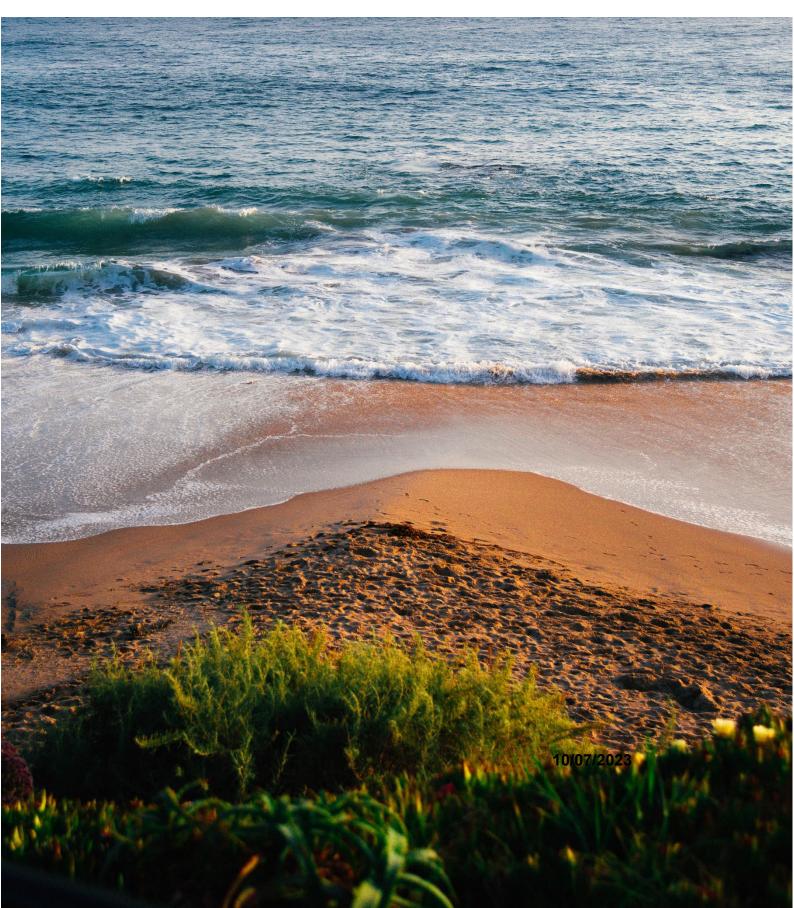# Evaluation of Psychoeducation Modules for Drug and Alcohol Support Service

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Evaluation of Psychoeducation Modules for Drug and Alcohol Support Service

Emily Deans, Wing See Yuen, George Economidis, Anthony Shakeshaft, & Sara Farnbach

Technical report number: 344

Contents

Acknowledgement of Country

The research team would like to acknowledge and pay respects to the traditional custodians of the lands, Tharawal, Eora and Dharug Country, where the Project was completed. Sovereignty was never ceded; it always was and always will be, Aboriginal land.

Ethics

Project aims and methods were approved by University of New South Wales (UNSW) Human Research Ethics Committee. Approval number: HC220331.

Funding Declaration

The Project was funded by South Western Sydney Primary Health Network (SWSPHN).

Executive summary

This report presents the learnings of a project (hereafter referred to as the Project) which used an outcome-based commissioning process to develop, implement, and evaluate psychoeducational modules provided to participants with complex support needs attending Rendu House. Rendu House provides a range of non-residential Alcohol and Other Drug (AOD) services to clients who experience compounding vulnerabilities, and for whom engagement and treatment retention is challenging. This report provides the initial findings of the Project, as of 30 June 2023. An updated report will be provided on 31 December 2023.

The Project was initiated by South Western Sydney Primary Health Network (SWSPHN), who adopted an outcome-based commissioning process focusing on impact, rather than business-as-usual activities and processes. Together with St Vincent de Paul Society and Rendu House, SWSPHN recruited Project Stakeholders to develop the psychoeducation program (360 Edge Consultancy) and to evaluate (National Drug and Alcohol Research Centre, UNSW) the Project and psychoeducational modules.

This evaluation addressed four aims that Stakeholders mutually agreed were the key objectives of the Project:

1. Explore the outcome-based commissioning process used by SWSPHN to fund a program at Rendu House.
2. Identify the feasibility of delivering a program to deliver psychoeducation modules to clients at Rendu House.
3. Establish the acceptability of the psychoeducation modules to Rendu House staff and participants.
4. Identify appropriate outcome measures to examine the impact of the psychoeducation modules on participants at Rendu House.

Summary of findings

The outcome-based commissioning process preceded the development of a program to deliver psychoeducational modules to clients with complex needs at Rendu House. A program logic was developed that mapped the psychoeducation modules to the following outcomes identified as important by stakeholders: participant retention, completion of program and goal achievement, improved mental health and quality of life and reduced AOD use.

The outcome-based commissioning process was positively regarded by Stakeholders as it provided them with clarity around the purpose of the psychoeducation modules, how the modules linked to participant outcomes, and led to changes in outcomes among participants. The psychoeducation modules were well received by Facilitators of the program and Rendu House participants.

Some interviewees reported that some of the psychoeducation module materials were too technical and lengthy for some participants. There were significant human resource requirements needed to deliver modules, which could potentially inhibit module delivery and sustainability. Clinical supervision was important to the capacity-building and professional development of Rendu House workers who facilitated the program. As the Facilitators were highly skilled in delivering the AOD programs they were able to deliver the psychoeducational modules.

The Rendu House facilitators positively regarded the psychoeducation modules because they were viewed as acceptable, able to be individualised and focused on participant outcomes. Participants also accepted and liked that the modules were flexible. Seven participants completed informed consent for the evaluation and completed the psychoeducation modules, and two are currently receiving the modules. Among these seven, psychological distress significantly decreased but there was no noticeable change to quality of life. Further data on participant outcomes will be provided in the updated report on 31 December 2023.

Recommendations

Recommendation A: *Future activity planning should incorporate the outcome-based commissioning process as it was of benefit and valued by stakeholders. Earlier involvement of developers and evaluators may assist with ensuring that stakeholders share a common view around project outcomes.*

Recommendation B: *The psychoeducation modules were well received by Facilitators and participants and should be considered for integration into routine practice at Rendu House and at similar services.*

Recommendation C: *Future implementation of the psychoeducation modules should maintain the ability to deliver the modules flexibly and for clinicians to judge when to adapt materials to facilitate comprehension and participation among clients. Given that other programs at Rendu House are group-based, the psychoeducation modules are a complementary service offering.*

Recommendation D: *Future implementation of the psychoeducational modules will require specific funding to support human resources, with more than one Facilitator delivering modules, to allow for existing duties to be completed. Adequate resourcing will avoid overburdening staff, which may reduce risk of staff turnover.*

Recommendation E: *Selection of Facilitators with previous skills in AOD may be important to deliver the psychoeducational modules. Highly skilled clinicians should be prioritised and less-skilled clinicians should be provided with additional training and supports around AOD treatment approaches. Facilitators may benefit from being inducted/ trained in the Catalyst program prior to delivery of psychoeducational modules.*

Recommendation F: *External supervision of new Facilitators at Rendu House tasked with delivering the psychoeducation modules is warranted, particularly considering the intensive and sensitive nature of this work. This supervision is likely only required for a few sessions because other staff members would be able to provide guidance and monitoring as part of their own internal supervision, upskilling and professional development as the program continues to be delivered over time.*

Recommendation G*: Revising technical language and simplifying some of the module handouts may enhance engagement with participants with low literacy levels. Embedding low literacy options for goal tracking to overcome barries for participants with acquired brain injuries and disability is recommended.*

Recommendation H: *The evaluation should be extended for at least an additional 6- to 12- months to expand the eligible participant sample for whom data can be calculated. It may also be possible to follow up participants over longer intervals to reliably conclude whether improvements on outcome measures are maintained over time (even beyond the life of the program).*

Glossary

AOD	Alcohol and Other Drugs
ATOP	Australian Treatment Outcomes Profile
Client	Individual presenting/ referred to Rendu House for AOD treatment
Facilitators	Rendu House staff member delivering psychoeducation modules to participants
K-10	Kessler-10
NDARC	National Drug and Alcohol Research Centre, UNSW
Participant	Client participating in psychoeducation modules
Project stakeholders	Rendu House, 360 Edge, SVDP and SWSPHN
SWSPHN	South Western Sydney Primary Health Network
SVDP	St Vincent de Paul Society, New South Wales
WHO-8: EUROHIS	World Health Organization Quality of Life Instrument- Abbreviated Version

1. Introduction

1.1 Orientation to the Project

Commissioned by South Western Sydney Primary Health Network (SWSPHN), St Vincent de Paul Society (SVDP) provides a non-residential alcohol and other drug (AOD) rehabilitation program at Rendu House for people seeking treatment for AOD dependence or experiencing harms from AOD.

SVDP's non-residential AOD rehabilitation service is a structured, 6-week program based on Uniting ReGen's Catalyst program [Uniting 2023]. It incorporates group and individual therapeutic interventions, recreation, and social activities to increase clients' coping skills and motivation for positive change. The Rendu House program provides up to 12 months of aftercare support, if required. Clinicians are interested in improving retention and rates of program completion, particularly among their complex clients.

A number of treatment barriers have been identified by Rendu House staff as inhibiting the engagement and retention of clients with complex support needs in the program. These can include poor physical and mental health, cognitive impairment, limited social supports and/or strained relationships, experience of trauma and/or domestic violence, significant legal issues and contact with the Justice System. Clients presenting to Rendu House may also come from low socio-economic areas, with limited finances and resources.

SVDP and SWSPHN expressed interest in designing, implementing, and evaluating a new psychoeducational initiative for delivery to individuals with complex support needs (as classified by the NSW Health Complexity Rating Scale). This Project involved developing new psychoeducational modules, led by 360 Edge (specialists in AOD consultancy), and the National Drug and Alcohol Research Centre, UNSW (NDARC) who was commissioned to evaluate the program.

SVDP was interested in exploring the worth and value of an outcome-based monitoring process that shifted focus from an 'activity-based' evaluation model of process measures (i.e., *how many services have been delivered and to whom?*) to understanding and evaluating outcomes for clients. The broader implication of this Project is to provide novel evidence around psychoeducation in AOD rehabilitation services and to build capacity among Rendu House to evaluate services beyond the Project.

1.2 Project Management Group

A Project Management Group was established and met fortnightly between June 2022 and June 2023 to discuss the design, implementation, and evaluation of the Project and the psychoeducation modules, including:

- Evaluation Team: **NDARC** (led by Emily Deans, Sara Farnbach, Anthony Shakeshaft, George Economidis and Wing See Yuen)

- Psychoeducational module developers: **360 Edge** (led by Steven Bothwell, Paula Ross, Amanda Davies and Richard Cash)

- **SVDP** and **Rendu House** staff (led by Monica Yanni, Rhiannon Cook, Christine Faddoul and Solange Frost)

- **SWSPHN** staff (led by Ben Neville, Nick McGhie, Val Burge and Swati Vir)

1.3 Evaluation aims

The Project was guided by four evaluation aims:

1. Explore the outcome-based funding process used by SWSPHN to fund the Project at Rendu House.
2. Identify the feasibility of delivering the psychoeducation modules at Rendu House.
3. Establish the acceptability of the program to Rendu House staff and participants.
4. Identify appropriate outcome measures to examine the impact of the psychoeducation modules on participants at Rendu House.

1.4 Participant eligibility to complete the psychoeducation modules

Complex needs are assessed at intake to Rendu House via the NSW Health Complexity Rating Scale (provided to NDARC via personal correspondence on 7 November 2022). The NSW Health Complexity Rating Scale assesses symptom severity and functional impairment across five domains, comprising: substance use, physical health, mental health, cognitive function, and socio-economic factors (including, social networks or social

supports, residential stability and safety, financial stability and safety, legal issues, recent prison release, children in care or child wellbeing concerns).

Client scoring 7 or above are categorised as having 'complex support needs' and are eligible to participate in the psychoeducation modules (hereafter, Participants). If a score is less than 7 at initial intake (i.e., considered 'non-complex'), but the client shows signs of complexity throughout treatment, they can be referred to the psychoeducational modules, based on the judgement of clinicians.

1.5 Development of psychoeducation modules and implementation at Rendu House

During the Project, 360 Edge worked collaboratively with Rendu House staff to draft ten psychoeducation modules to support the retention and engagement of clients with complex support needs.

360 Edge provided Rendu House staff who facilitated the psychoeducation modules (hereafter, Facilitators), with a Program Facilitator Guide for use when delivering the modules. The Facilitator Guide outlined the activities of each module and handouts to support each activity. 360 Edge provided two clinical supervision sessions to Facilitators to introduce them to the modules and support them to plan to deliver them.

Program completion is defined as completing the core component (Making a Start), and at least two other modules, which could be decided by the Facilitator and Participant in response to the needs and priorities identified during Making a Start. Participants met with their Facilitator weekly to complete the identified modules. Progress through the psychoeducation modules was self-paced, with time taken to complete modules unique for each Participant. The psychoeducation modules, as well as their goals and objectives, are briefly summarised below.

1) *Making a start* (core component): aims to collaboratively develop an initial "Recovery Plan" and goal setting.

2) *Problems and solutions:* aims to introduce a problem-solving framework, identify current problems and collaboratively problem solve to increase helpful thinking skills.

3) *Dealing with difficult situations:* aims to identify triggers, understand and practice coping skills for high-risk situations, and increase awareness and skill of assertive communication.

4) *Looking after your mental health (anger):* aims to introduce and build behavioural, relaxation and quick cognitive strategies to manage anger ("Personal Anger Defusing Plan").

5) *Looking after your mental health (low mood):* aims to introduce, understand and plan strategies to manage low mood.

6) *Looking after your mental health (anxiety):* aims to understand and plan strategies to manage anxiety.

7) *My supports:* aims to increase awareness and use of strategies to strengthen social supports and to improve communication and conflict management skills.

8) *Life needs and life skills:* aims to identify and enhance existing strengths and skills, and identify priority needs not covered in other modules.

9) *Looking after your physical health:* aims to increase understanding and use of strategies to improve physical health including exercise, nutrition, and sleep (development of a "Personal Physical Health Plan").

10) *Staying on track:* aims to introduce and build skills in relapse prevention (abstinence violation effect, craving management strategies, "Relapse Prevention Plan")

2. Methods

A mixed method evaluation was completed, which included qualitative and quantitative data to address the evaluation aims outlined in Section 1.3, as summarised in Table 1. This approach was chosen as it allowed for the exploration of stakeholder and Participant views (i.e., to explore acceptability and feasibility), as well as participation and outcome data to determine implementation and the impact of the psychoeducation modules, including participant outcomes. Due to the small sample size, quantitative data are largely reported as descriptives (i.e., number/percentage of participants, means, medians), though where feasible, paired samples t-tests were conducted to compare outcomes at intake versus program exit. Prior to data collection, the team sought ethical approval from the University of New South Wales Human Research Ethics Committee [Approval # HC220331, refer to appendix A]. All participants completed informed consent before taking part in the evaluation.

Table 1: Summary of evaluation components

Key evaluation questions	Data collection method					
	Qualitative data			Quantitative data		
	Interviews with staff (Rendu, SWSPHN)	Interviews with clients	Workshop with staff to develop program logic	Program (modules) delivery data [a]	Routinely collected client data from Rendu House [b]	Outcome based commissioning outputs and activities [c]
1. Explore the outcome-based funding process used by SWSPHN to fund a project at Rendu House and explore staff views about its pros and cons.	✓					✓
2. Identify the feasibility of delivering the psychoeducation module at Rendu House.	✓	✓		✓	✓	
3. Establish the acceptability of the program to staff and clients.	✓	✓				
4. Identify appropriate outcome measures to examine the impact of the psychoeducation modules	✓	✓	✓	✓	✓	

on clients at Rendu House.						

[a] Includes data collected by facilitators about implementation the psychoeducation modules.

[b] Includes, Australian Treatment Outcomes Profile [ATOP], Client Satisfaction Questionnaire [CSQ8], Client Outcomes Management System Questionnaire [COMs], Kessler Psychological Distress Scale [K-10]

[c] Includes information about Project timeframes, agreed priorities/plans, and decision-making processes.

2.1 Collection of information about the outcome-based monitoring process and activities

Data was collated from Project stakeholders (Rendu House, 360 Edge, SVDP and SWSPHN) pertaining to the outcome-based monitoring process followed to plan and evaluate the Project activities. Qualitative data was collected via interviews with Rendu House and SWSPHN (refer to Section 2.2), and documents surrounding the outcome-based monitoring planning and decision-making process were collated and summarised.

2.2 Interviews with staff and participants

A qualitative study using structured interviews was completed with Rendu House and SWSPHN staff and participants who completed the psychoeducation modules. Interviews explored perspectives around the strengths of, and limitations to, the outcome-based monitoring process, feasibility and acceptability of the psychoeducation modules, and aspects of the modules expected to lead to positive change to inform the selection of outcome measures.

Snowballing technique was used to recruit until all eligible Rendu House staff, SWSPHN staff and participants were invited to take part. Interviews were conducted according to participants' preferences (virtually, in person or phone). Interviews were digitally recorded and transcribed verbatim using an external transcription service after signing a confidentiality agreement. Interview data were deductively analysed [Miles & Huberman 1994], and key themes related to aims were developed. QSR NVivo [QSR International 2023] was used to manage data.

2.3 Routinely collected client data from Rendu House

Rendu House routinely collects data from clients as part of their business-as-usual process, including clinical measures collected at intake and discharge. Aggregated non-identifiable data from all Rendu House clients who attended the service were analysed to identify the proportion of clients eligible that received the psychoeducation modules during the evaluation timeframe. Clinical data were provided for participants who completed informed consent to take part in the evaluation.

2.4 Collection psychoeducational module delivery data

Rendu House staff recorded data around delivering the psychoeducational modules, including which modules were delivered, the number of modules completed, and total time taken to complete modules for each Participant. Descriptive statistics were used to summarise these data. Percentages were calculated for categorical data (valid percent where data was missing); mean and standard deviation for continuous data; and median values for skewed or count data.

Participants were encouraged to select one or more goal of focus during the program, these were documented during their engagement. The goals identified by participants were thematically analysed to identify the types and frequency of goals selected.

2.5 Identification of outcome measures using a co-designed program logic

A program logic was co-designed to articulate a model specifically for delivering the psychoeducation modules at Rendu House. The program logic outlines each psychoeducation module and links it with outcome measures and mechanisms of change (describing how each module is expected to impact on participants). This approach has the benefit of directly linking the psychoeducation modules with outcome measures, providing clarity around expected changes.

The program logic and outcome measures were iteratively co-designed by NDARC researchers and stakeholders. Stakeholders were identified by the Project Management Group and included representatives from 360 Edge, SVDP, NDARC, SWSPHN and Rendu House. An initial program logic was drafted and included outcomes identified as important by SWSPHN, SVDP and Rendu House, to reflect the original priorities of the Project [1]. Subsequent versions of the program logic were developed during a series of focus group discussions with project stakeholders (refer to appendix B). The program logic was refined until consensus was achieved among the stakeholders about the relevance of the outcome measures and their relation to the modules.

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[1] Outcomes were identified during the outcome-based funding process, refer to section 3.1.

Co-design was used as it incorporates the views of project stakeholders by developing equal partnerships and encourages the uptake of findings and project outputs [Foley, Attrill & Brebner 2021]. Focus group participants completed informed consent to engage in the co-design process.

3. Results

3.1 Explore the outcome-based commissioning process

This section explores the steps taken in the outcome-based commissioning process and the views of stakeholders about the process.

Key findings

- A series of three outcome-based commissioning workshops were held with SWSPHN, SVDP and Rendu House stakeholders which identified the need for a program focused on clients with complex support needs at Rendu House.

- Although stakeholders acknowledged early challenges in the outcome-based commissioning process associated with cross-agency communication and Project timelines, these were largely resolved via ongoing collaboration.

- Stakeholders positively regarded the experience of the outcome-based commissioning process. The process provided them with clarity around purpose of the new psychoeducation modules, how the modules were linked to participant outcomes and how their work led to changes in outcomes among participants.

- A needs assessment conducted by 360 Edge identified the opportunity for a new approach to incorporate individualised content addressing participant emotional, psychosocial, community and psychoeducational needs.

Steps taken during the outcome-based commissioning process

Guided by the principles of outcome-based commissioning; focusing on impact, as opposed to business-as-usual activities and processes, SWSPHN conducted three workshops with stakeholders from Rendu House and SVDP in early 2021 to identify the needs of the Rendu House clients, important outcomes which address that need, and potential strategies to achieve those outcomes.

The workshops identified the following as desired outcomes for clients:
- Building good connections

- Decreasing social isolation
- Decreasing physical health concerns
- Increasing emotional resilience
- Increased life skills
- Increased confidence
- Increased accessibility to life skills
- Improved quality of life

In response to the above outcomes devised in the workshop, Rendu House and SWSPHN decided to design and trial a psychoeducation approach for Rendu House clients who have complex support needs.

360 Edge is a consultancy with specialist skills in AOD, mental health and justice psychoeducation and was engaged to design the psychoeducation approach. 360 Edge undertook a needs analysis with Rendu House staff and clients prior to developing the new psychoeducation modules, to identify the strengths of the current day program and challenges to engagement, participation and retention.

The findings of this needs analysis were provided to NDARC on 13 September 2022. The primary suggestions for program changes were:

- More content on tools to manage anger problems.
- More tailored content around repairing relationships and building social supports.
- Inclusion of psychoeducation components (stages of change and motivation skills).
- More content to support community integration and the development of day-to-day life skills.

Staff perspectives on the outcome-based commissioning process
This section presents findings from interviews completed with stakeholders about the outcome-based commissioning process.

Theme one: Outcome-based commissioning process provided clarity around purpose and project design

Stakeholders reported that the outcome-based commissioning process provided them with a sense of clarity around the purpose of the new psychoeducation modules as it built their knowledge around how the modules were linked to participant outcomes (e.g., retention, mental health and quality of life).

> *For me it was like what's the purpose of this [the modules]? So, it was really good to say, 'hey we'll be working on monitoring the retention levels, or the improvement in mental health and quality of life'. To be able to have that in the back of your mind while you're delivering these modules and witnessing that improvement has been really rewarding.* ***Staff #1***

The experience of developing the program logic for the psychoeducation modules was positive for Facilitators, as it built their knowledge around the purpose of recording particular outcome measures, which appeared to give them a sense of clarity around their work.

> *I personally liked how we had the tools for the outcomes and we had process measures … I also really like the 'why these modules work' [of the Program Logic], it really did put into perspective, doing this will produce this, it's easy to see the outputs, tying into the original outcomes that we stipulated.* ***Staff #3***

Theme two: Outcome-based commissioning process encourages innovation

A few stakeholders reported that the outcome-based commissioning process was useful as it provided them with new insights around how their work led to changes in outcomes among participants. They appreciated the opportunity to move beyond counting numbers of activities to focusing on the impact of their work on participants outcomes.

> *It's one of those models [outcome-based commissioning] that's really innovative, and if it's actually worked out the right way it would be excellent because what we find in healthcare it's how many activities did you do? How many clients did you see? How many referrals did you complete? We barely look at if there's been a change.* ***Staff #3***

Theme three: Outcome-based commissioning requires effective stakeholder collaboration, adequate resources and time

During the early phases of the outcome-based monitoring process, stakeholders reported that there were challenges ensuring the various agencies were working towards similar outcomes. Stakeholders perceived that closer collaborations during the early stages of the Project would have been beneficial, as it was complex, and had several moving parts.

> *It took a little bit of pulling teeth…getting ourselves organised, getting into meetings, getting the brief out, having the evaluation panel [recruitment of NDARC to lead evaluation], we always got confused with scope. Everyone is quite new to the whole logistics of a research project as well, like ethics, etcetera.* **Staff #3**

Some staff expressed that the Project timeline was ambitious, and that participants progress towards outcome measures and completion of modules may take longer than anticipated due to the complex barriers to engagement that they may experience.

> *It comes down to time… Will they engage? Will they be there for the next week? I feel like there will be barriers to that…it's very likely that they may cancel or something else has come up in the next session. We try to keep in mind we're working on a deadline. We are aware of that. We can understand that, and it may be different if there's no deadline, maybe we could be doing things more efficiently.* **Staff #2**

3.2 Identify the feasibility of delivering the psychoeducation modules at Rendu House

This section presents aggregated data from all Rendu House clients who attended the service during the evaluation timeframe and routinely collected client data for participants who have consented for this evaluation. Information collected via Interviews with stakeholders and participants about the psychoeducation modules is also presented.

Key findings

- Of the 31 participants who were referred to the psychoeducation modules at Rendu House, 10 (32%) were assessed as having a NSW Health Complexity Rating Score above 7 and the remaining 21 (68%) were referred based on clinician judgement. Of the 13 eligible participants who consented to having their data used for this evaluation, 29% were female, 36% were Aboriginal and/or Torres Strait Islander, and 43% reported that they received income support as their primary source of income.

- Seven participants completed the three psychoeducation modules at the time of report, two are currently receiving the modules (as of June 2023), and four participants disengaged from the program before completion.

- Staff identified that the handouts were at times too technical and lengthy for some participants and that there were significant resource requirements needed to deliver modules, which could potentially inhibit module delivery and sustainability.

- Facilitators highlighted the importance of clinical supervision as key to their capacity-building and professional development. Although some participants acknowledged discomfort or difficulty retaining information from the psychoeducation modules, many recognised the efforts of Rendu House staff in this process and like the flexibility of service delivery.

Participant characteristics and outcomes

Program eligibility

During the Project timeframe, there were 185 intakes to Rendu House. Of these intakes, 31 (17%) were referred to psychoeducation modules. Of the cases that were referred to the psychoeducation modules, 10 (32%) met the complex case criteria (NSW Health Complexity Rating score > 7) and the remaining 21 (68%) were referred based on clinician judgement.

Characteristics at intake

Thirteen participants who entered the psychoeducation modules during the Project timeframe provided informed consent to have their data included in this evaluation. The mean age of these participants was 39 years (standard deviation [SD] = 10.7). Nearly three-in-ten participants (29%) identified as a cisgender or transgender woman. Over one-in-three participants (36%) identified as Aboriginal and/or Torres Strait Islander. Over two-in-five participants (43%) indicated that their primary income source was *JobSeeker* or the Disability Support Pension. Median NSW Health Complexity Rating score at intake was 7 (interquartile range [IQR] = 6-8).

Participation in the psychoeducation modules

Of the 13 participants included in the evaluation timeframe, seven completed the program (defined as completing three or more modules), four disengaged from the program (defined as completing fewer than three modules), and two are currently participating in the program as of June 2023. Of the 11 participants who have exited the program (i.e., completed or disengaged), the median duration in the program was 48 days (IQR = 36-86) and the median number of psychoeducation modules completed was 3 (IQR = 1-4).

Of the ten psychoeducation modules, the module with highest completion across the 13 participants included in the evaluation timeframe was "Making a Start", followed by "Staying

on track" (Table 2). A small number of participants (n<5) did not complete the "Overcoming barriers" activity in the "Making a start" module.

Table 2: Percentage of clients completing each psychoeducation module during the Project timeline, collected by clinicians

Module	% participants completed
Module 1: Making a start	92
Module 2: Problems and solutions	0
Module 3: Dealing with difficult situations	30-39*
Module 4: Looking after your mental health (anger)	<19*
Module 5: Looking after your mental health (low mood)	20-29*
Module 6: Looking after your mental health (anxiety)	20-29*
Module 7: My supports	30-39*
Module 8: Life needs & life skills	0
Module 9: Looking after your physical health	<19*
Module 10: Staying on track	54

*Note. N = 13. *Presented as a percentage range as cell size is <= 5. Rounded to the nearest whole percentage where full percentages are presented. Includes consenting participants who completed the program, are currently in the program, and who disengaged from the program.*

Reasons participants exited the psychoeducation modules

The most common reason for exiting the program were completion of psychoeducation program, followed by exiting the program due to disengagement, other health needs taking priority, or because the participant's immediate needs had been met.

Staff perspectives about the feasibility of delivering the psychoeducation modules

Theme four: Program Facilitator Guide and handouts were too technical and long

Facilitators reported that they adapted the module handouts and parts of the Program Facilitator Guide because they perceived that some sections were too lengthy and technical for participants to complete, particularly those with low literacy levels and acquired brain injuries.

> *I think with the modules itself…we had to tweak a few things. What I found challenging was that it had the facilitators guide, the tables and the worksheets all combined…It's already using terminology such as relapse and lapse, and a lot of clients don't know what the difference is.* **Staff #1**

Theme five: Outcome measures were difficult for participants to comprehend

Facilitators reported that some outcome measures (Goal-Based Tracker) were difficult to comprehend for some participants with cognitive impairments. For instance, the outcome measure asked participants to set a goal and assess their progress towards it at each session.

> *I do feel what ends up happening in some cases, and again this comes back to clients understanding, they may not understand the question. I notice sometimes that they answer the first one in a totally different way to the second one…* **Staff #1**

Consequently, staff recommended incorporating a simplified goal tracking measure, which would be more feasible for participants who have lower levels of comprehension.

Theme six: Delivering the psychoeducational modules limited Facilitators' capacity to deliver business-as-usual activities

Staff expressed concerns around limited human resource and capacity to deliver the psychoeducational modules sustainably beyond the Project timeframe. Further, staff relayed that facilitating the modules required significant AOD expertise and experience with implementing Rendu's existing Catalyst program (which not all staff are trained in). Staff suggested that changes to the team structure may be required to provide sufficient time for Facilitators to deliver the psychoeducation modules, and to redirect their existing duties to other staff (e.g., existing duties include clinician debriefing and case management).

> *It's very difficult because we've only got one staff member running the groups within the complex support needs program space… trying to keep up, from modules running on a daily basis, administrative duties, check ins and other additional items as per her contract and to support her team as well. It was quite a lot.* ***Staff #2***

Theme seven: Clinical supervision built the capacity and skills of clinicians to deliver the psychoeducational modules

Staff relayed that clinical supervision provided by 360 Edge was helpful and supported Facilitators to address challenges and increase their capacity to problem solve around module delivery. In particular, Facilitators appreciated the supervision with 360 Edge staff who had clinical experience with delivering psychoeducation initiatives to participants with AOD needs.

> *We now have supervision with 360 Edge. It was really beneficial. We took away that we were able to have these conversations around what strategies we put in place if we were to encounter such a client and it was just good talking about that, helpful.* ***Staff #2***

Participant perspectives about the feasibility of the psychoeducation modules

Theme eight: Mode of delivery enhanced accessibility to Participants

Participants reported that they appreciated the ability to receive the modules remotely and with no fee for service. They reported that the flexible delivery options made it logistically accessible to them, which enabled them to participate.

> *I'm in a position in my life where I can't afford to go and speak with a psychiatrist, or a clinical psychologist privately, on a weekly basis. So, there's a good balance between what's available to me from services like Vinnies...I've completed my time with [Facilitator's name removed] over the phone because I'm enrolled with another service as well. It's been handy because it's accessible because of that fact.* **Participant #1**

Theme nine: Completing outcome measures could be an uncomfortable process

Participants relayed difficulties and feelings of shame when completing the outcome measurement tools because they were a reminder that they *'had issues that needed ironing out' (Participant #1).* Some relayed stories of the process of getting comfortable with answering questions about their substance use, and that over time they adapted.

> *Nowadays talking about the substance abuse, it's not so bad but years ago I probably wouldn't have done it (ATOP). I would have just said 'Yes, I take ice', and that would have been it.* **Participant #4**

Participants expressed that the way Rendu House facilitators delivered outcome surveys supported them to feel comfortable with answering questions about their substance use.

> *She (Facilitator) put it like a caring sort of friend wise [way], and it made it easier that way. She made it seem like I was just talking to a friend and that actually helped quite a lot… She wrote all my answers that I said and then sent them out to me.* **Participant #4**

Similarly, participants reported that some questions relating to the frequency of mental distress, depression or feelings of worthlessness (K-10) were difficult to answer because they were unable to recall specific times they experienced each mood.

> *Just some of the questions that she asked I couldn't really give answers and that, or I was trying to like figure out the answers… about how often do I feel nervous, depressed, that everything was an effort, or worthless. I don't know because I don't really take notice of stuff like that.* **Participant #5**

Theme ten: Content was difficult to retain for participants

Participants had several competing demands to manage and reported that these demands took priority over the module activities (court attendance, meeting court orders and urgent health needs). Participants spoke about the challenges in retaining information, explaining that remembering tasks they intended to complete from the psychoeducation modules and reflecting on their progress towards goals was difficult.

> *It's [my memory is] a barrier [to completing the modules] because I've got organic brain damage, where there's parts of the brain that's dead. So yeah, my memory has suffered. I'll forget. When [Facilitator's name removed] rings me up the next week and says 'we talked about this last week and we're doing this today'. I don't know.* **Participant #6**

Participants appreciated being able to compare ratings around their goal progression, which helped them to remember what they were working towards and helped them to 'see' their progress.

> *One [goal] was a 4 at the start, like how confident I am about staying off and getting well. And then by the end of it, it was a 9. One was a 2 and I think got to an 8, the other [goal]. So that was good. When they do that at the start, I can't even remember what the numbers were back then. She didn't tell me what the numbers were to start with. She waited… and I went 'did I say that?'. What that did is give me belief in myself that what she was talking about can help.* **Participant #6**

3.3 Acceptability of the psychoeducation modules

This section reports on interviews completed by staff and participants about the psychoeducation modules and aggregated data from all Rendu House clients who attended the service.

Key findings

- Facilitators positively regarded the psychoeducation modules from an acceptability, individualisation and participant outcomes-centred perspective overall.

- Participants also accepted and liked the level of flexibility of the modules, explicitly noting its capacity-building focus as a key strength of the program.

Staff perspectives about the acceptability of the psychoeducation modules

Theme eleven: The psychoeducation modules were acceptable to Facilitators

Facilitators reported having a positive experience delivering the psychoeducational modules when they saw Participants experiencing positive outcomes that they perceived to be linked to the modules. Staff reported that there was a general willingness among existing clients to choose to receive modules to complete the program and for Participants to stay engaged with Rendu House for longer periods.

> *It's been amazing results so far … the general usual trend is that they start to drop off and disengage after you know 6 to 8 weeks … There's been a lot of successful completions [of the psychoeducational modules] in the last six weeks alone. I've had more closures because they've been successfully completing the program versus disengagements.* **Staff #1**

Theme twelve: The psychoeducation modules could be tailored to need

Facilitators relayed that the psychoeducation modules were tailorable and flexible, while still providing participants with structure to achieve their goals. The one-on-one delivery option was acceptable and meant that participants with different needs were provided for (e.g., Participants with acquired brain injuries and significant cognitive impairment).

> *I think with this program it really gives you that flexibility to cater to needs.* **Staff #2**

Theme thirteen: Facilitators noticed positive outcomes for participants

Facilitators reported that participants were engaging with the modules and developing knowledge and skills around their triggers.

> *A lot of the clients have been progressing towards the goals and they're reflecting on that as well. Like they look back, and they'll be like, 'hey at the beginning of the program I didn't know anything about anxiety. I didn't know anything about anger management. And now I've got all these tools in place and I've been using it outside of the treatment session'. So that's been really, really positive.* **Staff #1**

Participant perspectives about the acceptability of the psychoeducation modules

Theme fourteen: Psychoeducation module content was acceptable to participants

Participants expressed that the modules *"hit the core concepts of important information"* *(Participant #1)* related to their needs around mental health and AOD use, and strategies to prevent AOD relapse. Participants appreciated the *'life skills'* and *'my supports'* modules, which were perceived as unique and valuable service offerings.

Theme fifteen: Participants appreciated having flexible delivery options

Participants appreciated having one program Facilitator, who tailored the delivery of the modules to suit their needs. Participants expressed that there was latitude so they could focus on areas they wanted to develop or refine, and enough flexibility to ensure modules were tailored to their ability and need. Participants also expressed that one-on-one psychoeducation modules was an additional service offering at Rendu House which meant they didn't have to do group work.

> *"It was either that or you go in a group, and I'm not good with groups. If I was in a group and everyone's telling this and that, it'd probably just get me more where to go get on again"* **Participant #6.**

Theme sixteen: Participants noticed building skills around mental health and AOD

Participants relayed the various coping strategies they developed while working on the modules, including strategies to manage anxiety, anger, and low mood. Participants expressed they had more motivation to create alternative narratives for themselves after completing the modules, with some participants choosing to continue to develop skills through additional service offerings at Rendu House.

> *They were good, I learnt a few things, a couple of new strategies, I'm more determined, you know what I mean? I don't want to go back to jail, we worked on strategies to keep me out, things we can do to keep me out of jail… I've got strategies there, my toolbox, my experience was good, I'd highly recommend them to anyone.*
> ***Participant #3***

3.4 Identifying appropriate outcome measures to examine impact of the psychoeducation modules, and their feasibility

This section describes the outcome measures included in the program logic and reports their use during the evaluation.

Key findings:

- A program logic was developed which mapped the psychoeducation modules to outcomes (participant retention, completion of program and goal achievement, improved mental health and quality of life and reduced AOD use), which were measured with a corresponding outcome measure (Goal-Based Outcomes (GBOs) tool, Australian Treatment Outcomes Profile (ATOP), Kessler psychological distress scale (K-10) and the health and social functioning WHO-8: EUROHIS Quality of Life scale).

- Of the 7 participants who completed the outcome measures at intake and exit, psychological distress significantly decreased but there was no noticeable change to quality of life.

- Of the participants who completed the GBO measure on multiple occasions, most (n=9) chose a goal related to relapse prevention and used strategies to reduce or stop use or increasing knowledge around mental health and coping (n=7).

Outcome measures identified in the program logic

Outcome measures were identified during the workshops attended by SWSPHN, Rendu House and SVDP and refined during focus groups led by NDARC (refer section 2.5). Outcome measures were mapped to the psychoeducation modules in the program logic (refer to *Figure One*).

Unique treatment goals

The Goal-Based Outcomes (GBOs) tool [Law & Jacob 2013] is an 11-point scale for rating a client's progress towards a chosen therapeutic goal (refer to appendix C). The GBOs tool is easy to complete, reliable and validated, and has been implemented with populations with complex needs [Lloyd 2019]. Using the GBO, clients can select one or more of their own goals (goals are not specified) and rate the progress towards achieving their goals at multiple timepoints. The GBOs is not part of routinely collected data at Rendu House and was newly introduced during the Project to measure goal completion.

Drug and alcohol use

The Australian Treatment Outcomes Profile (ATOP) [Lintzeris et al 2020] is a commonly used tool to measure substance use among clients within AOD treatment settings. It is a simple, self-reported metric to ascertain substance use and screen for risk. The ATOP is part of routinely collected data at Rendu House, completed at intake and discharge.

Psychological distress

The Kessler psychological distress scale (K-10) [Kessler, 1996] is a widely used measure to identify psychological distress and to identify participants who may need further assessment and support for clinical mental illness. The K-10 is a simple and effective self-reported measure of psychological distress and is part of routinely collected data at Rendu House, completed at intake and discharge.

Quality of Life

The health and social functioning WHO-8: EUROHIS Quality of life scale [World Health Organisation 2012], is used to measure quality of life. The 8-item tool is simple, effective and is a shortened version of the World Health Organization Quality of Life Instrument-Abbreviated Version (WHOQOL-BREF). The EUROHIS-QOL 8 item index has been validated in treatment settings [Sica da Rocha 2012] and is part of routinely collected data at Rendu House, completed at intake and discharge.

Figure One: Program Logic outlining the psychoeducation modules for participants with complex support needs attending Rendu House

TARGET PROBLEM	MODULES TO BE DELIVERED			MEASURES		
	Best-evidence response components	*Why would these modules work?*	*Potential flexible activities*	*Process measures*	*Expected Outcomes for clients arising from modules*	*Tools used to measure Outcome*
Overall program goal: Engage & retain participants with complex support needs, improve their quality of life & mental health, and reduce AoD consumption	**CORE** Making a Start	**Making a Start.** Jointly identifying participants' goals and barriers to change via motivational enhancement therapy will increase the likelihood of engagement with appropriate modules and completion of treatment plan/goals [A]	Modules will be delivered one on one	Participants each have 1 or more clearly articulated goals (Module 1: Table 'Goals and reasons')	A. Participant retention, completion of program and goal achievement	A. Proportion of participants enrolled in/ completed the program. Proportion of participants achievement of goals (Goal Based Outcomes Helpful Ideas Tracker)
A. Participants with complex support needs experience challenges with completing treatment	**MODULES AVAILABLE TO SELECT (min. 2)** Problems & Solutions	Mental Health (anger, low mood, anxiety). Developing understanding of difficult moods and management skills (brief behavioural strategies, arousal reduction, relaxation and cognitive strategies) will increase ability to regulate emotions, contributing to improved mental health and decreased reliance on AoD [B, D]	Modules can be in-person, outreach or via phone/video	# of modules and sessions completed for each participant		
B. Participants with complex support needs experience poor mental health	Dealing with Difficult Situations	Problems & Solutions, Dealing with Difficult Situations, Life Skills. Developing problem solving and assertive communication skills will enhance engagement with treatment by preparing participants to overcome barriers & triggers and enhance ability to manage high risk situations for AoD & mental health [A-D]	Number & order of modules delivered Flexible scheduling	Extent of delivery of each module (fidelity: File audit / clinician report)	B. Improved mental health	B. Psychological distress K-10 / ATOP (psychological health status section)
C. Participants with complex support needs experience poor quality of life	Mental Health (anger) Mental Health (low mood)		Assertive follow up	Satisfaction with program (CSQ-8)	C. Improved quality of life	C. QoL (section 3 of COMS)
D. Participants with complex support needs experience harm from AoD dependence	Mental Health (anxiety) My Supports	My Supports. Developing behavioural and cognitive skills for strengthening or adding to supports/ social connections, communication and conflict resolution will enhance relationships and QoL [C]	Referral to other services Case management is delivered, via 1) same clinician or 2) different clinician (as clinician delivering modules)	*Acceptability of the program to staff ** *Acceptability of the program to participants**	D. Reduced AoD use	D. ATOP (substance use & general wellbeing section) &/OR severity of dependence
	Life Skills Physical health	Physical Health. Improving physical health will contribute to better mental health and QoL. Supporting participants to develop a tailored physical health plan will contribute to improved physical health (exercise, nutrition, sleep) [B/C]				
	Staying on Track	Staying on Track. Developing cognitive and behavioural skills around craving, withdrawal, and relapse (AVE, SIDS) management will reduce likelihood of lapse / relapse and promote improved mental health and QoL [B-D]		*Indicates collected for the current evaluation phase, not part of routine data collection*		

The feasibility of using the selected outcome measures to measure impact of the psychoeducational modules on participant outcomes

This section displays the use of the outcome measures by the participants that consented for the evaluation.

Psychological distress and quality of life outcome measures

Of the 13 participants included in the evaluation timeframe, 10 completed the K-10 and EUROHIS-QOL outcome measures at intake and 7 also completed these outcome measures when they exited the program (Table 4). The median number of additional progress assessments (i.e., in addition to intake and exit assessments) completed was 1 (IQR = 0-2).

Among the 7 participants who completed the K-10 and EUROHIS-QOL outcome measures at intake and exit, psychological distress significantly decreased but there was no noticeable change to quality of life (a paired samples t-tests showed a significant difference between K-10 scores at intake versus exit (p=0.02), but no difference between EUROHIS-QOL scores at intake versus exit (p=0.10)).

Table 3: Outcome measure scores at program intake and exit, for eligible and consented participants

Outcome measure	Intake (n = 10)	Exit (n = 7)
K-10 (mean [SD])	31 (8.1)	22 (8.7)
EUROHIS-QOL (mean [SD])	27 (7.8)	32 (3.1)

Note. K-10 = Kessler psychological distress scale. EUROHIS-QOL = World Health Organisation Quality of Life Scale EUROHIS 8-item index. SD = standard deviation. Higher K-10 scores indicate greater psychological distress. Higher EUROHIS-QOL scores indicate higher quality of life.

Substance use outcome measures

Of the 13 participants included in the evaluation timeframe, all completed the ATOP substance use measures at intake and 8 also completed the substance use

measures when they exited the program. The median number of different substances participants used in the 28 days leading up to intake was 1.5 (IQR = 0-2). Among the 8 participants who had completed the substance use measures at exit, the median number of substances used in the 28 days leading up to program exit was 1.5 (IQR = 0.75-2).

The most common substance used in the 28 days leading up to intake was cannabis, followed by amphetamines and then alcohol (n≤5 for each substance). The most common substance used in the 28 days leading up to program exit was alcohol, followed by cannabis, amphetamines, and benzodiazepines (n≤5 for each substance).

Of the participants who used alcohol, the number of days alcohol was used decreased by a mean of 6 (SD = 10.1) between intake and exit. Of the participants who used cannabis, the number of days cannabis was used decreased by a mean of 12 (SD = 14.4) between intake and exit. Of the participants who used amphetamines, the mean difference in number of days used between intake and exit was 0 (SD = 1.5).

Goal Based Outcomes

Of the 7 participants who completed the GBO tool on at least two separate occasions, the median number of outcomes chosen was 3 (IQR = 3-3.5). All participants indicated that they had improved on their chosen goals, with a mean difference rating of 3 (SD = 1.6; i.e., all participants indicated that they were closer to reaching their goal on the second occasion of completing the GBO tool compared to the first).

The most frequently chosen goal related to "Relapse prevention and using strategies to reduce or stop use" (chosen by 9 participants), followed by increasing knowledge around mental health and coping (chosen by 7 participants) and "Reduce reliance on substance use". A few (less than five participants) chose to focus on "Building and strengthening relationships", "Managing and implementing strategies to cope with low mood and anxiety to avoid using substances", "Learning ways to improve physical health", "Increasing social outings to avoid isolation", "Tracking

appointments", Saving money", Moving out of home", "Getting into a detoxification program" or "Getting full time employment."

4. Implications and recommendations

4.1 Outcome based comissioning process

- The outcome-based commissioning process was well received by staff/ stakeholders as an approach to design and provide clarity around the purpose of the new psychoeducation modules.

- Participation in the outcome-based commissioning process benefited Facilitators by building their understanding around why outcome measures were being recorded.

- Staff expressed challenges of ensuring module developers and evaluators were working towards similar outcomes.

Recommendation A: Future outcome-based commissioning planning should incorporate the outcome-based commissioning process as it was of benefit and valued by stakeholders. Earlier involvement of developers and evaluators may assist with ensuring that stakeholders share a common view around project outcomes.

4.2 Psychoeducation modules

- The psychoeducation modules were highly acceptable to staff and participants.

- Nearly half of the participants who completed the program participated in more than the minimum of three psychoeducation modules, further reinforcing eagerness to participate.

- The psychoeducation modules appear to be effective in aiding participants in achieving their own personal life goals, as evidenced by all participants reporting progress improvements via the Goal Based Outcome tool.

Recommendation B: *The psychoeducation modules were well received by Facilitators and participants and should be considered for integration into routine practice at Rendu House and at similar services.*

- The realities and experiences of participants with complex support needs is highly diverse, and the modules successfully provided flexibility to tailor to activities to individual needs and contexts.

- The skill of Rendu House Facilitator's in adapting language and delivery options to meet participants' needs was an important component of success of the program.

- Delivery options were highly accessible, including one-on-one, telehealth options and no fee for service.

- The psychoeducation program was a unique service offering, and a suitable option for participants who felt uncomfortable in group settings.

***Recommendation C**: Future implementation of the psychoeducation modules should maintain the ability to deliver the modules flexibly and for clinicians to judge when to adapt materials to facilitate comprehension and participation among clients. Given that other programs at Rendu House are group-based, the psychoeducation modules are a complementary service offering.*

- Implementing the psychoeducational modules is time and human resource intensive.

- The Project implementation was on top of Rendu House's Key Performance Indictors (KPIs), without additional resources or staff. Ongoing operations were stretched due to increase in attention needed for administration and delivery of modules.

Recommendation D: Future implementation of the psychoeducational modules will require specific funding to support human resources, with more than one Facilitator delivering modules, to allow for existing duties to be completed. Adequate resourcing will avoid overburdening staff, which may reduce risk of staff turnover.

- A high level of AOD clinical skills is required to deliver the psychoeducation modules which would present barriers for newly recruited caseworkers with backgrounds in other sectors i.e., mental health.

- Delivering the psychoeducational modules requires well developed AOD clinical expertise and experience, including in the Catalyst program.

Recommendation E: Selection of staff with previous skills in AOD may be important to deliver the psychoeducational modules. Highly skilled clinicians should be prioritised and less-skilled clinicians should be provided with additional training and supports around AOD treatment approaches. Facilitators will benefit from being inducted/ trained in the Catalyst program prior to delivery of psychoeducational modules.

- There are limited funds to allow for ongoing external clinical supervision (360 Edge) of Rendu House staff delivering the modules.

Recommendation F: External supervision of new and prospective Facilitators at Rendu House tasked with delivering the psychoeducation modules is warranted, particularly considering the intensive and sensitive nature of this work. This supervision is likely only required for a few sessions because other staff members would be able to provide guidance and monitoring as part of their own internal supervision, upskilling and professional development as the program continues to be delivered over time.

- Some outcome measures were too conceptually difficult for some participants to comprehend and required reflexive thinking skills beyond the participants capacity.

- Some of the module handouts could be simplified to improve clarity when provided to participants with low levels of literacy.

Recommendation G: Revising technical language and simplifying some of the module handouts may enhance engagement with participants with low literacy levels. Embedding low literacy options for goal tracking to overcome barries for participants with acquired brain injuries and disability is recommended.

- Although outcome data appear promising to date, it is too early to substantively conclude that these reported findings are 'true' effect that can be exclusively attributed to participation in the program.

- For many key outcomes, such as AOD use, insufficient participant sample size meant that we were not able to report on some results in order to protect participant confidentiality and were not able to conduct analyses to statistically test for differences between intake and program exit.

Recommendation H: The evaluation should be extended for at least an additional 6- to 12-months to expand the eligible participant sample for whom data can be calculated. It may also be possible to follow up participants over longer intervals to reliably conclude whether improvements on outcome measures are maintained over time (even beyond the life of the program).

5. Limitations

There were challenges retaining participants for interviews who consented to take part in this evaluation. Although we received consent from 13 participants, we were only able to engage five to complete an interview. This withdrawal rate could lead to a selection bias in the participants who did not disengage from the program (they may have systematically differed from those who disengaged early), resulting in participant perceptions reported in this evaluation disproportionately favouring the program.

The small sample of interviewed participants may impact on the generalisability and external validity of the data; these perspectives may not be representative of the wider population who are eligible to receive the psychoeducation modules, as well as the services delivered by Rendu House more broadly. Furthermore, considering the short timeframe of this evaluation, we are unable to discern with certainty whether the barriers identified thus far are the result of the modules, or expected implementation barriers that may naturally be rectified in time. Further time for recruitment will add more data to consider the program impact.

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7. Appendices

A. Ethics Approval

UNSW
SYDNEY

01-Aug-2022

Dear Dr Sara Farnbach,

Project Title	Evaluation of Psychoeducation Modules for Drug and Alcohol Support Service
HC No	HC220331
Re	HC220331 Notification of Ethics Approval
Approval Period	01-Aug-2022 - 31-Jul-2027

Thank you for submitting the above research project to the **HREC Executive** for ethical review. This project was considered by the **HREC Executive** at its meeting on **28-Jul-2022**.

I am pleased to advise you that the **HREC Executive** has granted ethical approval of this research project. The following condition(s) must be met before data collection commences:

Conditions of Approval:
N/A

Conditions of Approval - All Projects:

- The Chief Investigator will immediately report anything that might warrant review of ethical approval of the project.
- The Chief Investigator will seek approval from the **HREC Executive** for any modifications to the protocol or other project documents.
- The Chief Investigator will notify the **HREC Executive** immediately of any protocol deviation or adverse events or safety events related to the project.
- The Chief Investigator will report to the **HREC Executive** annually in the specified format and notify the **HREC Executive** when the project is completed at all sites.
- The Chief Investigator will notify the **HREC Executive** if the project is discontinued before the expected completion date, with reasons provided.
- The Chief Investigator will notify the **HREC Executive** of his or her inability to continue as Coordinating Chief Investigator including the name of and contact information for a replacement.

The **HREC Executive** Terms of Reference, Standard Operating Procedures, membership and standard forms are available from https://research.unsw.edu.au/research-ethics-and-compliance-support-recs.

For questions or concerns, please contact the Ethics Administrator using the contact details below.
Telephone: Human Ethics team telephone contacts
Email: humanethics@unsw.edu.au
Website: https://research.unsw.edu.au/human-research-ethics-home

Kind Regards,

Associate Professor Kathy Petoumenos
Human Research Ethics Presiding Member

This HREC is constituted and operates in accordance with the National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research (2007)*. The processes used by this HREC to review multi-centre research proposals have been certified by the National Health and Medical Research Council.

B. Summary of co-design workshops with NDARC, SVDP, Rendu House, PHN & 360 Edge

Workshop	Attendance	Discussion Points
25/10/2022	360 Edge National Drug and Alcohol Research Centre (NDARC) Rendu SVDP	• The need to identify retention and engagement as an outcome measure given characteristics of client group • Core modules and modules 'available to select' • Importance of goal attainment and including this as an outcome measure (emphasising the significant of module 1, and the client centred approach) • Inclusion of assertive follow up and referral to other services in flexible activities
22/11/2022	360 Edge NDARC Rendu SVDP	• Importance of mapping Fidelity measures and the extent to which each module was delivered. This was then added as a process measure to the PL • Discussion of Goal Based Outcome Goal Tracker (naturally embedded into module delivery) • Agreeance on core modules: Making a start, Dealing with Difficult Situations and Staying on Track • Language use, concerns around the term 'complex client', suggestion to reframe as 'clients with co-occurring needs'
6/12/2022	360 Edge NDARC Rendu SWSPHN	• Defining engagement and completion for each client • Minimum engagement to be included in analysis completion of three core modules • Best mechanism for tracking client engagement (discussion of internal process) • Expressed need for evaluation guide and client tracking document for Rendu House
17/01/2023 28/03/2023	NDARC Rendu SVDP SWSPHN	• Ongoing case management through outreach worker added as 'flexible activity' to support main program Facilitator • Status of closed files and potential ways to capture those who come back or turn up in other services

		• Potential for data linkage in the future to track client outcomes beyond the Project

C. Goal-based outcomes rating tool

How close are you to the goals you want to get to?

On a scale from zero to ten, please circle the number below that best describes how close you are to reaching your goal today.

A score of zero means no progress has been made towards a goal, a score of ten means a goal has been reached fully, and a score of five is exactly half way between the two.

YOUR FIRST GOAL

Enter brief description of goal

0	1	2	3	4	5	6	7	8	9	10

Goal not at all met   Half way to reaching this goal   Goal reached

YOUR SECOND GOAL (if appropriate)

Enter brief description of goal

0	1	2	3	4	5	6	7	8	9	10

Goal not at all met   Half way to reaching this goal   Goal reached

YOUR THIRD GOAL (if appropriate)

Enter brief description of goal

0	1	2	3	4	5	6	7	8	9	10

Goal not at all met   Half way to reaching this goal   Goal reached