvement and feedback from consumers and/or carers and the community which is incorporated into the plan.	The organisation identifies an issue, presents this to consumers and/or carers and the community for them to make decisions or propose actions to address the issue.	The organisation asks consumers and/ or carers and the community to identify an issue and make all the key decisions on the development of solutions to address the issue. The organisation supports them to accomplish this.
Examples	<p>Giving: Flyers, mailouts, factsheets, press releases, brochures, newsletters, public displays, websites, public meetings</p> <p>Gathering: Surveys, phone-ins, focus groups, in-depth interviews, suggestion boxes</p>	<ul style="list-style-type: none"> • Workshops • Consumer representatives on management committees, advisory groups • Public meetings/ patient forums • Online discussion groups • Circulation of proposal for comment • Conferences or seminars • Evaluation surveys 	<p>Strategic alliances built utilising a combination of other methods (including those mentioned in Information and Consultation) for example:</p> <ul style="list-style-type: none"> • workshops • consumer representatives on committees or advisory groups • round tables • patient forums • surveys • focus groups 	<p>Shifting some or all of decision making on particular issues to consumers. For example: spending on specific budget items, management of particular programs by consumers e.g. mental health consumer advisory groups</p>	<p>Community appointed management committees e.g. Aboriginal Community Controlled Health Organisations</p>



(Source: As adapted for the National Safety and Health Service Quality Standards: Standard 2 [2012] from the Brager and Spechts Ladder of Participation [1973] and Queensland Health's Consumer and Community Participation Toolkit [2007])

A review by the ACSQHC (2014a) identified that of the 10 NSQHS Standards, Partnering with Consumers was found to have the largest amount of unmet actions across healthcare services. This serves to demonstrate that while there is increasing interest in CEP, challenges remain in ensuring that strategic service level endorsement of CEP translates to practice. The ACSQHC propose a series of focal points for services that will assist in meeting this challenge (p. 2):

- The purpose of the partnership
- Having strong leaders who communicate a strategic vision of partnering with consumers
- Identifying and developing strategies for partnering with consumers that are appropriate for the organisation
- Working towards the establishment of an organisational culture that values partnering with consumers as part of core business.

While these overarching focal points are of assistance, the myriad of competing priorities that are both demanded of - and unique to - AOD clients and services must be duly considered to ensure the success of CEP (Hinton, 2010). In Victoria, CEP has been embedded into AOD policy and frameworks. However it continues to be less advanced than mental health in this area (Clarke & Brindle, 2010). While CEP practice in AOD is still under-developed when compared to mental health, Victorian policy and frameworks focussed on AOD sector CEP may provide some guidance for Queensland equivalents. Additionally, in 2005 the New South Wales Mental Health and Drug and Alcohol Office released a *Guideline to Consumer Participation in NSW Drug and Alcohol Services*. This was updated in 2015 and explicitly acknowledges that 'the needs of drug and alcohol consumer groups vary from other consumer types' (p. 2). At the time of writing, excepting Project Gauge, there is largely no AOD focussed CEP structural support, guidelines or resources dedicated to Queensland public health AOD services. Clarke and Brindle (2010) highlight that CEP is a key accreditation requirement for AOD services in Victoria and unequivocally state that, 'there is no escaping it; consumer participation is a requirement for all publicly funded alcohol and other drug services' (Clark & Brindle, 2010, p. 17).

State context

Within the Queensland context the importance of developing AOD specific CEP policies, frameworks, training and resources cannot be overstated. The *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019* has established 'better engagement and collaboration' as one of the 'four pillars of reform' (QMHC, 2014, pp. 14-15). This whole-of-government strategic plan states that 'people with lived experience, their families, carers and supporters must be valued partners in developing policies and services' (p. 11). 'Shared commitment 1' is focussed on 'engagement and leadership priorities for individuals, families and carers' (p. 18). The QMHC is leading this commitment in partnership with Government agencies, including the Department of Health and HHSs, peak bodies, representative groups, and consumer, family and carer representatives. A core intention of 'Shared commitment 1' is to 'improve inclusion, meaningful participation and outcomes by drawing on the diversity of the experience and wisdom of people with a lived experience of mental health difficulties and substance use problems, their families and carers' (p. 18). Also within the strategic plan under 'Shared commitment 3' the State Government identifies the prevention and reduction of 'the adverse impact of alcohol and other drugs on the health and wellbeing of Queenslanders' as a 'stage one priority' (p. 20).

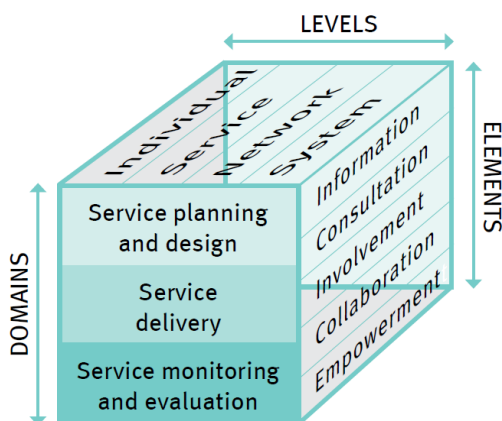
To realise this commitment the *Queensland Alcohol and Other Drugs Action plan 2015-17* includes two key actions (p. 18):

- **Action 34** – Map the extent of alcohol and other drug service users’ engagement in the co-design, delivery and management of services, program and policy development.
- **Action 35** – Develop best practice principles for engagement of alcohol and other drug service users in the co-design, delivery, and management of services, program and policy development.

Of note is that the *Queensland Mental Health Commission Act 2013* - under which the Commission was established and sets out the Commission’s role and functions - Section 35 states that ‘the chief executive under the *Hospital and Health Boards Act 2011* must take the whole-of-government strategic plan into account when negotiating service agreements under that Act to the extent the agreements relate to the delivery of mental health and substance misuse services’. In short, this highlights the importance of each HHS entering into service agreements that support Queensland public health AOD services to undertake CEP.

A common concern for services in embedding CEP is resourcing. For example, service feedback identified in the ACSQHC (2014^a) review indicates resourcing is a key concern for services in implementing *Standard 2: Partnering with Consumers*. It is also reflected by Clarke and Brindle (2010) in stating that ‘service providers by and large do not have the time or money to undertake consumer participation projects. AOD services have not been funded for consumer participation (except occasionally for one off projects)’ (p. 23). This is a particularly important consideration when seeking buy-in from managers, workers and services that may already feel stretched and perceive their time is best spent on clinical and/or support work. Subsequently, how can good CEP be achieved in Queensland public health AOD services in the least resource intensive and sustainable way? A potential step forward is to ensure that AOD services have readily accessible AOD specific support and resources that can be adapted to meet the needs of each service.

In 2012 Health Consumers Queensland [HCQ] (2012a, p. 7) developed a community engagement framework to assist HHSs to introduce and implement consumer engagement strategies at a local level. HCQ’s (2012b, p. 12) framework is underpinned by a set of nine overarching principles supporting an approach to engagement which occurs across:



- three key domains of organisational operation
 - service planning and design
 - service delivery
 - service monitoring and evaluation
- four different levels of engagement
 - individual
 - service
 - network
 - system
- five elements of engagement across a continuum which identifies an increasing level of consumer and community participation and influence in the engagement process from:
 - information, through to
 - consultation
 - involvement
 - collaboration
 - empowerment.

(Source: From Health Consumers Queensland, 2012b, p. 12)

Specific to Queensland's approach to AOD CEP, the *Queensland Alcohol and Other Drug Treatment Service Delivery Framework 2015* 'acknowledges the value of meaningful engagement with clients to ensure services meet their needs' (MacBean et al., 2015, p. 11). Further to this, there are a range of engagement strategies readily available as outlined in the framework which 'include a mix of quick, opportunistic tools (such as feedback forms, surveys, questionnaires and suggestion boxes) to deeper engagement options (such as client meetings, focus groups, consumer committees and opportunities to be a member on boards, reference groups and interview panels where appropriate)' (p. 11). When Queensland public health AOD services embed CEP, these types of strategies, tools and resources may prove valuable and adaptable to individual service contexts.

While mental health services currently use the 'Your Experience of Service' survey, there is no current validated experience of care survey endorsed specifically for Queensland public health AOD services. This will be an important future consideration for Queensland public health AOD services in demonstrating high quality care. One such specific tool, the 'Treatment Perceptions Questionnaire' has been developed in the United Kingdom (Marsden et al., 2000). However, this example should be viewed with caution as its applicability to Queensland client groups and service contexts is untested.

West Moreton HHS hosted the *Mental Health Alcohol and Other Drugs (MHAOD) Statewide Clinical Network Consumer and Carer Partnership Project* (2015). The aim of the project was to identify current CEP practices of MHAOD services in selected HHSs across Queensland and develop a series of recommendations 'to improve opportunities for consumers and carers to be involved in the development, planning, delivery, and evaluation of MHAOD services' (p. v). Consistent with that which has been previously discussed, they found that while mental health services have embedded CEP in practice, AOD services examined in this project are 'in their infancy and requiring focussed effort and consideration to evolve sustainable practices' (p. 2). They point to the need for a current CEP framework that is representative of the contemporary service system that would support services in embedding CEP. It is worth noting that the project makes mention of instances where combined MHAOD services initially indicated established AOD specific CEP however, after more detailed questioning and examination, it was found that combined services had only some crossover with no AOD specific CEP.

In 2008 the Australian Injecting and Drug Users League (AIVL) undertook research (*Treatment Service Users Project*) into the participation of clients in drug treatment services. The AIVL research found 'while 'satisfaction' may be on the radar of some agencies, it has been of concern that there appears to have been minimal attention given to meaningful and active 'participation' by drug treatment service users in a full range of activities involved in providing such services' (AIVL, 2008, p. 11). In addition the study found the reality of client participation tended to fall inside the "low degree' end of a participation continuum' (p. 11). Such studies highlight the need for services to ensure that genuine efforts are made to engage AOD clients at multiple levels in order to improve AOD client experiences of care. Importantly, the implication here is that AOD issues are as relevant and unique as mental health issues and an emphasis should be on engaging clients to participate on multiple levels who have lived experience with AOD issues.

The second phase of the AIVL project (*Treatment Services Users Project Phase Two*) also developed a framework based on *Arnstein's Ladder of Participation* consistent with NSQHS Standard 2 (AIVL, 2011, pp. 26-27):

Degree of consumer involvement	Type of participation	Example of Activity
HIGH	<i>Activities in which consumers share in decision-making</i>	<p>Consumer representatives involved in service planning committees: The service has had a consumer representative as a member of any committee that plans or makes decisions about services or programs.</p> <p>Consumer representatives attend staff meetings: The service has had a consumer representative regularly attend staff meetings.</p> <p>Consumer representative involved in staff recruitment: The service has had a consumer representative involved in the recruitment process for new staff at the service (e.g. a consumer representative contributed interview questions or was a member of an interview panel).</p> <p>Consumer representative involved in staff performance appraisal: The service has had a consumer representative involved in assessing staff job performance (e.g. consumer representatives meet with the nursing unit manager to give feedback on staff performance).</p>
MID	<i>Activities in which consumers have non-decision-making roles</i>	<p>Consumer involvement in resource development: Consumers involved in writing or reviewing written materials such as brochures, fact sheets, newsletters, magazines or educational resources.</p> <p>Consumers involved in staff training: Consumers involved in determining the content of in-service training that is directly relevant to consumers and their treatment.</p>
	<i>Activities that promote and support consumer involvement</i>	<p>Consumers are supported to conduct their own group activities: A service has ways to help consumers facilitate and run their own support groups (e.g. fitness groups, mums' and dads' groups) such as providing space, training or transport.</p> <p>Service displays user group publications — consumer forum: The service displays or makes available in other ways the publications of drug user organisations (e.g. NUAA, VIVAIDS, WASUA).</p>
LOW	<i>Activities concerned with providing information to or receiving information from consumers</i>	<p>Consumer councils: Committees or groups of consumers whose role it is to advise the service about how services and programs are run.</p> <p>Forums: Open meetings in which consumers can express their views about how services or programs are run.</p> <p>Surveys: Surveys that specifically ask consumers for their opinions about how programs and services could be improved.</p> <p>Suggestion box: The service provides a box where consumers can leave written comments regarding their views about how the service or programs are run and suggestions for changes and improvements.</p> <p>Complaints process: The service has put in place a process for consumers to register their complaints about the delivery of the service</p> <p>Produce resources for consumers that include information about service planning: The service has written or produced its own brochures, fact sheets, newsletters, magazines that specifically include information about changes to the policies and programs of the service.</p>
LOW	<i>Consumer participation built in to the values and policies of the service</i>	<p>Consumer participation incorporated into the vision or mission statement/consumer charter of rights: A document is produced outlining client/patient rights, responsibilities and expected levels of service.</p>

(Source: From Australian Injecting and Drug Users League, 2011, pp. 26-27)

Metro North Mental Health – Alcohol and Drug Service (ADS) provides one example of an early journey to better embed CEP in the context of inner city and outer suburb public health AOD services in Queensland. It is noted that there are other HHSs that are committed to improving CEP within their respective districts and that these HHSs will each have a unique contribution to make to improving CEP. Metro North HHS incorporated the HCQ Framework within the *Consumer and Community Engagement Strategy 2013-2015*. While this strategy has now been superseded it demonstrates the methods which can be implemented to achieve the core elements of the framework (Metro North HHS, 2012, pp. 14-15):

Core Elements	Our promise to consumers and community	How (NB: this is not an exhaustive list – all methods should be flexible and support the vision and purpose)
<p>Inform To provide consumers and community with balanced and objective information to assist them in understanding the problems, alternatives, opportunities and/or solutions</p>	We will keep you informed	<ul style="list-style-type: none"> • On-line information • Media articles • In-house publications • Information trees through non-government organisations • Displays and noticeboards throughout facilities
<p>Consult To obtain consumer and community feedback on analysis, alternatives and/or decisions.</p>	We will seek your feedback	<ul style="list-style-type: none"> • Patient experience surveys • Focus groups • Discovery interviews • Consultative workshops
<p>Involve To work directly with the consumers and community throughout the process to ensure that concerns and aspirations are consistently understood and considered.</p>	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how consumer and community input influenced the decision.	<ul style="list-style-type: none"> • Consumer and community champions network • Consumer and community advisory groups • Consumer and community involvement on committees • Involvement of consumer groups in the development and review of patient information • Consumer and community involvement in reviewing patient suggestions, complaints and compliments
<p>Collaborate To partner with the consumers and community in each aspect of the decision including the development of alternatives and the identification of the preferred solution.</p>	We will look to you for direct advice and innovation in working with us to formulate solutions and will incorporate your advice and recommendations into the decisions to the maximum extent possible.	<ul style="list-style-type: none"> • Consumer and community advisory groups • Consumer and community involvement on committees • Quality deliberative processes e.g. citizens juries, 21st Century Dialogue
<p>Empower Empower consumers and where appropriate carers to be actively involved in decisions which improve their experience and care.</p>	We will keep you informed, listen to and acknowledge concerns and provide feedback on how consumer and community input influenced the decision.	<ul style="list-style-type: none"> • Development of person-centred models of care • Systems that support the implementation of person-centred models of care

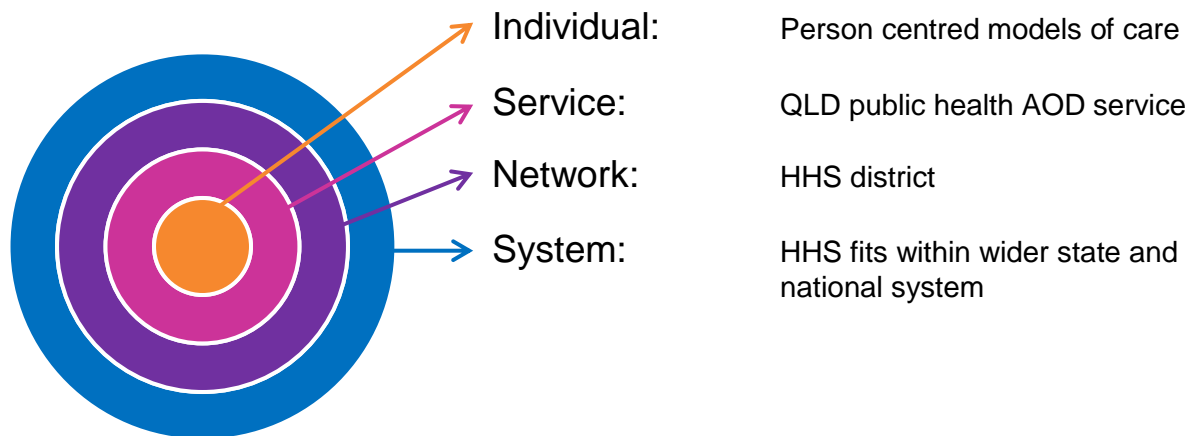
(Source: From Metro North Hospital and Health Service, 2012, pp. 14-15)

The *Connecting for Health Strategy for Inclusive Engagement, Involvement and Partnerships 2016-2018* (2015) identifies Metro North HSS' current commitment to client participation and is supported by the *Metro North HHS Health Service Strategy 2015-2020* (2014). The development of the Connecting for Health strategy is consistent with recommendations made to HSSs in the West Moreton HHS Consumer and Carer Partnership Project (2015). Notably, strategic principals employed by Metro North HHS include client-centred care, maximising client experience and forming meaningful partnerships. The inclusion of CEP in Metro North HHS strategic planning highlights the importance that CEP is supported by higher level processes and provides Metro North HHS with the impetus to drill down to address AOD specific issues.

While client participation in the context of health service provision occurs on many levels, the most common current level of participation in Queensland public health AOD services is likely to be at the individual level where models of care tend to be person-centred. A literature review conducted by Ti, Tzemis and Buxton (2012) found that even internationally there is limited engagement occurring at the policy and service planning levels in the AOD sector. They note that lack of reporting and research on these efforts may in part explain these findings. They also highlight unique barriers to engaging stigmatised populations such as people who use drugs which emphasises the importance of keeping CEP activities contextually relevant and achievable for both clients and services.

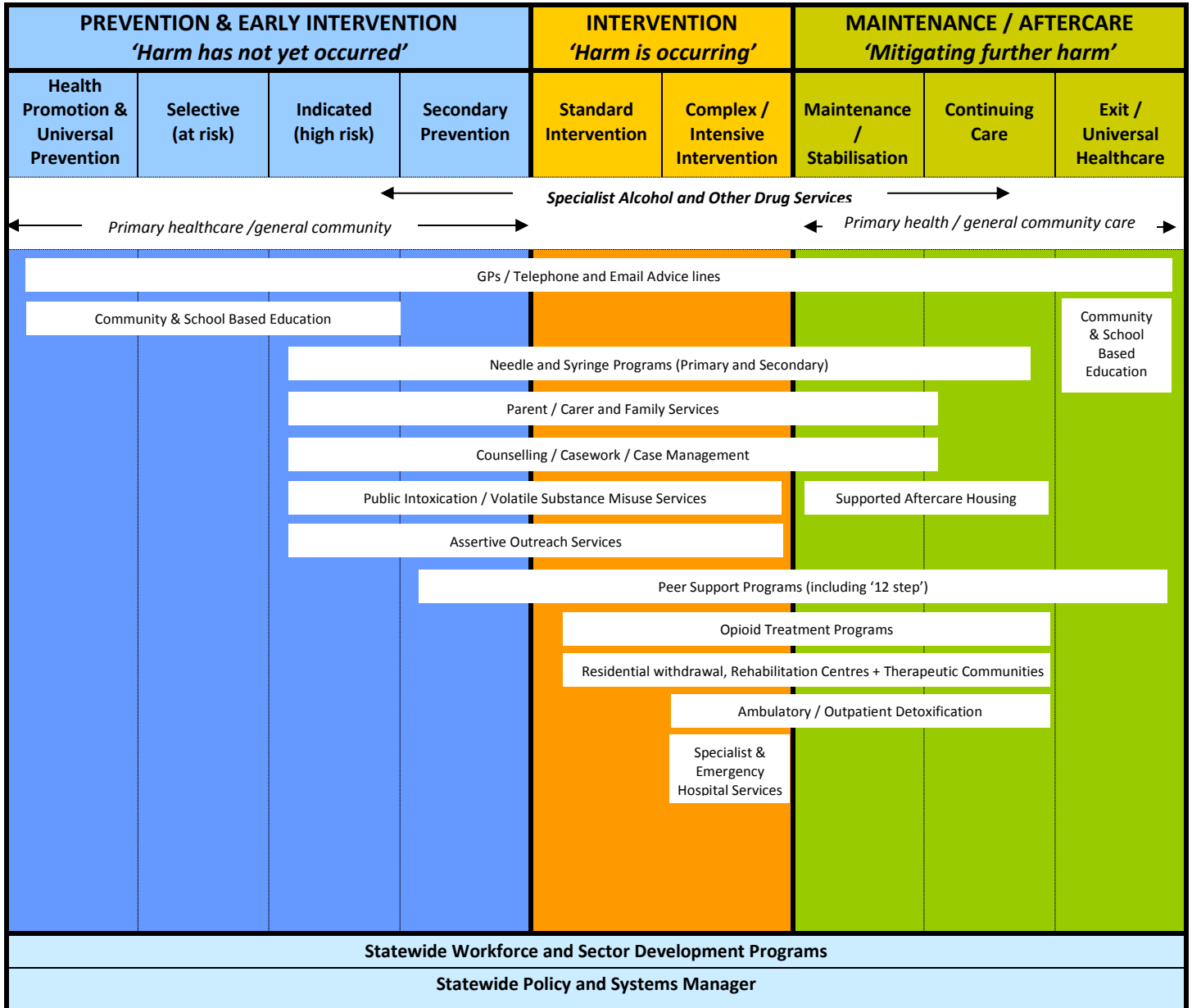
ADS found that while person-centred care was occurring on individual levels of participation on a daily basis in a variety of settings, service and network level engagement processes required improvement. Likewise, a review of service and network level engagement may be a pertinent starting point for Queensland public health AOD services and provide an achievable means to assist in improving the treatment journey of people who are accessing these services. Specifically, ADS identified a need to improve feedback and complaints processes. According to the HCQ framework this represents elements of 'information and consultation', at 'service' and 'network' levels, that affect change in domains of 'service monitoring and evaluation' and 'service delivery.' The resulting improvements led to the implementation of a genuine reciprocal process where client feedback and complaints are encouraged and communication about outcomes are posted via notice boards throughout ADS sites. Service improvements continue to occur on various levels due to better consultation with ADS clients. This provides a starting point for ADS to facilitate better relationships and trust with their client group and creates strong foundations on which to build genuine higher level CEP.

The following figure illustrates the position of Queensland public health AOD services in a broader environmental context:



AOD client group complexity

As identified in the *Queensland Alcohol and Other Drug Treatment Service Delivery Framework* (MacBean et al. 2015, p. 4), AOD clients access treatment and support along a continuum from government, non-government and generic health care services. Client treatment and / or support varies in accordance with the level and type of treatment the client is seeking or the type of treatment that is required upon assessment at presentation to service providers.



(Source: From Queensland Alcohol and Other Drug Treatment Service Delivery Framework, 2015, p. 4)

Clients who access Queensland AOD services present for specialised treatment and support services which are provided in a variety of settings. Treatment types vary from site to site and can include:

- Intake and screening
- Assessment
- Counselling
- Therapeutic intervention
- Treatment planning and review
- Brief intervention
- Discharge planning, aftercare/ continued care
- Consultation and liaison
- Therapeutic groups
- Mentoring programs
- Information and education – Individual & Group
- Needle and Syringe Program – Primary & Secondary Services
- In patient withdrawal management
- Ambulatory / out-patient withdrawal management
- Opiate Treatment Programs
- Nicotine replacement therapy
- Psychopharmacology
- Queensland Illicit Drug Initiative Program (QIDDI)
- Queensland Magistrates Early Referral into Treatment (QMERIT)
- Queensland Courts Referral (QCR).

A 'one size fits all' approach does not ensure meaningful participation for clients given the complexity of interventions and treatment types being utilised. In addition, service delivery occurs in a variety of contexts ranging from information provided over the phone to brief outpatient or inpatient withdrawal to ongoing therapeutic interventions. Differences also occur within populations who access the same service type. For example, people who inject drugs who access primary or secondary needle and syringe programs vary in relation to drug of choice and include the use of both licit and illicit drugs.

In addition to drug/s of choice and legal status, some clients who access needle and syringe programs may not identify as 'injecting drug users', including for example, people who inject performance and image enhancing drugs such as steroids. Meaningful engagement and participation methods must explore ways to ensure opportunity is provided to all service users despite the point of entry and level of intervention. Considerations should also include specific populations who access services and include clients who:

- Identify as Aboriginal / Torres Strait Islander/ South Sea Islander
- Come from culturally and linguistic diverse backgrounds
- Are refugees
- Are young people
- Are people with a disability
- Are people with low levels of literacy
- Are same sex attracted or sex and gender diverse.

The following figure represents AOD client group complexity in relation to CEP:



Ensuring the inclusion of diverse populations within the engagement process will result in more representative data. Such populations may experience greater and / or different barriers to CEP given the additional disadvantage they may have experienced. Additional steps and specific strategies will need to be undertaken to ensure CEP includes the wide range of sub-populations involved. Examples of tailored engagement could include working with culturally specific organisations, youth services, LGBT organisations and utilising tools such as low literacy feedback methods, culturally specific workers and targeted consultations.

Development of endorsed AOD specific strategies within respective HHSs will assist with improving CEP. These strategies should include identifying key performance areas such as fostering inclusion of specific 'hard to reach' populations by tailoring engagement to their needs. In addition, any strategies need to address the unique challenges and barriers to CEP in the AOD field. Subsequently, evaluation measures should be developed to capture and continuously improve CEP activities with this client group.

Barriers to client engagement in the AOD field

It has been reported that 'while consumer participation in drug treatment settings has been institutionalised in policy and practice internationally, in particular the United Kingdom, there has not been an equal level of formalisation in Australia' (Bryant et al., 2008^b, pp. 138-139). Indeed, various reports indicate that AOD clients feel they are not receiving proper opportunities to engage with service providers for a variety of reasons. Subsequently, further investigation into the specific challenges and barriers experienced by clients of AOD services is required.

Recently, Jude Byrne (AIVL) highlighted that it is critical for services to reflect on policy and organisational culture in perpetuating a lack of CEP (Warhaft, 2015). She indicated that despite challenges experienced by some organisations in involving mental health consumers in higher level CEP activities, they (mental health consumers) 'are given a much easier ride into participating as consumers than are drug users' (as quoted in Warhaft, 2015, p. 19). She also described the relationship of people who use drugs with AOD organisations and policy making bodies as 'appalling' saying 'they find us a very difficult group to deal with ... They're frightened of us, they don't understand us and they don't particularly like us' (p. 19). AIVL (2008) go further to suggest that people who use drugs are perceived as lacking interest and even the capability to engage in the planning and delivery of services.

Research conducted in 2008 as part of the AIVL *Treatment Service Users Project* revealed overall 'there was considerable support for the further development of consumer participation in drug treatment services, but the predominant obstacle was the view that it is not consumers' place to take part, and that they lack the interest and skills to do so' (Bryant, et al., 2008^b, p. 138). The research included the views of 64 service providers and 179 service users and examined a broad range of issues associated with CEP in the AOD field. Predominantly, both service providers and service users agreed 'including consumers' views about service provision would improve service quality' but there were some inconsistencies between clients and service providers when it came to the optimal level of involvement (p. 140). Fewer service providers reported 'that their service would be willing to include consumers in 'high'-involvement activities in which consumers would share in decision-making that relates directly to staff (such as staff training, recruitment and performance appraisal)' (Bryant et al., 2008^b, p. 141). Bryant et al. (2008^b) concluded CEP projects need to consider and introduce training for both service providers and clients to maximise usefulness particularly in relation to higher-level engagement.

AIVL (2008) suggests that the AOD treatment context may offer part explanation to the lack of participation in service delivery and planning activities and why this has not been encouraged by services. Of particular note is the time at which AOD clients are usually accessing services for support. The context of AOD use means clients enter services 'at a time when they are extremely vulnerable and may have health, social, financial and legal issues to manage, which creates challenges for people in articulating and asserting their needs and rights' (AIVL, 2008, p. 18). Therefore, an innovative, responsive and flexible approach to engaging AOD clients experiencing these issues which acknowledges these vulnerabilities and power dynamics is required.

People who use illicit drugs in particular experience unique barriers when engaging in CEP activities. Some AOD clients who access treatment services may be fearful of perceived repercussions associated with being part of an engagement process. For example, fear of being denied access to treatment based on negative feedback or being perceived as a 'difficult' client is pertinent for clients accessing pharmacotherapy services (AIVL, 2008). Clarke & Brindle (2010) highlight the point that fear is a significant barrier for AOD client participation stating 'service users may fear that their treatment will be affected or even withdrawn if they give negative feedback to AOD services' (p. 22). As a result, demonstrating to clients that their feedback does not affect treatment is essential.

Fear of the very process of engagement is a barrier for some clients. Considerations such as power dynamics highlight that AOD clients 'may be frightened of speaking their mind in front of professionals for fear of making a fool of themselves or not being taken seriously' and 'often the higher the level of participation, the greater the fear of failure' (Clarke & Brindle, 2010, p. 22). Issues associated with fear of engagement can be further exacerbated when working with specific populations. For example, young people may feel a higher degree of fear when asked to participate and need extra support to build confidence and self-esteem as 'most have never been in a position of influence' (The Werry Centre, 2009, p. 43).

Life experiences of health service users impact on the engagement process. AOD clients are dissimilar to other health service consumers and experience distinctive journeys within the health system. While the impact of stigma on help-seeking has been well discussed in the mental health arena, the illicit nature of the use of many substances undeniably is a 'significant contextual difference facing consumers of drug treatment services compared to other health consumers... illicit drug use marginalises, isolates and stigmatises people and this can act as a significant barrier to the formation of relationships based on trust and mutual understanding between service providers and consumers of drug treatment services' (AIVL, 2008, pp. 18-19).

While undertaking research investigating the UK experience of user involvement in AOD services, Hinton (2010) highlighted the attitudes of workers within services as being a contributing factor. The stereotyping by AOD workers of users accessing services which 'lead to discriminatory practices in provision and the fear, ignorance and moral judgements about illicit use and lifestyle choices mean that users become exempt from the basic rights afforded to other NHS patients' (p. 31). Further, this type of stereotyping and 'negative and moralistic views have become embedded in the fabric of treatment services and means that addiction services are not based on the interests of patients but on the assumption that every user lies... which does not provide a good basis for user involvement' (p. 31).

To this end, there is a need to raise awareness that feelings of distrust exist between clients and services that are exacerbated by the concept of people who use drugs as deviant in some health services (AIVL, 2008). The very nature of any illicit activity is tied up in the personal values, beliefs and opinions of workers operating in services and in some cases clients themselves feel a sense of shame and fear of being judged as a result of this. Likewise, staff may also experience personal ethical dilemmas in working with a person involved in illicit activities whether that is at a service level or an individual level. AOD services in particular are charged with responsibility to ensure that workers are supported, critically reflective and clear about practice frameworks so that clients have positive experiences of care. This will both increase the likelihood of future help seeking behaviour and will also assist in building better relations between services and clients providing solid foundations for CEP.

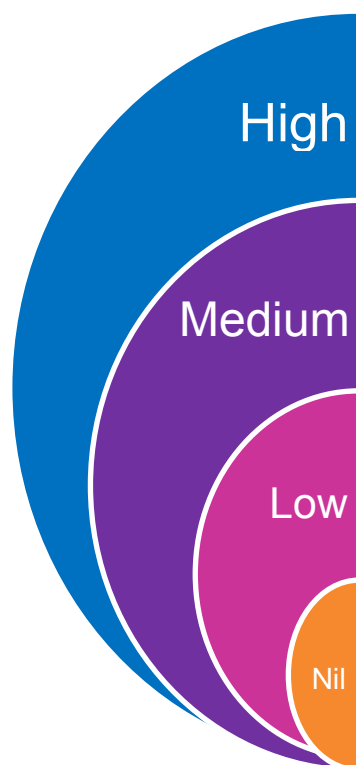
Further to this, the medical model of treatment may impact on the clinical typology of how clients are viewed by service providers. Subsequent client involvement can be impacted by the interpretation of people who use drugs and require treatment as patients who are 'needy', 'deficient' or 'lacking' because of their illness' (Bryant, et al., 2008^b, p. 141). Coupled with the already stigmatised nature of illicit substance use, this may exacerbate an already strained relationship between service providers and people accessing AOD services. This does not devalue the medical model but rather suggests that there is a need for practitioners who operate within this context to be cognisant of the implicit message AOD clients may receive when seeking treatment. Such acute awareness brings light to ways in which these issues can be addressed. While these are challenges in implementing CEP, the nature of CEP provides opportunities for forging new ways of conceptualising treatment and breaking down these barriers.

As a result, when considering CEP it is important to undertake an analysis of need coupled with a process of critical reflection throughout services as 'the implementation of meaningful consumer participation, policies and practices' are 'highly dependent upon the opinions and beliefs of those involved' (Bryant et al., 2008^b, p.139). Ensuring CEP occurs is reliant on support and commitment from all levels of operation from front-line to management levels. Also important is the structural integrity of the commitment to involve clients in engagement with the service. This highlights the importance of embedding CEP in to policy, strategic frameworks and accreditation processes in order for CEP to become the organisational cultural norm rather than the exception. However, there is a risk that well intentioned efforts can be undermined by issues such as 'a lack of resourcing, a failure to embed involvement into strategic objectives and service provision, an absence of guidance or mechanisms to promote enforcement and differing goals among key stakeholders' (Hinton, 2010, p. 34).

Effective resourcing is identified in much of the literature as being an important consideration when engaging clients and as previously discussed, remains a common concern for services broadly (Clarke & Brindle, 2010; Hinton, 2010; MacBean et al., 2015; The Werry Centre, 2009). Accurate consideration must be given to what is achievable for services. This involves planning to meet realistic targets to avoid objectives becoming tokenistic. Effective resourcing is inclusive of providing remuneration for clients who engage and provide a service, such as consumer consultancy. Particularly within AOD services issues regarding cash payments are sometimes raised and alternatives such as gift cards are used. This should be treated with caution as 'this method of payment is considered by many service users to be demeaning, as it implies that consumers should not have the same freedom of choice in spending money as the rest of society' (Clarke & Brindle, 2010, p. 28). An AOD service user was quoted when discussing voucher payment as opposed to cash payment stating that it's 'very insulting demonstrating that users can't be trusted to cope with cash because it's assumed they will buy drugs.....It's infantilising' (as quoted in Hinton, 2010, p. 34). As outlined in the *Queensland Alcohol and Other Drug Treatment Service Delivery Framework 2015*, 'clients who participate in service development activities should ideally be paid for their contribution and reimbursed for any outlay or expense they incur' (MacBean et al., 2015, p. 13).

In sum, AOD service users are generally not receiving adequate opportunities to participate and many services require support and resourcing to ensure this occurs. Effective CEP will benefit both clients and services however multiple barriers must be addressed through a process of service needs analysis, policy and strategic planning, support from all levels of service and critical reflection. One of the most pertinent challenges faced by services and clients alike is the pervasive stigma associated with people who use drugs. Additionally, the criminalisation of people who use certain types of drugs presents unique issues that must be considered to ensure client safety and anonymity. While this is a challenge to the implementation of CEP, the nature CEP also provides a mechanism for addressing these issues.

The Scope of Influence figure below has been adapted from the HCQ *Consumer and Community Engagement Framework* (2012^b) elements of engagement. It provides one illustration of how CEP may be applied in the context of Queensland public health AOD services:



People who use alcohol and /or other drugs are members of an established Client Advisory Committee that regularly works in partnership with your service to improve the planning and delivery of services for clients in your HHS.

People who use alcohol and / or other drugs are invited to help clinicians develop resources to ensure the language used is not stigmatising and that recommendations are realistic. Your service provides reimbursement and / or payment to clients for their time.

Your service surveys clients to find out the best time to run a group activity.

Information is provided to people who use alcohol and / or other drugs about new resources that have been developed by your service.

Benefits of AOD client engagement and participation

CEP legitimises decisions made by services and recognises the expert knowledge held by those who identify as being AOD users (Bryant et al., 2008^a). As stated in the *Nothing about us without us* report, 'people who use drugs themselves are often best able to identify what works in a community that others know little about; they need to be involved if we want to create effective responses with people experiencing problems with substance use' (Jürgens, 2008, p. iii). Jürgens notes evidence of meaningful and pertinent contributions of AOD users in the areas of advocacy, harm reduction and HIV prevention. Specifically, these contributions have been made 'by making contact with those at greatest risk; providing much-needed care and support; and advocating for their rights and the recognition of their dignity' (p. iii).

In addition, important benefits to clients include (Clarke & Brindle, 2010, p. 19):

- Consumers who feel they have a say are more likely to be positive about new proposals and strategies or changes to existing services if they are involved in the planning process. A feeling of ownership creates greater cooperation between the consumer and the service provider.
- Consumers are a (largely) untapped resource who are able to contribute to the growth of an organisation by providing feedback on programs, as well as offer solutions or answers to problems.
- Consumers may develop a better understanding about the connection between funding and services and may be less likely to express resentment and suspicion of how resources are applied.
- Trust is built between service users and staff.
- As services improve through the use of consumer participation, staff experience greater job satisfaction.

Important benefits to service providers include (Clarke & Brindle, 2010, p. 20):

A better service system

- Higher quality services which are more responsive to consumer needs.
- A service system which is more sensitised to the service users' right to be there, to be heard and to hear how decisions affecting them are made.
- Clients learn the value of peer support.

Empowerment and psychological wellbeing

- As service users engage in the participation process they are more able to express their dissatisfaction with services and to offer solutions or ideas for improvement.
- Disengagement from a particular service is less likely if a service user is given the chance to voice concerns.
- Listening to and valuing a person's experiences and knowledge promotes self-esteem. This is a particularly positive outcome for a person who uses AOD services and may be carrying the shame and stigma of their drug use.
- Participation changes a person's position from always needing help to being able to contribute and help others.
- A sense of empowerment contributes to the person's own recovery process. In fact, the very act of participating improves recovery outcomes.

Skills and confidence

- Involvement and participation connects people. It provides support and promotes networking and friendship among peers, workers and policy makers.
- Service users may gain skills in areas such as how to run meetings, communicate ideas, make decisions, deal with conflict and gain support for a cause. These skills can be transferred to a person's wider life and may ultimately lead to employment.

The wider community

- Consumer participation in publically funded organisations provides opportunities for participation in democratic decision-making. This can build the capacity of service users to engage as active citizens in other arenas.

In summary, the potential benefits of actively and purposefully engaging clients of Queensland public health AOD services will include ascertaining how our services are 'perceived and received', the impact services are having, improving the quality of services and program delivery, building relationships with the clients who access our services, and improving outcomes with clients (Health Issues Centre, 2014, p. 2).

Facilitating client engagement and participation

Inclusion of AOD sector recommendations and key lessons is essential to achieve effective and active CEP. Recent recommendations relating specifically to the AOD sector and CEP from the ANACAD Roundtable include (McDonald, 2014, p. 8):

1. That, in providing advice to the Australian Government and others, the ANCD stresses the need to raise the status of consumer participation in the AOD sector, and to resource it adequately.
2. That the ANCD promotes the next phase of the National Drug Strategy (NDS) giving far higher prominence to consumer participation than has been the case in previous phases, moving beyond general statements of principles towards a position where consumer participation is accepted as an integral part of NDS and agency governance.
3. That the ANCD encourages governments to provide leadership and funding for consumer participation in AOD agencies within their respective jurisdictions, including resources to further build the consumer workforce.
4. That the ANCD encourages AOD agencies developing or upgrading their consumer participation initiatives to explore, with those potentially affected by the initiatives, the contributions that drug user and other consumer advocacy organisations can provide.
5. That the ANCD encourages the national AOD research centres and researchers in other institutions to develop and implement research into consumer participation in Australian AOD settings. Priority could be given to identifying the outcomes for consumers and agencies of such initiatives, clarifying the causal pathways and enabling contexts, and providing guidance on transferability and scaling-up.
6. That the ANCD promotes policy work and resourcing that gives specific, prominent and separate attention to the contributions, within the AOD sector, of families and carers, rather than having this subsumed into discussions of consumer participation.

Hinton (2010, p. 36) also identified key lessons throughout her research and made key recommendations for implementation in Australia:

- A commitment to user involvement must be underpinned by proper resourcing, particularly for volunteer reimbursements.
- A commitment to user involvement must be part of the performance standards for the organisation's funding.
- The commitment must be embedded into strategic objectives of an organisation.
- The commitment must also be embedded into service provision so that it is a core part of service delivery activity.
- Stakeholders need to agree on the goal of user involvement, its meaning and its purpose.

In addition to the above recommendations, Sarrami-Foroushani, Travaglia, Debono and Braithwaite (2014^b) identify key facilitators of CEP such as ensuring collaboration is occurring with consumer organisations, managing the scope and size of the project, and proper resourcing and financial support. Following a large scale scoping meta-review of CEP models, they put forward an 8-step model of undertaking evaluation and assessment to better facilitate CEP (described as Consumer and Community Engagement [CCE], p.12):

Step 1: Aim	The first step in the process is to decide on the focus of the CCE intervention. Although an obvious stage, the importance of this step, which forms the basis for the next stages, is often underestimated. The aims of CCE are often unclear and diverse, and interventions may fail, or may not be effectively evaluated, if their purpose, aim and target are not clearly defined.
Step 2: Type of engagement activity	Once the aim is defined, it is necessary to identify which CCE activities are most relevant in light of the aim. Potential CCE activities range from involvement in research, service planning and delivery, through SDM [shared decision-making], policy-making, development of informational materials and decision aids.
Step 3: Participants	After the aim and type of CCE activity have been determined, relevant participants must be identified. CCE participants may be consumers, relatives and carers, citizens and members of the public, members of specific communities, non-government and health consumer organisations, and they may be seen as co-providers, collaborative researchers, and policy-makers.
Step 4: Preparedness to be involved in the process of CCE	One of the emerging themes in this scoping meta-review was the lack of preparedness of stakeholders involved in CCE. Education and training in preparation for participation in CCE activities are crucial prerequisites for any CCE intervention. Assessment of the need for, and the availability of, appropriate forms of education, training and information materials are essential.
Step 5: Engagement methods	Depending on the topic and the individuals involved, potential engagement methods can be developed and applied. These range from strategies which best suit micro-engagement (such as SDM and DAs), through focus groups or discussions that bring together members of a community or communities, to public inquiries which can open debates on health care to a whole community.
Step 6: Measurement of the CCE	Evaluation and measurement of CCE activities will involve process and outcome evaluation. This will include an assessment of the elements such as availability of evaluation tools; measurement of people's experience; and assessment of effectiveness and outcomes.
Step 7: Barriers to CCE	In order to implement CCE, potential barriers need to be identified and addressed. This review identified several barriers, including: cost; culture; structural issues; situation-specific limitations; and population-specific limitations.
Step 8: Facilitators of CCE	In order to implement and enhance CCE processes, potential enablers of CCE need to be identified and harnessed. Facilitators of CCE may include key clinical or patient groups and governmental support.

(Source: From Sarrami-Foroushani, Travaglia, Debono and Braithwaite, 2014^b, p. 12)

Conclusion

Evidence continues to emerge in support of embedding CEP in to practice across the continuum of health services. CEP is a key accreditation standard for health services in Australia and public health AOD services are not exempted from this standard. It is recognised that many Queensland HHSs strategically support CEP however it is critical that strategy translates to action. Specific to AOD services, moving forward with CEP will require consideration of the unique challenges and barriers experienced by AOD clients. It also requires adequate resourcing, critical reflection, analysis, agreement, long-term commitment, communication and importantly collaboration. Greater involvement of AOD clients in a variety of levels of participation is fundamental to fulfilling not only an ethical obligation for service providers but also a clearly articulated right of individuals accessing health services.

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