Advocate

The eMagazine of the Network of Alcohol and other Drugs Agencies Issue 3: September 2020

Social determinants

- NCOSS
- Jenny Valentish
- Karen Urbanoski and Karen Milligan

NADA network of alcohol and other drugs agencies

CEO report

Larry Pierce NADA

As you will no doubt be aware, I will be retiring from NADA, after 21 years as CEO. This takes effect in a few weeks, on 30 September—it has been a pleasure and a privilege to serve.

Over the years I have witnessed massive changes to our sector. We began as a small and less diverse group of services, underfunded and not well recognised nor supported by the department or the districts. Over time we attained significant new sources of government funding (e.g. 1999 NSW Drug Summit and the Commonwealth's 'Tough on drugs' funding streams). And with that came funding requirements (e.g. NMDS client data reporting, accreditation and a number of service standards and guidelines); we rose to this challenge and integrated these into our operations and service delivery.

The size and the nature of our workforce has evolved to meet these new requirements, to provide a more diverse and integrated service 'menu' for clients; the most significant of which was the integration of mental health support interventions and a shift to trauma informed and client centred care. We increased our engagement with, and involvement of, clients as consumers and experts in their own care. We expanded and diversified our service delivery partnerships with other government and social services agencies to meet client driven priorities and needs.

We are now recognised as an integral part of specialist AOD treatment and support service, providing between 30–40% of all AOD health services in NSW. We are major contributors to, and drivers of, research and service development activities across the state. I can say with certainty that we are an innovative and high-quality service delivery sector, and this makes me proud to have NADA play a part in supporting this.

I would like to take this opportunity to thank the NADA staff, past and present, for their outstanding work, crafting and delivering the NADA program over the years. I'd also like to thank all the directors of the NADA Board—it's been a pleasure working with you. Also, I'd like to thank NADA's stakeholders, from the NSW Ministry of Health and the Australian Government Department of Health, the drug and alcohol directors of the Local Health Districts, the Primary Health Networks, the AOD academic institutions, the AOD Peaks Network, NCOSS, the health funded peaks and state-wide organisations on the NGO Advisory Committee, NUAA and a raft of other organisations without which NADA cannot do its job effectively.

We are an innovative and high-quality service delivery sector, and this makes me proud to have NADA play a part in supporting this.

Finally, I thank all of the NADA membership for their continued involvement in the network, and as I have always said, we exist for the members and they are our strength. I am sure my replacement, Robert Stirling, also has this as his first principle for managing NADA and its program and for maintaining our collective vision of a connected and sustainable non government AOD service sector in NSW.

Consumer insights

Trinka Kent, NADA

The social determinants of health are the social and economic conditions in a person's life, which play a significant role in their overall health and wellbeing. These are unique to each individual, though for people who experience AOD use issues, some factors are pervasive, such as discrimination and stigma, social exclusion and access to economic resources. These factors not only contribute to the development of problematic substance use, but become exacerbated by it, and present as significant barriers to access and receive appropriate treatment.

To understand more about this issue, I spoke with a range of consumers who were courageous enough to share their stories and insights. They spoke about discrimination, poverty, unemployment, lack of housing and education impacting their health and drug use. They nominated flexible and inclusive services, and the importance of having workers with lived experience as being helpful in AOD services.

What have been some of the main factors that have impacted your health and drug use?

Sarah, a 29-year-old Aboriginal woman accessing a community based AOD program reported, 'We grew up in social housing. Unemployment and addiction were the norm where I come from. We grew up poor. Mum was a heroin addict, and dad left home when I was young. I left home at 16 because family dynamics were too stressful. My younger siblings ended up being removed from her care not long after. I did not finish school because there was too much going on at home. At 18, I became the legal guardian of my six-year-old sister. I soon had children of my own. I had no supports. It was hard for me to pursue any goals for myself, as I was caring for a family.'

'I knew I was Aboriginal but was not connected in any way to my culture. I didn't know where I belonged. My grandmother was Aboriginal and was forced to marry a white man which has had long-lasting impacts on my family,' said Sarah.

Jack, a 28-year-old male engaged in a residential program said, 'I went to a private school, but we weren't wealthy. I felt inferior to the other kids because we could not afford the things most of my peers at school had. I also felt different because of what went on at home. Dad was an alcoholic and abusive and they both smoked weed. I was allowed to smoke. I was diagnosed with ADHD and social anxiety and it helped me relax. I found school very challenging and ended up dropping out to pursue an apprenticeship.'

Maryanne, a transgender woman engaged in a residential program said, 'I went to a strict Christian private school and felt very alienated. I knew I was different. Looking back now, I would have identified as queer. I was confused about my sexuality. I was bullied by students and teachers. Religion at school taught me that people like me went to hell. Suffice to say I felt very uncomfortable in my skin. Drugs ended up becoming a way of self-medicating.'

Consumer insights

continued

What supports has AOD worker/service provided that you've found most helpful?

Lenny, a 50-year-old man who is seeing an AOD counsellor, said, 'Having someone to advocate for me, I can't read or write so finding services and advocating for myself has always been challenging.'

'My AOD worker is someone with lived experience. He is able to disclose his shared experiences freely with me, which I have found incredibly beneficial. I don't feel any judgement from him, I feel understood and just know he can relate to whatever I am going through,' Lenny added.

'Having staff that have been through the program helps. It's comforting to know there are people who have had similar experiences to myself and are now living full, meaningful lives,' said Jack.

'Being introduced to aftercare helped me stay on track after leaving rehab. I finally found a place where people understood me without having to explain myself,' said Maryanne.

'Being involved with a service that supports me with my goals. I do not have to fit into a program. I choose what my goals are feel supported to achieve them. It has been very holistic. I've been able to achieve my treatment goals as well pursue education, start my journey of connecting to culture, have been supporting with DCJ matters, and attend counselling to address underlying issues,' said Sarah.

What practice tips can you give AOD services to best support their clients?

'Services need to be more LGBTIQ friendly, like put some posters up or display something to indicate that the service is inclusive and celebrates diversity,' said Maryanne.

'Services need to be a bit more progressive in catering to people who identify as something other than their gender such as having non-binary like sleeping areas, toilets and showers. It would help people like me feel a lot more comfortable and included,' Maryanne added.

'More flexibility in catering to individual needs—for example timelines should be flexible, not everyone is ready to leave at the same time. Some people don't have the same level of support or safety as others,' said Jack.

Register now for NADA webinars

25 Sept

Innovation and evaluation: NADA members

The feasibility of adolescent AOD services in Headspace Centres and an evaluation of cognitive remediation therapy in residential AOD

10-11am

Two presentations; one will discuss what evidence based AOD interventions exist that would be suited for use in Headspace settings; the second, examines the implementation, feasibility, acceptability and outcomes of a cognitive remediation program in Lives Lived Well's AOD residential rehabilitation. Register now.

29 Sept

Providing inclusive AOD treatment for gender and sexuality diverse people

12:30–1:30pm

The webinar will explore the use of inclusive language and practice tips for supporting gender and sexuality diverse people in AOD treatment. Register now.

Masters of incarceration

Chris Sheppard, Effective AOD transition worker

My experience of being incarcerated was a learning experience, every time. The days were long, and the nights seemed to go forever. Inside your fellow inmates were your only friends, in some cases, your enemies. We worked five days a week for payment totalling 18 dollars. In one prison I was in, you got six toilet flushes a day and a three-minute shower.

I first entered the justice system as a person who used amphetamines; I left as a person using opiates. In a unit of 50 men with a fair percentage of people using gear, there might have been two syringes in the whole unit—catching a blood borne virus was a certainty. There seems to be a big gap—which I take as political reasoning—between harm minimisation in the justice system, with inmates having no access to needle syringe programs, compared to the amount of money being spent on treatment inside for hepatitis C.

The justice health system was hit and miss. It was always a long wait to see a health worker after you put a request form in. Sometimes the request form didn't even make it to the health services, adding to your anxiety and frustration, while the reason you wanted to see a health worker would escalate. Sometimes to the point where people become very unwell, to even losing their life.

A lot of people in prison have been victims of crime as children, but there never seemed to be any therapeutic services in prison to deal with such issues, and if there is, they are few and far between. People are ordered into doing group work and sometimes a person's trauma just does not allow them to sit comfortably in groups. There is an overpopulation of people living with trauma in prison and no one to help people to address what is going on for them around this. I had been living with trauma from when I was a ten-year-old boy into my early forties before I even knew what the word trauma meant. You are constantly triggered by staff in correctional centers who don't understand the effect trauma has on people.

There seems to be sayings like 'that's how it was back in the day', 'child abuse was a common thing', 'DV was as common as having dinner', 'it's just how it was'. But abuse that happened 40 years ago, no matter what excuses people say, is abuse, just as it is for someone to go through now. People need to be treated with dignity and respect and given the chance to heal no matter their age, race or gender.

People often come out of prison in good health with certificates of some training they did inside, but they face a lot of barriers when trying to find work. Housing needs to come first so people can feel safe, clean and feed themselves, so they can be healthy enough to find or go to work. We need programs to be funded and run that are big enough to support people upon their release to get them into work, as well as using these same programs for an alternative to sentencing a person to prison.

Masters of incarceration

continued

My advice for services supporting people post release from custody is:

- Be bloody patient. Yes, we need to understand trauma and how it works and the effect it has on a person, but we need to understand the person we are working with EQUALLY, to how we understand what trauma means.
- Put yourself in their shoes and ask yourself, 'How would I feel if I had to go through this—what effect would this have on me?' 'How does a lifetime of disconnection from community affect a person?' 'What have they gone through to get to using ice or other drugs?' Because then you will understand more about the person and their drug use and how to best support them.
- Reassuring a person that you are there for them and that you care for them is as important as life saving medication in my books.
- Make referrals that suit the person's needs and follow up with the service after making the referral. Build solid relationships with other services and workers, like GPs prescribing opioid treatment, the pharmacists who are dosing people in your area, and staff in government drug health clinics.

I am now working as an effective AOD transitional worker. Unfortunately, there is a stigma that comes with the title of a peer worker in our sector. I believe it is good for people like myself and all of the others out there that have done their PHD of lived experience, to be known for what we actually do, and how effective we are at supporting people in the community to rebuild and restore normality and peace in their lives.

The female experience

Jenny Valentish and Rosemaree Miller, NADA

Over the last decade, less than 40% of Australian clients receiving treatment for their own substance use identified as female.[1] On the surface, this uneven ratio of female to male clients could suggest that more men than women experience problematic substance use in Australia. However, a growing body of evidence indicates that there are differences in the experience of problematic substance use for individuals who are female or male.[2] Moreover, an individual's gender[3,4] may also impact the trajectory of their recovery from problematic substance use.

In her 2017 book, *Woman of substances*, Jenny Valentish explores the female experience of AOD use. In this research-memoir hybrid, Jenny artfully intertwines discussion of her own experiences with the factors known to contribute to problematic substance use for individuals who identify as women. I sat down with Jenny to discuss some of the social determinants that affect the female experience of AOD use, and how this knowledge can be used to inform treatment, evidence based practice and research in the non government service sector.

How is the female experience of AOD use unique, and how does this impact women in treatment for problematic substance use?

Experience of trauma 'Nothing is completely unique to women in treatment; however, women are perhaps more likely to have experienced sexual trauma.[5] So, that means if there are no gender specific treatment options, talking about traumatic experiences in a mixed setting can be uncomfortable for women in treatment.'

Child-care responsibilities 'Even if a woman is in a stable relationship when she has children, she may still be discouraged from seeking help because of child-care responsibilities. A woman could initially engage in treatment, but she may not be able to sustain this if, say, her partner or family are unable to assist with child-care. Alternatively, she might feel that leaving her chidren with a partner, or even her family, is not a safe option.'

Eating disorders 'Eating disorders and substance use go hand in hand, especially for women.[6, 7] It's quite hard to find treatment services that tackle both at once. If these comorbid issues are severe, it can mean that some people may fall between the cracks. Is a detox ward going to take on a client who needs to be properly fed and monitored for their eating disorder? And how likely is it that an eating disorder ward would take on a client who is in withdrawal? In either scenario, the client might feel they have to lie and pretend that the withdrawal, or the eating disorder, isn't happening, which can be dangerous.'

Stigma around substance use 'There's a lot of judgement around female clients, especially mothers, which can lead them to conceal their drug use a lot more. This can create what's called 'telescoping',[4] when it appears that women become addicted much faster than men. In actual fact, that severity of dependence could be partly because some women conceal their substance use for a longer time before seeking treatment.'

The female experience

continued

'Women often present at the pointier end of the issue as they have 'fallen through the gaps' and are usually at risk of losing their family. This in turn, increases the stigma felt by our women. We aim to create a warm, welcoming and stable place for her recovery. We work closely with mother and child/ren through age appropriate play, guided psychotherapy and continuous self-reflection. We rebuild wounded relationships, foster healthy attachments and create supportive networks to reduce stigma, enhance wellbeing and improve outcomes for recovery and families.' **Kate Dodd, Phoebe House**

What are three ways in which services could better support their female clients in treatment?

Provide gender-sensitive treatment 'I think there need to be options available for women to seek women-only treatment, and there are options, but there aren't enough—particularly if you have a child that you need to have with you. It's harder to find that kind of service. Treatment is usually considered to be gender-neutral, but is this true if the experiences of men are used to judge what is normal?[3] Because more men than women are in treatment as a direct result of there being more barriers for women to access treatment than men, so, unfortunately, any statistics you get from treatment services can feed into the old idea that substance use is primarily a male problem.'

Ensure trauma informed care is available 'Staff would need to understand that women who have reached the stage of needing treatment are very likely to have experienced cumulative trauma.[8] Not understanding how cumulative trauma works can make it harder for staff to support female clients. Say, if you've experienced sexual abuse as a child, and then start using drugs to self-medicate, you might increase your likelihood of being in unsafe situations. This can lead to the mindset where an individual may think they are a bad person, and that bad things always happen to them. When, in fact, the way cumulative trauma works is that when you add something like drug use to the experience of trauma, that itself predisposes an individual to being preyed upon by opportunists and predators.'

Practical support with safety and resources 'The woman's safety has to be a priority. Use your discretion and take any safety concerns she may have seriously. Be careful with the privacy of these clients and if there isn't an option for trauma informed care at your service, then refer the woman to an appropriate service that can provide this care. It is important to make the referral process as streamlined as possible, though. A woman may be juggling child-care with other responsibilities while seeking treatment, and she may not be able to follow up with more than one referral at a time, particularly if she's being bounced around town.'

Summary and next steps

Individuals who identify as women, men or another gender face many of the same challenges when receiving treatment for problematic substance use. However, considering some of the social and practical barriers that women may face in accessing treatment could improve the retention of female clients with your service. You can achieve this by creating an environment in which female clients will be more likely to engage with and continue their treatment.

Jenny Valentish is a freelance journalist and writer who has published three books, including the 2017 'Woman of substances'. Jenny is also an ambassador for Monash University's Brain and Mental Health Laboratory, a board director of SMART Recovery Australia, and the chair of SMART Recovery International's communications and brand committee.

Resources

NADA's AOD treatment resource
Working with women engaged in AOD treatment

Eating disorders
Butterfly Foundation
The national charity for people impacted by eating disorders and body image issues, and for those who support them.

Trauma informed care
The NSW Domestic Violence hotline
Provides counselling and referrals to women experiencing domestic and family violence.

Rape and Domestic Violence Services Australia
Provides support for people affected by sexual, domestic or family violence.

Spotlight on trauma informed practice and women
This resource, produced by Women's Health Victoria, features a list of up-to-date and freely available research and resources.

WE ASKED YOU

How do you engage culturally and linguistically diverse people

Valentina Angelovska CEO—2Connect Youth & Community

What are the barriers for culturally and linguistically diverse (CALD) people, especially young people, to engage with AOD services? There's a general lack of knowledge about AOD services and how they may help. Services may not be able to cater for language needs, cultural understanding and sensitivities to the intricacies surrounding cultural community experiences. They may practice a more individual approach whereas a young person can be more family and community orientated. There are help seeking barriers too; people may hide AOD use for fear of isolation from the family, culture or community.

How has 2Connect addressed these barriers? We provide basic information about AOD services, how they can be accessed, and highlight confidentiality principles. We translate information into different languages, and make it family and community focussed. The language we use is non-clinical, and free from jargon. We reach audiences through platforms like language specific radio, places of worship, or a cultural specific dancing group. We partner with services (e.g. Nepalese and Macedonian welfare groups) to provide specific presentations to these communities. It helps that our staff come from diverse backgrounds—many are bilingual—we also use interpreters.

We use a holistic family and community approach in our clinical work. For example, we enquire about family, and engage with a parent or other family member, not just the young person. We also provide flexible service delivery e.g. mobile outreach to settings where young people already attend, such as schools.

Describe the outcome for these clients. By breaking down the barriers to access and taboos surrounding help-seeking, we have increased access for culturally and linguistically diverse young people and families. With successful engagement, there's a greater chance for young people to meet their goals, and young people able to connect with the service to meet their support needs. All in all, we have achieved greater successful therapeutic outcomes.

The female experience

continued

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There's no place like home

Michelle Ridley, NADA

Housing is a social determinant of health and wellbeing,[1] and access to housing is a basic human right.[2] This doesn't just mean 'a roof over one's head', but the right to live somewhere in security, peace and dignity.[3] Sadly, safe and secure housing is a right not shared by everyone in our community, and this is strongly linked with poor health outcomes.

Every night, almost 120,000 people are homeless in Australia.[4] Before COVID-19 there were already 50,000 people on the waitlist for social housing in NSW, and with unemployment growing due to its impact, an increasing number of people will become at risk.[5] This predicted rise is overwhelming to consider, because homelessness was already one of the main issues impacting people's access and retention to AOD treatment in NSW.[6,7]

In NSW, people are most likely to experience homelessness due to domestic and family violence, accommodation issues (housing crisis, inadequate or inappropriate dwellings) and financial difficulties (housing stress, unemployment).[8] Research suggests that around 60% of these people had no problematic drug use issues before they were homeless.[9] Therefore, as AOD workers, we cannot just focus on the person's drug use. We need to also explore and support them with their educational outcomes, housing situations and income, as it is these conditions, in which they are born, live and age, that are most significant.[10]

So considering all this, I asked practitioners working on the frontline with people experiencing homelessness for practice advice. And also, ways that we, as community members, help change the housing crisis in NSW.

Elizabeth Gal, Peer Practice Leader at Neami National, suggests:

Validate what a client is experiencing and acknowledge that the system may not be set up in a way that currently works for them. This is really important to acknowledge, because from my own personal experience, feelings of low self-worth can come with trying to make changes and having so many barriers in the way.

Being patient with clients and meeting them where they're at, rather than trying to force my goals. At the same time though, it's important to have the tough conversations, and I tell my clients what I'm seeing and how I believe they can have/do something different when they're ready.

Focus on a client's strengths. Most of the time they don't see their own strengths, quite often because they use them in 'negative' ways. When I'm able to pull a strength out of a 'negative' story I've been told, clients value that so much.

David Chivers, Senior AOD Transition Worker at Community Restorative Centre, suggests:

Be realistic and help your client understand how challenging things can be. We want to engender hope

There's no place like home

continued

Released into homelessness

By Dale

I was once homeless, unemployable, and whether real or imagined, isolated from society. The hopelessness that I felt led to depression, and very quickly, a dependence on illicit drugs. I was soon financing my habit through crime, and was subsequently arrested, convicted and sentenced to 10 years imprisonment. My last sentence was the seventh or eighth time I had returned to prison for drug related crime, and while it would be convenient to attribute my recidivism to drug use, the truth of the matter was that I felt trapped and disempowered. I wanted help but had no idea how to ask for it, or whether or not help even existed.

Accommodation provides people with security and peace of mind. The data shows, however, that around 4000 people are released from NSW prisons each year into relative homelessness. They are being released with two nights' emergency accommodation and a social security payment amounting to $550. While it may be possible to feed and clothe oneself on this amount, it is quite simply not enough to pay for three weeks' accommodation, which is the amount of time that you must wait until your next Centrelink payment becomes available.

And so this vulnerable population are forced into homelessness. When in this situation, being told that there is nothing available or that 'we are doing everything that we can' is like being slapped in the face. Repeated slaps can not only cause resentfulness, but can also create a sense of otherness. This can unfortunately force people with the best of intentions to make bad decisions.

Providing people with affordable accommodation could reduce the likelihood of people reoffending because of homelessness. Governments should consider this proactive approach.

for our client but there are many myths circulating, that gaining social housing can be easy, particularly for people leaving prison. Gaining safe and secure accommodation can be extremely challenging. We try our best to prepare clients for this reality (before their release from custody, where possible), whilst reassuring them that we will be there to assist them in any way possible.

Encourage flexibility. We encourage clients to consider *all* options available to them. We try to help clients make informed decisions. For example, clients often say they don't want to consider a boarding house because they've heard bad things about them, particularly in relation to the prevalence of drug use. Yet, there are some very good boarding houses and they are certainly preferable to some temporary accommodation places.

Share the responsibility. We encourage clients to persevere. We support them to 'knock on every door' possible by completing referrals (we help complete paperwork if needed) and making calls with them. There are services that can help and being persistent in asking for their support is crucial. We don't do everything for the clients, rather we empower them to take responsibility and action. We also reassure them that we're not just leaving them to deal with this alone. Often 'just being there' as someone to listen to them can be extremely valuable as well.

And advice for how we can, as community members, help to change this situation?

We can open up solutions based conversations around this topic, in as many arenas as possible. Have conversations with people who don't necessarily agree that people who experience drug dependence should have housing support, find out what their reasons are, ask them what they think will work and speak to the facts of those reasons, to show them evidence that points differently to how they're thinking. This is just a small starting point but the more that we talk about it, outside the usual circles, and continue to do so consistently, eventually politicians will have to listen, as it will be on people's minds when it comes time to vote (Elizabeth Gal, Peer Practice Leader, Neami National).

Get involved in campaigns and advocacy work like everybodyshome.com.au or acttoendstreetsleeping.org (Fiona, Service Manager, Neami National)

There's no place like home

continued

Other services and information

Link2Home is available 24/7 for statewide homelessness information and referral telephone service. This service can help provide an emergency response, such as link people to temporary or crisis accommodation.

Domestic Violence Line is a NSW statewide telephone crisis counselling and referral service, open 24/7, for women and persons who identify as female, who are experiencing domestic and family violence. They can help with referrals to crisis accommodation.

For housing information related to COVID-19 refer to Tenant's Union COVID-19 guide, Residential tenancy moratorium on evictions during COVID-19 and DCJ rent choice assist.

Other organisations to refer to are Homelessness NSW and Tenant's Union NSW.

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Hungry for change

Sharon Lee, NADA

In a wealthy nation like Australia, a country that produces far more food than it consumes, bare supermarket shelves during the onset of COVID-19 came as a surprise. Community panic buying clashed with supermarkets' just-in-time supply chain to cause an inventory shortfall; there were no tinned tomatoes, rice nor pasta in sight.

'Everyone now has a basic understanding of I could not get what I need,' said Jenna Bottrell, Program Manager of Continuing Coordinated Care Programs in the Central West.

But for some, this experience is recurring.

Food security

Food security exists when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life.[1]

Food security is a human right,[1] yet food *insecurity* affects 6.9% of people in New South Wales,[2] and this rate is much higher among asylum seekers and refugees, Aboriginal and Torres Strait Islander people, people receiving social security benefits or experiencing homelessness.[3]

'Food insecurity is closely linked with income security,' declares Phary Stamatis, Program Manager of Mission Australia's Kings Cross Youth Services.

Indeed, while a diverse range of groups experience food insecurity, household income is the strongest predictor of risk. For people on low incomes, buying food can be a discretionary expense, to be juggled with rent, medical, and energy bills.[4] When people don't have enough food, they may skip a meal, or reduce the size. They might bulk dishes with cheap rice, and eat fewer vegetables. They may feel anxious about their food supply or feel deprived by a lack of choice. It may prevent them from joining friends and family to share a meal. They may experience food insecurity periodically, like the day before payday, or each and every day.

Food insecurity can have wide-ranging impacts on a person's physical and mental health.[5] It has been associated with diet related chronic conditions such as diabetes, metabolic syndrome and obesity[6] alongside the health care costs. When someone doesn't know when or where their next meal is going to come, finding that often becomes their central focus and can take priority.[7]

'You can't expect someone to focus on their mental health or AOD dependence if the biggest stress of the day is that they haven't got food for the next three,' says Jenna. 'You can't look towards the future if you're looking for your next meal.'

Where can people turn for food?

Since the 1970s, the Australian government has funded emergency relief, which today includes food and voucher programs, as well as other services for emergencies. A variety of food related charity programs exist alongside this.[8]

Hungry for change
continued

Charitable food services work to alleviate hunger and provide temporary relief until food security can be improved. This sector comprises suppliers like food banks and rescue services, as well as community food programs, the agencies that directly supply to people through meals, cooking classes, breakfast programs, outreach services or pantries. But only a fraction of people who experience food insecurity access this relief,[9] considering it as an option of last resort; people say they experience stigma, shame, and hopelessness when they use them.[10] While food charities offer critical support, reports on the nutritional,[11,12] and cultural[13] inadequacy of foods provided are common.

Yet due to government cutbacks in welfare social protection systems, these charities have become an extension of the safety net. And because government support has proved precarious,[14] this net is illusory. Due to COVID-19, food banks are facing challenges with a lack of volunteers because of distancing restrictions and lack of donations due to rising consumer demand. Emergency food assistance do not, in and of themselves, offer pathways out of food insecurity.

A food secure future

Governments, business and the community need to address the four pillars of food security. Following are a few example actions:

Access: capacity to acquire a healthy diet Policies that promote full employment and job security are bound to be helpful for our clients and the whole of society. Income support should be raised, to meet the cost of healthy food and the real cost of living. The net should also be widened to support those who currently fall through the cracks. NADA has joined the ACOSS campaign to raise the rate for good seeking a permanent and adequate increase to Newstart, JobSeeker, Youth Allowance and related payments.

Availability: supply of food within a community Community based food system solutions—providing healthy, sustainable, culturally appropriate food with minimal waste—can supplement income support payments. Sustainable funding, flexibility and community ownership[15] are key to success for these innovations. Examples include pop up fresh food markets in low income areas and community gardens (see box, overleaf).

Utilisation: appropriate food use based on knowledge of nutrition and care The NSW Government should invest more in programs like FoodREDi which build peoples' skills to cook tasty, healthy meals. NADA members have filled this gap by building upon healthy food supplies. Jenna distributed food boxes to clients in partnership with a greengrocer during the onset of COVID-19; recipes and cooking tips for the more unusual items were included.

Stability: access to adequate food at all times and no risk due to sudden shocks or cyclical events Diversity is key to building resilience. Australia needs to diversify its large scale monoculture production, supermarket dominated, export oriented system with local, small scale production; growing a range of breeds and seeds; shorter supply chains; and diets comprising a wide variety of fresh, healthy foods.

Organisations working towards a better food future include Sustain and the Australian Food Sovereignty Alliance.

Practice tips

Clients need a stable base before they can tackle things like AOD recovery or employment. As AOD workers, we can often go automatically into therapeutic work, but instead we need to firstly support our clients with their basic needs, like housing and food. If your client returns multiple times for emergency relief, have a conversation about their situation to understand the context. Talk with them, ask them what's happening and most importantly, *listen*. It could be a crisis or an unexpected bill. If it is a bill, support your client and call the provider together to negotiate, so they can learn the skills to advocate for themselves. Otherwise, ask how you can help them, to prevent this pattern from recurring. This may include helping them with budgeting or referring them to a financial counsellor for extra support. Click here to find a financial counsellor near you.

While people can currently access their superannuation due to COVID-19, there's nothing in place to develop their skills to manage this, knowing it will end. Counsel them on this to build their financial skills or refer them to a financial counsellor. There are many non government community organisations that can provide a financial counsellor at no cost.

Thank you Phary and Jenna for the tips.

Hungry for change
continued

Photo supplied

Growing resilience

Fresh food, good health, cultivating community
Community Greening, a program run by the Royal Botanic Gardens Sydney, facilitate community led gardens in social housing estates all across NSW. Phil Pettitt, who co-ordinates the program, has a background in horticulture, and has learned community development skills on the job.

Projects often start with someone reaching out on the phone. The program team encourage the enquirer to see whether there are more people interested in the project, 'to get things going'. The project team co-designs the garden with the community so it 'works well for them'. The community also build it so they gain a sense of ownership.

The Community Greening team develop participants' knowledge and skills in horticulture and sustainability through a series of workshops. The participants grow herbs and vegetables, improve their health and burst with community pride.

To learn more, contact Phil Pettitt or visit the Community Greening webpage.

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Widen the lens

NADA's Larry Pierce spoke to Anna Bacik, Director of Policy and Research at NCOSS, to hear their perspective on the problems underlying effectively addressing AOD use issues.

Historically, the addiction medicine field, the general community and certain program typologies within the non government AOD sector has primarily seen AOD dependence as a personal/clinical management issue. Yet over the past decade or so, there has been a big shift towards a holistic approach to treating clients in AOD treatment services that identifies mental health, homelessness, disadvantage, and stigma and discrimination as key issues to address.

NCOSS view poverty and disadvantage as the primary drivers that contribute to people needing social services and health assistance. To quote Anna, 'It is well established that when people are living in poverty, lack social supports, have been the victims of systemic discrimination, don't have access to stable employment or access to the resources/circumstances to engage with ongoing employment and/or education, throwing AOD use issues into the mix can make those people more vulnerable.'

From my long experience in the AOD field, I am aware that many health and social service providers regard drug use as adding to the complexity of the needs people have, contributing to their ongoing social exclusion and compounding their experience of social inequality and poverty.

Anna and I talked about the World Health Organisation's Ottawa Charter, the social determinants of health, and the United Nation's Sustainable Development Goals. She was clear that through using more of a health promotion lens, the range of social factors mentioned above, and most importantly, income and secure stable housing, are the supports people need to help them and their families to improve health and social functioning. Creating supportive environments for health—access to universal health care, housing and employment and safe communities (environments) provides an overarching framework to support successful AOD treatment.

This is the lens we should consider using in our work. If basic needs are not met, then AOD treatment alone cannot hope to address clients' underlying needs. Anna believes that we should see this as an overall social problem that is shared by all of us. She sees the historical approach of looking at AOD as mainly an individual problem is problematic, in that it relegates most of the blame to the individual. She argues that we are all responsible for contributing and creating healthy and supportive environments for people to live in.

NADA would argue that there is a greater need for the state and national government agencies to work in a more integrated and collaborative way so that AOD programs and program providers can more easily access housing and social services support for their clients.

And here Anna says, 'Poverty is bad for health, violence is bad for health, discrimination and stigmatisation is bad for health and most importantly—being dispossessed of your country is bad for your health.'

From this perspective AOD use issues are not simply an aberrant phenomenon and/or an individual's moral failure, but becomes completely understandable in a wider social and health context.

I am encouraged that our sector is incorporating a wider social and welfare lens more fully into the design and delivery of our AOD programs. The work that organisations like NADA need to do is clear—make deeper linkages with the social and community sector organisations we work with, and advocate not only for better resourcing of our members to take on a wider social/welfare approach to working with our clients, but for governments to make the link between poverty, disadvantage and AOD work, to devise more holistic government policy and funding arrangements that will facilitate the collective work we need to do.

Why do you ask gender and sexuality questions

Raquel Lowe Health Education Officer, Community Services—Odyssey House

Why does Odyssey House think it is important to ask the gender and sexuality questions?
We know how important it is to get a full and clear picture of all our clients, but because there are still gaps in the data around help seeking behaviour and substance use of sexuality and gender diverse communities, we need to know if, how, and how frequently LGBTIQ communities are accessing our service.

It is important to provide our clients with the opportunity to tell us who they are, in their own words. You cannot rely on stereotypes and the only way to correctly identify someone's sexuality and gender identity is by asking them. Referring someone as a he or she because of the way they present or asking somebody if they have a boyfriend/girlfriend rather than partner, are examples of how we may unintentionally make assumptions if we don't ask the question.

How do you support staff to ask the question?
Gender and sexuality questions have been embedded into our assessment process and are required fields when creating a new file in our client management system. If staff require more support, we educate them on the importance of asking and refer them to NADA's 'Asking the question' eLearning course.

How does it improve outcomes for clients?
Worrying about whether it is safe to disclose their gender identity or sexuality can be a source of anxiety for LGBTIQ clients. Asking the question takes the pressure off them, assuring them that their whole self is welcome.

There may be additional health, mental health, and social concerns for LGBTIQ clients accessing AOD services. For example LGBTIQ clients are more likely to have mental health concerns, more likely to smoke tobacco regularly and may be at greater risk of exposure to blood borne viruses, so asking the question also allows for more holistic care/treatment planning with the client and potentially better outcomes.

Simone Angus-Carr Western Sydney Programs Manager—Noffs Foundation

Why does Noffs think it's important to ask the gender and sexuality questions?
We need to know our audience—their demographics, sexuality and gender—so we can better equip our service and clinicians to provide clinically relevant and holistic services. Asking questions relating to gender and sexuality helps to create a safe space from the beginning; it normalises the issue so if clients want to talk, the conversation has already been started. It's also important to us to make a habit of not assuming.

How do you support staff to ask the question?
When clinicians start working with us, we train them on our assessment practices and systems, including the relevance and importance of questions and how to conduct an in-depth psychosocial assessment. We provide them with ongoing and in-depth training, as well as clinical supervision.

How does it improve outcomes for clients?
Asking the question enhances service provision and improves client outcomes, not only from a clinical perspective, but allows for linkages with services. Sexuality and gender are important aspects of identity development during adolescence, so they're important to outcomes. They lead to conversations about acceptance by self, peers and family and about safe sex, with same gender partners or partners of another gender, something that may not be covered much in mainstream places like schools. Allowing a safe space for these conversations also allows for discussions and education about AOD use in sexual situations.

TRANSLATING RESEARCH INTO PRACTICE

Services for women and mothers

Addressing the social determinants of health as part of treatment

Karen Urbanoski Associate Professor, University of Victoria, Canada
Karen Milligan Associate Professor, Ryerson University, Canada

Women, and particularly mothers, face numerous barriers to seeking help for problematic substance use, including stigma and fear of child welfare involvement. Effective treatment services for women provide wrap-around supports that address these common barriers as well as co-occurring challenges with mental health, histories of trauma, and the social determinants of health. In North America, Australia, and elsewhere, comprehensive and integrated services (that offer coordinated access to primary care, substance use and mental health treatment, pre-natal care, parenting and child welfare services) are becoming increasingly common. While such treatment programs share the goal of reducing fragmentation of health and social services, there is no shared understanding of a service model in practice, leading to wide variability in the supports that women actually receive.

In 2014, we began a system-level study of integrated treatment programs for pregnant and parenting women who use substances in Ontario (Canada's most populous province). As part of that study, we sought to better define the essential service components of these programs, paying particular attention to how they connected with women's perceptions of care.[1] The work was guided by a project advisory board that included service providers, managers and agency directors, decision-makers and other women's health researchers.

When we conducted this study, there were 34 integrated programs operating within Ontario's publicly funded substance use treatment system. All were outpatient programs, given challenges for mothers to attend residential services where children are not allowed. We purposively selected 12 programs to represent the geographic diversity of the province (rural versus urban), years of operation, and program size. During site visits to these programs, we conducted semi-structured interviews with managers (n=22) and counsellors (n=15). Women who were service recipients (n=106) also completed the Ontario Perception of Care Tool for Mental Health and Addictions (OPOC-MHA).[2] This 32-item scale measures perceptions of treatment access and entry, as well as perceptions of care during treatment (including satisfaction with services, level of participation in care, counsellors, environment, and discharge planning). Open-ended questions are used to obtain feedback on the most helpful aspects of care and areas for improvement. Comparison data were obtained from a provincial database of OPOC-MHA scores for women of child-bearing age (19-44) who attended standard treatment programs (n=207).

Data from the service inventories and interviews yielded insights into service models across programs. All programs were undefined in length, meaning that women could stay for prolonged periods of time. This is in contrast to standard outpatient programs offered in this specialized treatment sector, which are often restricted in the number of sessions a given client can attend. Most (9 of 12) programs also offered the flexibility of home visits to reduce barriers to access (e.g., transportation or childcare). All programs reported embracing a harm reduction philosophy, which they interpreted as "meeting women where they are at', supporting women's decisions around their treatment goals, and teaching safer substance use practices. Women receiving opioid agonist therapy (OAT) were welcomed at all programs, which is still not always the case among treatment centres in North America. Most (n=9) also identified as being trauma informed and attended to trauma experiences in service planning and provision. Most programs served only women, although one had some programming for fathers and male partners.

All programs offered individual and group based counselling for substance use and counselling to address maternal mental health needs (primarily mood and anxiety disorders. More intensive psychiatric services (including medication consults) were limited, as was OAT. That is, although programs had resources to offer in-house psychosocial counselling and psychotherapy (including cognitive behavioural and motivational interventions), they tended not to have physicians on-site who could prescribe and manage medications for psychiatric disorders, including substance use disorders, and relied instead on referrals to outside agencies. About half of the programs indicated that they offered primary care and pre-natal services on-site or through a partner (e.g., on-site care by nurse/doctor once a week or month). Children's mental health services were rarely offered.

All programs offered coordination with child welfare (e.g., attending meetings with women, facilitating supervised access visits with children, helping women navigate the system). Program staff and leaders singled out this aspect of care as particularly important to their ability to meet the needs of women and families. Parenting support was offered by all programs, including manualized parenting interventions in some cases. Where manualized parenting interventions were offered, however, these were designed for a general population. In related work on integrated programs, we have highlighted the need for parenting interventions that are specifically designed to address parenting in the context of substance use and social-structural disadvantages (e.g., poverty, racialization, criminalization).[3]

Ancillary supports for the social determinants of health (e.g., food security, life skills training, housing supports, and transportation supports) were variably provided. Whereas life skills training was part of most programs, only one had an on-site housing worker. Access to food, childcare, and transportation supports were also limited and not able to meet demand. This is reflective of governmental divisions that separate funding and administration of health care services (where substance use services are located) from social services. When unavailable, most programs tried to connect women with services by referral.

Perceptions of care for women who participated in integrated programs were more positive than those of women who attended standard substance use treatment programs. This association did not differ by client age, ethnicity, sexual orientation, or whether treatment was mandated by child welfare or the legal system. Women cited flexibility and tailored services as key strengths of the integrated programs. Others singled out support with childcare, food, transportation, and services beyond substance use treatment as being key. Consistent with studies that show an association between strong therapeutic relationships and outcomes, the importance of counsellors and the quality of the therapeutic relationship/environment was emphasized:

> 'I find this is the only place where there is no judgment, so I am free to present my true being and voice any and all concerns because if they don't understand, I know they will try to figure out a way to help me deal with whatever it is.'

While the therapeutic process appears to be critical to positive perceptions of care in integrated programs, less is known about the role of specific services in this relationship and in shaping outcomes. In the next phase of this study, we are exploring how maternal and child health outcomes differ between integrated programs and standard treatment, and whether this varies across programs depending on the number and types of services offered.

For treatment programs that are working to improve access and services for women and mothers, this research suggests:

- the delivery of comprehensive and integrated services can improve women's experiences of care processes.
- tangible supports, such as for childcare and transportation, and flexibility in location of services (e.g., home visits), can help to address challenges that prevent women from attending appointments and making use of other services.
- in jurisdictions (such as Ontario) where substance use services were established and evolved quite separately from medical care, additional efforts may be warranted to ensure that there is meaningful integration.

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WE ASKED YOU

How do you engage Aboriginal and Torres Strait Islander people

Jolene Mokbel Clinical Co-ordinator
Salvation Army Youthlink AOD/Mental Health Programs

What are the barriers for Aboriginal and Torres Strait Islander people to engage with AOD services? Aboriginal and Torres Strait Islander people may find difficulties in accessing the relevant support services, especially when they are experiencing multiple needs in addition to AOD use (e.g. physical and mental health, social, economic and housing needs). Many Aboriginal and Torres Strait Islander young people have also found medical clinics to be unwelcoming and stigmatising. As a result, it is common for young people from Aboriginal and Torres Strait Islander communities to have experienced unpleasant experiences when accessing clinical support.

How has Salvation Army addressed these barriers? The Salvation Army has designed a program to help address the alienating experience which many Aboriginal and Torres Strait Islander young people feel in traditional clinical settings. Our program includes a care co-ordinator who not only builds rapport with Aboriginal and Torres Strait Islander young people, but also helps the young person navigate through a range of services. The care co-ordinator works collaboratively with our program's clinician to help the young person receive the AOD/mental health treatment they need along with support to address social and structural concerns. This in turn provides the young person with greater accessibility to seek holistic support that focuses beyond their AOD treatment.

Describe the outcome for these clients. We have seen more Aboriginal and Torres Strait Islander young people express willingness to seek AOD treatment along with other support to improve their quality of life. Many times, the young person makes one life change (e.g. securing accommodation, engaging in work/study, seeing a medical professional etc.) which then leads to a positive impact on their overall wellbeing (including reducing or avoiding AOD use).

Download now

Alcohol and other drugs treatment guidelines for working with Aboriginal and Torres Strait Islander people—in a non-Aboriginal setting

While we know that Aboriginal community controlled health organisations are essential in the provision of specialist AOD treatment for Aboriginal people, it is important that non-Aboriginal service settings are safe and accessible for Aboriginal people who access these services.

The guidelines are intended to support services to establish better relationships and linkages with Aboriginal organisations and in Aboriginal communities. The guidelines also provide practical guides and resources to support workers and organisations to improve their service delivery when working with Aboriginal service users.

Watch the webinar video recording
Presenters: NADA's Suzie Hudson and Raechel Wallace

Continuing coordinated care

By Michelle Ridley, NADA

To best support people accessing drug treatment, we need to not only help them with their substance use, but also with any other concerns impacting their health and wellbeing, such as housing, legal or economic problems, and unemployment. However, doing this is not always easy. Gaps in service provision and a lack of collaboration across the different sectors, are common issues AOD services face. While positive attempts have been made to build partnerships with other services and sectors, particularly at local levels, systemic barriers remain, and these impact on our client outcomes.

The Continuing Coordinated Care (CCC) program is a state-wide service funded through NSW Health, to help people experiencing AOD issues with care coordination, intensive outreach support and access and advocacy to other services (e.g. health, housing, and education). The program does not provide AOD treatment but is an additional support, which works to compliment the work of the AOD service provider, with the main aim to help people access and/or stay engaged in AOD treatment.

The program is delivered by three organisations: St Vincent de Paul, Mission Australia, and The Buttery. Services were rolled out across the 15 NSW Local Health Districts (LHDs) from July 2018 onwards. NADA was funded to provide the program providers with a dedicated clinical consultant to support them to navigate the service system through systemic advocacy, liaison, training and advice.

Evaluation overview

The NSW Ministry of Health conducted an evaluation to assess the CCC program progress, and the work of NADA's clinical support role. As of 31 December 2019, all planned CCC services had been implemented, with services scaling up to support approximately 800 active clients per month across NSW by late 2019.

Key challenges included:

- homelessness, one of the major factors impacting client's access and retention in AOD treatment. Barriers to securing housing included gaps in homelessness support services and lack of temporary, social and affordable housing.
- gaps in available treatment services (e.g. residential rehabilitation, services for women/parents and clients with co-existing mental health issues),
- physical distance and transportation. The greater the transportation difficulty/distance/cost, the greater the challenge to retaining clients in AOD treatment.

CCC clients rated their quality of life/wellbeing well-below the population normative range at program entry. Preliminary outcomes data indicate clients who completed the service experienced improvement in quality of life/wellbeing, reduced severity of dependence, reduced rates of homelessness/risk of homelessness and reduced rates of domestic violence.

LHD staff perceived the program as being highly valuable, the majority rating the continuation of this service as 'essential' in their district.

There was a high level of satisfaction with the NADA CCC program consultant expressed by CCC program providers.

Key areas where the CCC consultant had contributed to achieving the objectives of the program included:

- establishing new relationships between the program services and relevant organisations/agencies, especially FACS/DCJ, LHDs, PHNs and other AOD services
- brokering agreements between CCC program services and stakeholder agencies (e.g. FACs)
- establishing the CCC program within the network and forming referral pathways
- facilitating collaboration across teams through the all CCC program forum
- targeted training to up-skill staff quickly in key areas.

So where to now?

The CCC program will continue to provide support to people across NSW after being refunded for a further four years. The Buttery, Mission Australia and St Vincent De Paul will continue to deliver this service.

NADA's clinical support role will continue to work with the CCC program but also extend to support the wider NADA membership, with the goal to strengthen and expand the AOD continuing care services within the non government sector so people can better access quality, person centred, integrated services. To learn more aboutthe program or the clinical support role, please contact Michelle Ridley.

Access and equity
in alcohol and other drug treatment in NSW

By Michelle Ridley, NADA

The freedom to achieve good health is something people do not all share equally.[1] This is also true in the realm of addressing substance use issues; peoples' ability to access and make choices about treatment options are not equitable.[2]

A key issue for the AOD sector is the difficulties that clients have in accessing and staying engaged in treatment. To better understand these issues and to offer insights into how we can better support clients navigating AOD treatment, NADA commissioned the Centre for Social Research in Health (CSRH UNSW) to conduct research into the barriers and enablers for access and equity in specialist AOD treatment in the non government sector.

The researchers interviewed 20 consumers of NADA member services and 15 sector stakeholders, including frontline AOD service providers, advocacy groups and peak bodies. All participants were asked their views about ways to support people to access and stay engaged in treatment, and how to help maintain positive outcomes after completing treatment.

Study overview

The study found that accessing treatment was easier for people with more resources, such as housing, a supportive family, financial security, and knowledge of the system; whereas people experiencing homelessness and/or involvement in the criminal justice system were found to face the greatest difficulties accessing treatment. The findings from this research are not unique to the NSW AOD treatment sector, with national and international studies showing co-occurring mental health problems, housing issues, restricted income and debt, and criminal records, adversely affect people's ability to engage and remain in treatment.[3,4,5]

Key areas found to enhance successful access to treatment included:

- websites with detailed and accessible information that permitted the best opportunity for self-matching to treatment
- short waiting lists and flexible, warm, and welcoming intake procedures
- families and other support people who could help navigate treatment entry or provide support while a client was on a waiting list
- prior experience with the system, and therefore the knowledge and skills needed to navigate re-entry.

Key areas that supported people to stay engaged and complete treatment included:

- having staff and other clients who were warm and accepting
- services that provided clean and comfortable physical environments
- approaches that valued and supported client self-determination
- services where supportive peer relationships were actively encouraged and seen to be part of the therapeutic journey.

Key practice suggestions for AOD services

- Standardise the online presence of services to support self-referral and self-determination in service choice
- Strengthen the role of people with lived experience in all aspects of the treatment journey
- Consider ways to increase the size and contributions of the peer workforce
- Increase the availability of AOD treatment places
- Include families and support networks in a client's treatment journey (if this is a client's choice)
- Increase the attention given to staff training and retention
- Always consider the quality of the physical environment
- Consider whether all rules and regulations are necessary
- Continue the work to shift deficit assumptions of people with problematic substance use
- Recognise the limits of overly individualised approaches within AOD treatment integrated services.

Access and equity research
Read the full report or the report summary

Download the research

Watch the webinar video recording
Presenter: A/P Joanne Bryant (CSRH UNSW)

Watch the video

Access and equity in alcohol and other drug treatment in NSW

continued

The team at NADA are excited about the learnings from this research, which will help shape our future advocacy and capacity building projects. This research has not only highlighted the barriers around access and equity in AOD treatment in NSW, but also the enablers and successes of our member services in delivering quality treatment. Stay tuned for next issue of the Advocate where we'll explore the recommendations further.

NADA would like to thank the team at CSRH UNSW for undertaking this research, and importantly, the consumers, NADA members, workers and other stakeholders who took part in the interviews and study. For any further information please contact michelle@nada.org.au or suzie@nada.org.au.

More resources

- NADA's resource Working with families and Dovetail's training, Working with families and significant others
- Embedding a strengths based approach [PDF] in client conversations (a resource taken from the aged care sector that provides an excellent comparison between a deficit and a strengths-based approach)
- The Consumer participation audit tool will help you gauge how your service is progressing in relation to consumer participation in all aspects of service delivery
- LGBTIQ inclusive guidelines for treatment providers
- AOD treatment guidelines for working with Aboriginal and Torres Strait Islander people in a non Aboriginal setting

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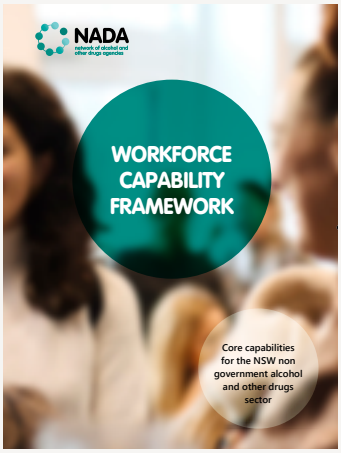


See the framework

Social determinants

Central to workforce performance are capabilities—the knowledge, skills and attributes that all workers in this sector must demonstrate to perform their roles effectively.

The **Workforce Capability Framework: Core Capabilities for the NSW Non Government Alcohol and other Drugs Sector** describes the core capabilities and associated behaviours expected of all NSW non government AOD workers.

Capability expectations around the topic of 'social determinants' link to **capability 1.2** (understand and apply relevant theoretical and practice-based frameworks) and **capability 6.2** (undertake effective care planning). Specifically, to demonstrate capability, workers are expected to recognise the role of social determinants and the need for structural interventions to address health and social inequalities (**Indicator 1.2c**) and incorporate an understanding of social determinants when planning care (**Indicator 6.2g**).

Notes

Domain:	areas of professional responsibility
Capability:	the knowledge, skills and attributes that a worker in the sector is expected to have in order to perform their work efficiently, effectively and appropriately
Indicator:	examples of observable behaviours or results

Useful resources

Definition

The World Health Organisation defines the social determinants of health as the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies and politics. See illustration.

Resources

NADA resources that address the social determinants of health

- Complex needs: eLearning
- Working with women engaged in AOD treatment
- Working with diversity

Australian Institute of Health and Welfare Australia's health 2020

Australia's health 2020 serves as a 'report card', looking at how we are faring as a nation. It includes short statistical updates and longer discussions exploring selected topical issues.

My life my lead: Opportunities for strengthening approaches to the social determinants and cultural determinants of Indigenous health

In 2017, the Australian Government Department of Health, in conjunction with the Advisory Group on the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023, led an extensive consultation process (My life my lead) across Australia to listen to people share their stories and experiences. The consultations examined the integral and supportive role culture plays, and analysed how social factors such as education, employment, justice, income and housing impact on a person's health and wellbeing at each stage of life. The learnings from the consultations are summarised in this report and will guide the ongoing development, implementation and delivery of future policy and programs, and support the ongoing commitment from the Australian Government to Closing the Gap.

Beyond bandaids: Exploring the underlying social determinants of Aboriginal health. Papers from the social determinants of Aboriginal health workshop

This monograph outlines specific recommendations against the range of social determinants of health for Aboriginal and Torres Strait Islander people.

Applying the social determinants of health in everyday practice: Lessons from the APS Congress

The APS Public Interest team convened a forum to discuss and showcase the valuable application of a social determinants of health approach in everyday psychological practice. The forum included a panel of practitioners who shared their experiences of using this approach across different areas of practice.

Evidence review: The social determinants of inequities in alcohol consumption and alcohol related health outcomes

The National Centre for Education and Training on Addiction, Flinders University, was commissioned by VicHealth to undertake a review of alcohol consumption and related harms from a social determinants and inequalities perspective. This report [PDF] examines the literature on these issues, presents the main findings on interventions that hold potential to address inequalities in relation to alcohol, and identifies gaps and makes recommendations for future work in this area.

Basic income

This presentation [PDF] explores the concept of basic income—a periodic cash payment unconditionally delivered to all on an individual basis, without means test or work requirement.

Five ways healthcare organizations can address social determinants of health

Healthcare providers can address social determinants of health through five approaches—awareness, adjustment, assistance, alignment, and advocacy, according to a report from the National Academies of Sciences, Engineering, and Medicine. Read more.

NDARC Technical Report No. 228 Social determinants of drug use. (2004)

This report [PDF] focuses on environmental risk factors for drug use, particularly those that also contribute to other psychosocial and behavioural problems. It examines how our social institutions and policies can influence the environment in such a way as to reduce drug use and related problems.

Farewell Larry!

As you are all aware, Larry Pierce is leaving us after 21 years at the helm of NADA. How do you describe such an individual, how do you describe his legacy? The Board of NADA has attempted to capture this with a word cloud (*above*). Larry, we all wish you the very best and thank you for your numerous contributions to the sector.

'The philosophers have only interpreted the world, in various ways. The point, however, is to change it.' — Karl Marx

These pithy words from Karl Marx, describe the legacy that Larry Pierce will leave for us all at NADA—Larry is a doer, striving for change and bringing us all along on the journey!

Larry has always prided himself and his leadership style as being firmly based in egalitarianism and from that we have all benefited. His ability to encourage and motivate the team and those around him will be missed, but there is no doubt that what he has created at NADA will continue to grow and evolve. Larry's passion for the members and the incredible work they do has always been his priority—and the sector has matured under his guidance. All who know him, will always remember his fierce and fearless advocacy on behalf of members.

A doyen of the AOD sector, Larry is much loved, bringing with him both humour and humility—we have personally enjoyed a warm friendship filled with fierce debates, laughs and wise counsel. He may not be swinging into the office anymore, but we know that he will never be far from the sector, and we hope that he continues to keep us honest.

Suzie, Rob and the NADA team

Stopping stigma at the source

Alcohol and Other Drugs Media Watch (AOD MW) is an unfunded collective of rogue researchers, clinicians and journalists who volunteer their time to advocate for better media reporting on AOD related issues.

The idea for AOD MW first emerged in 2016 during a VAADA board meeting where I had complained about a piece of poor media reporting. I lamented that I had contacted ABC Media Watch about it though had not received any response. One of the other board members suggested that our sector needed its own version of Media Watch. I thought, 'that's actually a great idea!'

I called for support for the initiative from the sector and was pleased to get in principal support from the stake peaks, including NADA, and other organisations. Also, from people such as Alex Wodak, Nicole Lee, David Caldicott, Monica Barratt, Matt Noffs, and Jenny Valentish.

Since officially launching in 2017, AOD MW has published critiques of almost 100 news stories, developed guidelines for journalists, consumers and commentators. We've even had ABC Media Watch report on two of our stories! And in June we released our first video episode, a critique of the Channel Seven 'documentary' on Ben Cousins.

Our second video describes my experience in making a complaint to the Australian Press Council about a story in the Daily Telegraph about the NSW Coronial Inquest into the deaths of six young people at music festival.

The Australian Press Council is the industry regulator of newspapers. As such, it is not surprising that they ruled in the favour of the Daily Telegraph.

AOD MW has made a second complaint to the Australian Press Council about the Herald Sun's reporting on the Melbourne Medically Supervised Injecting Room. Once again, the Council found in favour of the newspaper. We know the industry regulation model is not very effective for alcohol so why would it be any different for the media?

Nevertheless, we will continue! The best way we can continue to advocate for better media reporting on AOD related issues is calling out the media when they are perpetuating stigma and misinformation, or just being salacious. AOD MW aims to support people in the sector to develop pieces for publication on our website, video episodes and to make complaints to the Australian Press Council.

We are all volunteers and need your support. If you spot some poor reporting, the AOD MW team are here to support you to raise awareness of this issue.

You can also let the team at SANE Australia know.

Dr Stephen Bright (Edith Cowan University) is the founder of AOD MW.

Impact of COVID-19 on NADA members

The State and Territory AOD Peaks Network collaborated to develop an online survey to understand the impact of the COVID-19 pandemic on AOD treatment and support services. The key findings from NADA members:

71% reported that the COVID-19 pandemic had significantly affected their services

75% reported moving from face-to-face delivery to telehealth, with 80% of those indicating that they would consider maintaining these changes

65% of members reported that they had reduced client numbers to support appropriate risk mitigation measures (e.g. physical distancing)

48% reported an increase in demand for their services, with only 12% reporting a decrease. Sixteen per cent (16%) were unsure and 24% reported no change in demand

63% reported that there had been no change to staff numbers as a direct result of COVID-19, with 38% reportedly accessing the JobKeeper scheme. There was a reported need to support the workforce through training and promoting self-care.

'We have had to change everything in some way.'

NADA thanks all members who completed the survey. NADA has used the results of the survey to inform advocacy on behalf of members and NADA's sector and workforce development initiatives. Click here [PDF] to access the NSW report.

From the data and our engagement with members, we know that changes have impacted AOD treatment differently, and will continue to change as we navigate this unprecedented time. **What next:** NADA has commissioned an independent study into the impact of COVID-19 by the Drug Policy Modelling Program, UNSW. Whilst we appreciate that members are feeling over surveyed, we urge members to complete the survey by **Wednesday 23 September** to ensure that we can provide independent advice to government to advocate on your behalf.

Take this survey

For more information contact Robert Stirling.

A less lonely road

While studying at Boston University School of Medicine, I observed American media painting a 'war' on opioids. Yet I believe that the discourse surrounding AOD dependence may be better informed by narratives of hope—lessons which may be gleaned from other nations that have developed successful strategies for managing substance use disorders. So I created an animated film series to examine the management of AOD dependence in Australia, the first nation in the English-speaking world to establish safe injection facilities.

In my series, I first contextualized current patterns of substance use across Sydney and explored treatment models and public health interventions. I showcased the 'heroin shortage' of 2001 and the Uniting Medically Supervised Injecting Centre in Kings Cross. I then unearthed inspiring recovery stories gathered from participants at Odyssey House New South Wales, a residential rehabilitation facility in Sydney. The service runs the Parents' and Children's Program, supporting parents undertaking AOD treatment to live with their children.

Three graduates of the program contributed their individual stories, unified by motifs of financial insecurity, anxiety, depression, domestic violence, sexual abuse, and post-traumatic stress disorder. These commonalities point to the importance of addressing and managing the psychosocial determinants of health.

The graduates also conveyed how their substance use affected their family dynamics. They felt that their preoccupation with using and acquiring substances prevented them from fully addressing their children's needs. However, once they engaged in parenting classes through Odyssey House's family support services, they developed more nurturing relationships with their children. Thus, by supporting parents, Odyssey House's Parents' and Children's Program helps to break an intergenerational cycle of trauma and dependence.

Ariana Kam is a 2019/20 U.S. Fulbright Scholar, currently studying at Boston University School of Medicine. To learn more, visit www.alesslonelyroad.com.

Do you have something to share

Contribute to the Advocate to connect with NADA members and stakeholders. Promote new services and projects, innovative partnerships, awards and achievements, or research activity.

Email an expression of interest to Sharon Lee.

NADAbase update

Tata de Jesus NADA

Reporting

NADA submitted to the Primary Health Networks the Quarter 4 January–March data reports for members who receive Primary Health Network funding.

Apart from the monthly data submissions to the Ministry of Health, NADA also submitted to the relevant representatives the bi-annual report (January–June 2020) for the methamphetamine, youth and continuing coordinated care projects.

If you are a member who has recently Ministry and/or Primary Health Network funding and would like NADA to report on your behalf, please contact NADAbasesupport@nada.org.au.

Data entry reminder

NADA have recently received feedback from the Ministry regarding the use of service contacts to log activity with clients by our members. The NSW Health Data Dictionary defines a service contact as 'contact made with a client for the purpose of providing a service that results in a dated entry being made in the client's record.' Please consider the below pointers when entering data in the service contact field:

- Only a service contact between the client and the service provider should be reported
- A service contact can include either face-to-face, group, telephone or video link service delivery modes
- Not included: A service contact with a carer or family member (unless they are a registered client) or another health professional or a health worker involved in providing care

Kindly note that only successful contacts made between service provider and client should be entered into NADAbase. Service contacts do not include follow up phone calls or referral calls/emails to allied health services. We would advise such information be recorded in case notes instead.

What's been happening?

Asking sensitive questions

We recently held a webinar on asking sensitive questions with the aim of providing practical tips that can help workers to broach sensitive and difficult topics. Watch the video recording.

Two new companion documents: Importer guide and ATOP for importers

The NADAbase importer guide leads users through the activities involved in successfully importing data to NADAbase from a bespoke client record management (CRM) system. A companion document to the 2019 NADAbase data dictionary [PDF], this guide primarily focusses on organisations who use their own CRM system to record client and episode data.

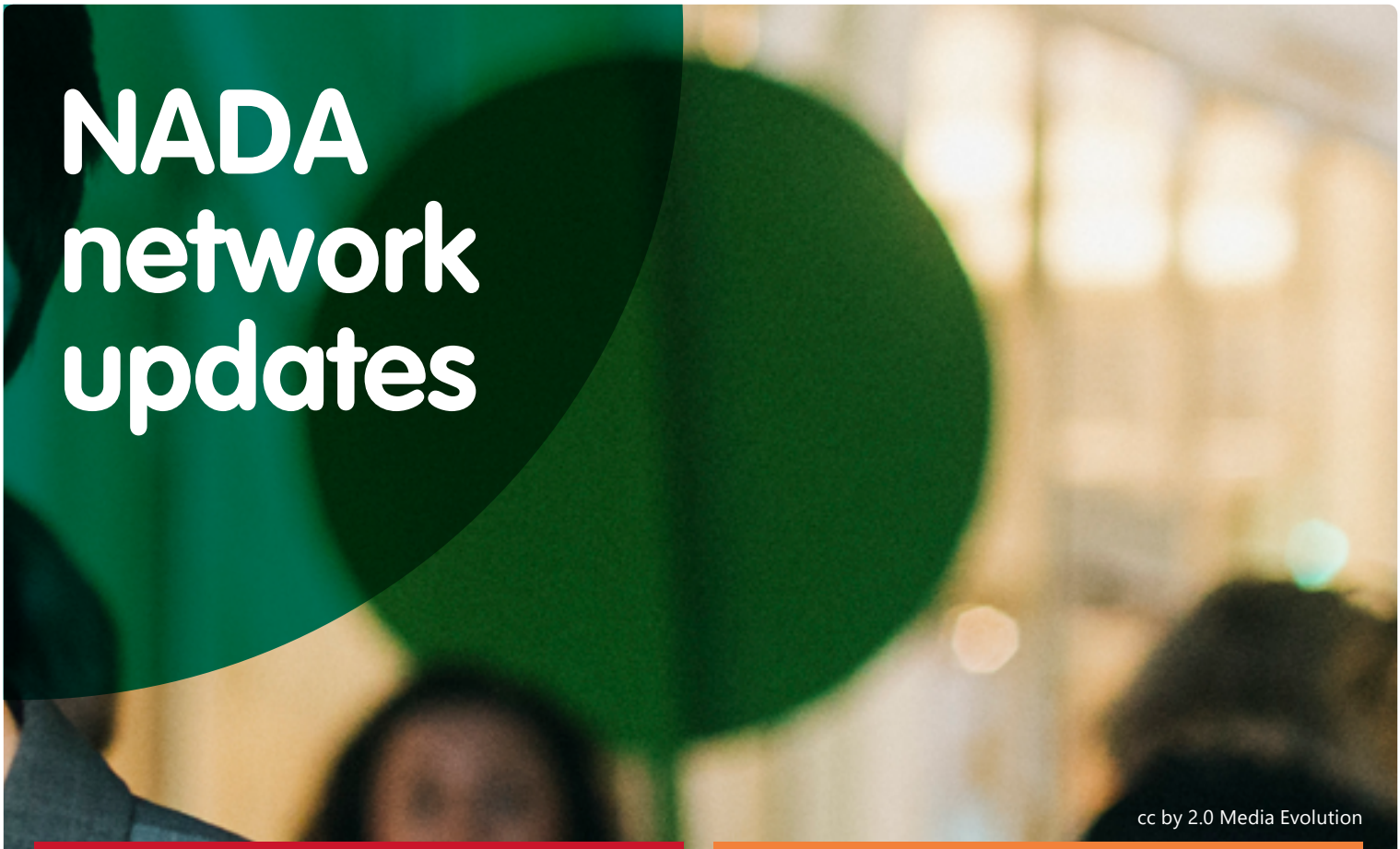
The NADAbase data dictionary: ATOP for importers [PDF] is an interim guide to support NADA member services with the use of the Australian Treatment Outcome Profile (ATOP) in NADAbase. A companion document to the 2019 NADAbase data dictionary [PDF], this guide supports the collection, reporting and analysis of the outcome measurement tool.

What's next?

FY2020/21 is a year of quality improvement for NADAbase. We now look to enhance:

- Data quality—through better data checks and validations, data dictionary updates, extracts and monitoring
- Analysis of data—continue data snapshots collected, and prepare data to be research ready allowing members opportunities to use it for independent research

NADA network updates



cc by 2.0 Media Evolution

NADA Practice Leadership Group

The NADA Practice Leadership Group met virtually in July 2020 and discussed current projects in the AOD NGO sector. Tonina Harvey from the Ministry of Health presented the NSW Health Clinical Care Standards to the group, highlighting feedback from the NGO sector is integral to the implementation of the standards.

Highlights of the July meeting were:

- The NPLG is looking forward to the implementation of both Capability Framework and Clinical Care Standards. It is hoped that the two pieces of work aids in service provision and organisational management, creating a more robust AOD NGO sector.
- The NPLG is looking at a piece of work around the AOD NGO sector's needs around supervision, and the need for support pathways for managerial positions.
- The AOD NGO sector has adapted well to the changes brought on by the pandemic; and it has showcased how resilient the sector is.

Youth AOD Services Network

The Youth Network has been meeting regularly online since the onset of COVID-19 restrictions. Network members from services located outside of the Sydney metropolitan area have found the online meetings particularly useful and have requested that they are continued ongoingly to help them stay connected to their professional peers.

Training and networking events for the Youth Network for FY 2020-21 are now being rescheduled to take place online wherever possible and will include these more frequent online 'catch-ups'. The 'Find hope' suicide and self-harm prevention workshop, originally scheduled for May, will now take place in October in Sydney based venue.

Other upcoming projects for the Youth Network include a fully updated online service profile and ongoing development of cross-sector referral pathways and strategies for improved communication between non governement and government-funded services for young people in NSW.

Women's Clinical Care Network

Most NADA member residential services for women are now undertaking a staggered approach to returning to full client capacity and programming, while non-residential services are continuing to provide quality care to clients both remotely and in person.

The telehealth model for working with clients has had notable benefits for most Women's Network services; however, they have raised specific concerns that ongoing lack of funding will not allow them to continue working in this way, despite the potential advantages of the hybrid model. NADA is continuing to advocate to funders in this regard.

The dialectical behavioural therapy skills workshop for network members that was previously planned for the first half of 2020 will now take place before the end of the year with the addition of a second day of training. An appropriately COVID-safe venue will be organised for this event.

Soon on NADA's website: An updated online service profile including all members who work with women.

Gender and Sexuality Diverse AOD Worker Network

The network has met in April and June and finalised its first work plan.

- **Advocacy**
  Influence health and social policy and practice
- **Funding opportunities**
  Seek opportunities to fund network activities
- **Supporting the workforce**
  Provide a supportive network for gender and sexuality diverse workers in the AOD sector. Support AOD workers to be more inclusive of gender and sexuality diverse people
- **Build AOD treatment service capacity**
  Improve AOD services for gender and sexuality diverse people

29 Sept

Providing inclusive AOD treatment for gender and sexuality diverse people The webinar will explore inclusive language and practice tips for supporting gender and sexuality diverse people. Register now

Community Mental Health, Drug and Alcohol Research Network

Great news! CMHDARN has been funded for another year to build research capacity across the mental health and AOD community sectors. By supporting research at a service level, CMHDARN aims to improve the quality of service delivery and thus the outcomes for people living with mental health and AOD issues.

To learn about the new and exciting projects CMHDARN has to offer, join our mailing list.

Apply now for ethical consultation for your research/evaluation project
The CMHDARN Research Ethics Consultation Committee provides ethical guidance by researchers and experts in the fields of mental health and AOD for research being conducted in these sectors. Anyone who is conducting research relating to clients/consumers in the mental health and/or AOD sectors is encouraged to apply to the RECC. Learn more. Learn more.

CMHDARN
Community Mental Health, Drug & Alcohol
RESEARCH NETWORK

Turn and face the strange

Working in times of change can be challenging. Triple Care Farm's senior psychologist Lauren Mullaney shares some advice to help us navigate through choppy waters.

For the fifth month in a row, you're at home trying to work while your kids, your pet, or your partner vie for your attention. The washing is piled high in the corner, and you try to ignore it, because that's for when you 'officially' knock off for the day.

Or you might be at work, transitioning back from online counselling to face-to-face.

You might just be frustrated because, for some reason, again, you forgot to unmute Zoom and gave the best monologue of your life that nobody heard.

I don't know. But it brings me to my point… swallowing change can be hard. Particularly in this current climate and the state of the world right now.

Whilst I'm sure this isn't new to you, it is worth acknowledging that working in times of uncertainty can be scary and daunting. On top of this, if we are also working with people who are finding it overwhelming, it can be a pretty difficult thing to navigate. Quick changes to the way we work can create shifts in organisational culture that can lead to feelings of inadequacy, lack of confidence and frustration.[1] On top of this, COVID-19 itself brings its own challenges outside of the organisational change. It can induce feelings of helplessness, loneliness and depression[2] and exacerbate old fears and prejudices[3] in ourselves and in the people we work with. What this continues to highlight is the need for consistency and safety. And not just safety in a physical sense (even though that's important); but in a psychological sense.

Practicing self-care

As you navigate your work right now, it's important to consider what is going to be helpful; look at what's within your control and taking a considered approach. Some of these things may include thinking about the following[4,5]:

- How do I stay connected and maintain relationships with my colleagues and with my family/ friends
- How do I practice emotion regulation and maintain good habits and exercise
- How do I maintain structure in my day and have a routine (i.e. get ready for work, have a dedicated work place, maintain a schedule, take breaks)
- How can I seek help when needed and balance my work/life divide
- How can I access appropriate resources and information from reliable/valid news sources

Some of us may already have access to these answers, and some of us may still be looking. If you are experiencing distress, or not, it is okay. Your reaction is what it is, and it is within the scope of your control to respond to. Moving forward, I would implore you to continue to celebrate wins no matter how small (yours and your colleagues), and to reorientate yourself to your values (i.e. why do you do what you do?!). Looking after yourself and monitoring your health is essential, because you are essential.

While I certainly don't want to moralise what we 'should' do, at the end of all this what may help to make it more palatable may be our ability to reflect on how we got through it all. For instance, *did I do the best that I could with the resources I had, as a professional in the industry*? Or, more importantly, *did I do the best that I could do as a human being in these weird and strange times?*

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Profile

NADA board member

Ed Zarnow
Chief Operating Officer, Lives Lived Well

How long have you been with NADA?

My association with NADA has been over the past nine years as an active network member in regional NSW. I represent Lives Lived Well (formally Lyndon) with services based in the Central West, Blue Mountains, Illawarra and the far South Coast of NSW. Lives Lived Well also provides AOD services in Queensland.

What does an average day look like?

Every day is a good day when you believe in the work you are doing and I am fortunate to be in a position where I am able to provide support to our frontline staff working with clients. This affords me the challenges and offers new opportunities to make each day a rewarding experience.

What experiences do you bring to the NADA Board?

I bring a diverse range of practical experience in health management, operations and financial acumen associated predominately with a rural and regional focus. My strong ties to the regional services and communities I have worked with supports my ability to manage the bureaucracy, which can sometimes stifle government organisations, to secure successful outcomes for our stakeholders.

What are you most excited about as being part of the NADA Board?

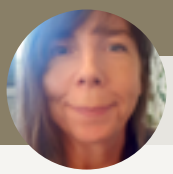
For me it is the opportunity to work alongside likeminded people who want to help with the planning and leadership of an organisation that is focused on providing advocacy and support for its members.

What else are you currently involved in?

Over the years I have been involved in a management capacity on many school and sporting organisations, as well Rotary. Family is extremely important to me and my time is often spent with them and enjoying additional recreational activities.

A day in the life of...

Sector worker profile



Rachel Hill
Art therapist, Triple Care Farm

How long have you been working with your organisation?

I have been working at Triple Care Farm for over two and half years.

How did you get to this place and time in your career?

I completed my placement at Triple Care Farm as an art therapy student at Western Sydney University. I thoroughly enjoyed my experience and continued working at the organisation after my placement ended.

What does an average work day involve for you?

I facilitate individual and group art therapy for young people residing at the farm. Art therapy is as an optional component in the program to further support the counselling stream by offering young people a non-verbal means to express and work through emotional content. Project briefs may include making an affirmation collage, self-care mandala, a mask or a hope vessel. Tie-dye shirts and fluid painting on canvas is a popular 'Open art' activity.

What is the best thing about your job?

When a young person finds a passion for creativity, often an unrealised aspect that they have that potential to be expressive. I also feel very fortunate to be working in an art room with a view of horses in the paddocks, pine trees and free roaming chickens! On a sunny afternoon, art therapy takes place outside, and working in the natural environment may further enhance wellbeing.

What do you find works for you in terms of self-care?

I have many forms of self-care including painting in my studio with my music playlist; going to the gym—spin class is my favourite; and spending time in nature such as bushwalking has a restorative effect for me.

Member profile

2Connect Youth & Community

2Connect *Youth & Community* is an award-winning organisation that has been supporting young people and families in the South East Sydney region for over 30 years. 2Connect provides a range of holistic complimentary services for young people who have issues or concerns related to AOD and/or who may be experiencing homelessness, unemployment, or disconnection from their family, school and community.

Our clients

Our clients are young people aged 10–25 years who live, work, study or stay in the St. George, Sutherland and Canterbury areas. Parents and families of young people are also clients as we have a holistic approach.

Our services

Our services empower young people and support them to create the changes they want for a more positive future. We offer a range of complementary and specialist services in various health and wellbeing areas, including holistic and complimentary services relating to AOD use, including practical and emotional support (case management and counselling), support and guidance for families on how to best support young people with AOD issues, referrals to appropriate services for complementary support, and resources and information about AOD use and related issues.

Our workers can see clients on-site in Brighton or Sutherland, or in an outreach setting, such as local health services, local parks or cafés, or at school. Support can include attending other meetings, such as school meetings or court in support of a client.

We offer AOD prevention, early intervention and therapeutic group work for young people, and provide information and support on harm minimisation to clients. Group work includes art or music therapy and preventative skills-building groups for young people at risk of AOD harms. Our team works collaboratively with complementary services such as specialist mental health, primary health, legal and housing services, as well as educational staff in schools. We also run successful community development projects to address specific local needs and issues. This includes chairing and collaborating in the St George Community Drug Action Team and undertaking assertive street outreach work to access and engage with young people.

Peer support

We have a youth-led peer education service called **Keep it Safe** where local young people participate in training to support and educate their peers on AOD and mental health, and where to get help.

Supporting diversity

We value diversity and have specialised in cultural diversity work for many years. We have developed programs and access strategies to meet the specific needs of young people in the local community from a range of diversities including culture, gender, ability and sexuality. In addition to ensuring that young people from diverse backgrounds are supported in culturally safe and responsive ways within AOD support, we also specialise in delivering diversity programs more broadly:

Man to man: a five-week program for young men from multicultural backgrounds to build life skills and leadership. Activities include mentoring, motivational guest speakers, sporting activities and workshops.

Glisten: supports young people who identify as same-sex attracted and/or gender diverse and features individual and group support, community education to address homophobia/transphobia and discrimination, and regular events for clients, their friends, partners and allies.

We also run education and support programs, including AOD education, for local multicultural communities such as Nepalese, Chinese, Macedonian and Arabic groups.

2Connect Youth & Community was named the NSW Youth Service of the Year by Youth Action NSW in 2019.

Contact us

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International Consortium for Health Outcomes Measurement

Developing a standard set for AOD dependence

NADA's clinical director, Suzie Hudson, was invited to participate in an International Consortium for Health Outcomes Measurement (ICHOM) working group to develop the 'ICHOM Standard Set for Addiction'.

ICHOM standard sets

The ICHOM standard sets are standardised outcomes, measurement tools with time points and risk adjustment factors mapped out for specific health issues. Developed by a consortium of people with lived experience of that issue and experts from the field, standard sets focus on what matters most to the person. By creating a standardised list of the outcomes based on the person's priorities along with instruments and time points for measurement, we can ensure the person remains at the centre of their care. Anyone can freely use the standard sets, and they come with webinars and a community of practice to support you with implementation.

Why should I use them?

People are encouraged to use an internationally agreed upon 'addiction' standard set for the potential it has around outcomes, AOD treatment and benchmarking. It is also significant because it has had the input from consumers—what they consider are the outcomes they might want from treatment e.g. improvement in my wellbeing. Using the standard sets, we may learn from each other across the world about the types of interventions that appear to have the best outcomes for specific health issues.

However, it is also understood that people may be wedded to the measures they already use, and therefore they can use this ICHOM standard set as a point of comparison regarding the elements or domains they are asking about, e.g. the standard set asks about 'involvement in education attainment as an indicator of economic status'—does my current set of outcomes measure cover this element?

How do they decide what to include?

ICHOM brings together global teams of patient advocates, healthcare professionals and researchers to define outcomes in their standard sets. See the website for their methodology.

What does the ICHOM standard set mean for the non government AOD sector in NSW?

- It firmly places AOD treatment in the health sector with a specific emphasis on it being a health issue that can be treated if someone is concerned about the impact of their use on their health and wellbeing
- It affirms the need for outcomes measurement to be applied to AOD treatment provision and be informed by consumer goals and needs—what they want to get from treatment
- ICHOM standard sets contribute to the development of value based health care—which underpins the NSW Health approach to provision of health care and provides the framework for this strategic approach: measuring outcomes that matter to the person who is receiving the care
- It helps the non government AOD sector and NADA to review the current outcomes measures being collected and consider how they align with international approaches.

To learn more, visit the ICHOM website.

Alcohol and other drug cognitive enhancement program

By Elodie Druitt, Acting Regional Manager North West, St Vincent De Paul Society

As a longer-term residential rehabilitation and withdrawal management service located in Armidale, Freeman House operates as part of St Vincent De Paul Alcohol and Other Drug Network. Program and treatment content within the network aims to provide cohesive and evidence based approaches to reduce the number of people experiencing a dependency on AOD, reduce the level of harm to the individual and the community, improve psychosocial and wellbeing outcomes and help participants build upon their own social capital.

Matching interventions and services to each individual's needs is a critical component for service delivery; treatment and support is tailored to the range of determinants of substance use and not just the using behaviour. Over time Freeman House has evolved into a holistic program modelled on cognitive behavioural therapy, dialectical behavioural therapy and psychosocial education.

While these intervention types have seen improvements for people, an ongoing barrier for some participants has been cognitive capacity, notably in areas of impaired memory and response inhibition functions.

In 2018, Freeman House took part in the Alcohol and other drug cognitive enhancement (ACE) program, to trial cognitive remediation intervention with participants via a 12-session group delivered over six modules. Three workers from Freeman House, myself included, attended a comprehensive two-day workshop.

Soon after the training, we delivered the 12 sessions to a group of 13 participants with the only attendance requirement being that they had engaged in the data collation process in prior months. Of the 13 participants, all had had varying lengths of stay within the Freeman House Rehabilitation program.

Each of the six modules introduced participants to the basics of the human brain and the five executive functions. Every session provided education on the purpose of the relevant executive function and used practical activities to cement the learnings. During and outside of the sessions, participants were required to engage in simple but effective 'brainwork' tasks as a means of enhancing function. The objective was for these remediation tasks to improve a person's uptake of new information, particularly that which would be received during the regular and ongoing Freeman House program. The hope was ACE would assist participants to increase their outcomes related to their recovery goals, because they had developed their ability to understanding the core learnings from their regular AOD treatment.

The formal data collection process prior to ACE delivery supported participant engagement and reduced attrition. Participants appeared to take the program seriously and expressed a sense of pride toward being involved in a research study. Those who expressed willingness to engage in the program provided positive feedback during and at the conclusion of the program, whereas participants who expressed reluctance towards the program remained reluctant throughout the course of the pilot.

While there was a small sample size making site specific conclusions difficult, those who participated in the sessions and follow up data collection were associated with an average improvement in executive function of 8.17 points out of 10.[1]

Throughout the delivery of the pilot, facilitators recognised its potential as an additional core component of our regular program. We could see strong linkages between the information delivered in ACE and components of already established groups, particularly the dialectical behavioural therapy modules that concentrate on emotion regulation and distress tolerance and the cognitive behavioural therapy modules on relapse prevention. Furthermore, the remediation strategies that focus on strengthening participant's ability to think about the future and plan their goals in specific and measureable ways, complimented established case management practices around recovery goal planning.

Since the pilot, Freeman House has been delivering ACE to people in the early stages of rehabilitation. While we have not collected specific outcomes data, reassurance that the program has been helpful to participant recovery has been provided anecdotally during groups. Participants have described the information and resources delivered in ACE as applicable to their day to day recovery journey, and has enabled an increased level of concentration, minimised adverse behavioural and emotional reactions and improved their insight into their own behaviour, perceptions and general thought processes.

Bibliography

1. ACE Study—Freeman House, Alcohol and Drug Cognitive Enhancement, Preliminary Results—June 2019.

Congratulations

NGO Sector Development Grant: Round 2

NADA is pleased to announce the following successful NGO Service Development Grant Round 2 applicants:

Calvary Riverina Drug and Alcohol Centre

Women's wellness and recovery program (Stream 1) Create a three-day week group program in a central and accessible location during school hours, which increases accessibility to treatment for women services by providing childcare options provided within the women's community.

Community Restorative Centre

Leaving custody and staying out during COVID-19; a CRC mapping, research and capacity building project (Stream 1) Improving access to holistic AOD support for people leaving custody during COVID-19, improving responses to clients already connected with services, as well as expanding the support available to larger numbers of people leaving custody.

Directions Health Services

COVID-19 connectivity project (Stream 1) Ensuring that particularly vulnerable individuals and families impacted by AOD use in the NSW Southern and Murrumbidgee regions can seek and receive appropriate support during the COVID-19 restrictions. This includes prioritising access to Aboriginal community members, other diverse community members who are subject to multiple vulnerabilities, and those whose ability to engage with services is compromised by financial constraints.

Drug and Alcohol Multicultural Education Centre

DAMEC consumer participation strategy (Stream 1) Develop a strategy that cements consumer inclusion as 'core business' in DAMEC, informed by the meaningful input of the diverse culturally and linguistically diverse (CALD) communities' perspectives. Generate (through research and consultation) knowledge of different methods of CALD client participation, including safe mechanisms to foster open and critical dialogue, that can be applied within DAMEC as well as to the AOD sector more broadly.

The Glen Centre (in partnership with ADARRN)

Aboriginal rehabilitation model of care training (Stream 1) Ensure staff across the four ADARRN member organisations have the skills and training necessary to provide residential AOD rehabilitation services to Aboriginal people in line with the framework outlined in the ADARRN model of care. Facilitate the adoption of a standardised model of care across the sector and provide a training package for the ultimate outcome of strengthened cohesive residential rehabilitation services for Aboriginal clients across NSW.

Haymarket Foundation

Bourke St Aboriginal and Torres Strait Islander project (Stream 1) Employing indigenous consultants with AOD expertise to develop a version of the successful Bourke Street program, tailored specifically to Indigenous clients. The project will also train staff in working with Indigenous clients, ensure that the material that is being delivered is culturally appropriate and that there is reduced stigma and discrimination for Aboriginal and Torres Strait Islander clients. We will establish an Indigenous client working party as a voice to management, with the aim of giving a long-term, consistent focus to Aboriginal and Torres Strait Islander clients.

Kathleen York House

Development of online telehealth resources to support women during the COVID period and to continue post pandemic whilst still out in the community (Stream 2) Develop and capitalise on resources to be used throughout the COVID-19 response period and ensure that they can continue to be utilised post-pandemic to engage wait-listed women in care and, where, applicable commence treatment prior to admission.

Sydney Medically Supervised Injecting Centre (in partnership with Black Dog Institute)

Accurate assessment of, and response to suicide risk among clients attending the Uniting Medically Supervised Injecting Centre (Stream 2) Enhance capacity to more accurately assess and respond to acute suicide risk among MSIC clients by better equipping MSIC staff with the skills to respond to acute suicide risk, developing materials in relation to suicide risk for dissemination among MSIC clients and provide resources to build capacity across the AOD sector in responding to suicide risk among AOD clients.

Triple Care Farm

Evaluating the effectiveness of telehealth options for young people accessing AOD support (Stream 1) Capture data that assesses staff and young people's understanding of the perceived impacts of telehealth service of provision, and to capture if there is a discrepancy between staff's 'beliefs' around telehealth provision and that of young people's views. That data will then be evaluated as to the effectiveness of working with telehealth and use the results for quality improvement at Mission Australia/Triple Care Farm.

Updates

Programs

Continuing coordinated care

Since the COVID-19 pandemic, the Continuing coordinated care (CCC) programs adapted their service provision to online, remote support, via telephone, online meetings and facilitating Smart Recovery groups etc. More recently some of the teams have started to provide face to face support and like other NADA member services, are continually reviewing their service delivery model to adapt to the ever-changing covid environment. NADA's CCC clinical program manager has been providing support to CCC program staff and other NADA members including:

- facilitating monthly Community of Practice online video meetings for all CCC staff across the state
- networking with DCJ executive staff to organise a roundtable meeting between DCJ, NADA member women's residential rehabilitation services and MOH to improve collaboration and referral pathways
- funded the provision of ACON Pride training for CCC program staff.

For more information, contact michelle@nada.org.au.

Consumer engagement

NADA's consumer engagement coordinator met with member services involved in our 2017 Consumer Participation Project to discuss their current consumer engagement activities and any further support needs. Our consumer engagement coordinator has also been consulting with consumer representatives to discuss ways to provide them with ongoing support, such as providing a platform for representatives to meet and share projects and updates.

For more information, contact trinka@nada.org.au.

Groups and sub-committees

Reconciliation action plan working group

The latest iteration of NADA's 'Innovate' reconciliation action plan (RAP) is due to be released in October, with the RAP Working Group providing valuable input to the updated plan along with some excellent suggestions for further enhancing our commitment to improving cultural safety and the inclusivity of Aboriginal and Torres Strait Islander people within the AOD sector. This will include regular communications from the working group with the wider NADA membership as well as an art competition for NADA members. Further details about this exciting opportunity for local Aboriginal artists will be available soon.

For more information, contact resli@nada.org.au.

Consumer engagement board sub-committee

The inaugural NADA Consumer Engagement Board Sub-committee is continuing to meet and provide invaluable insight and input into developing the voice of consumers within the AOD sector. Moving forward, the sub-committee will be co-chaired by board members, Latha Nithyanandam (Kathleen York House) and Libby George (Drug and Alcohol Services Inc), and consumer representative, Fabian Galbraith.

For more information, contact resli@nada.org.au.

NADA practice leadership group

Meet a member

Peter Kelly Associate Professor School of Psychology, University of Wollongong

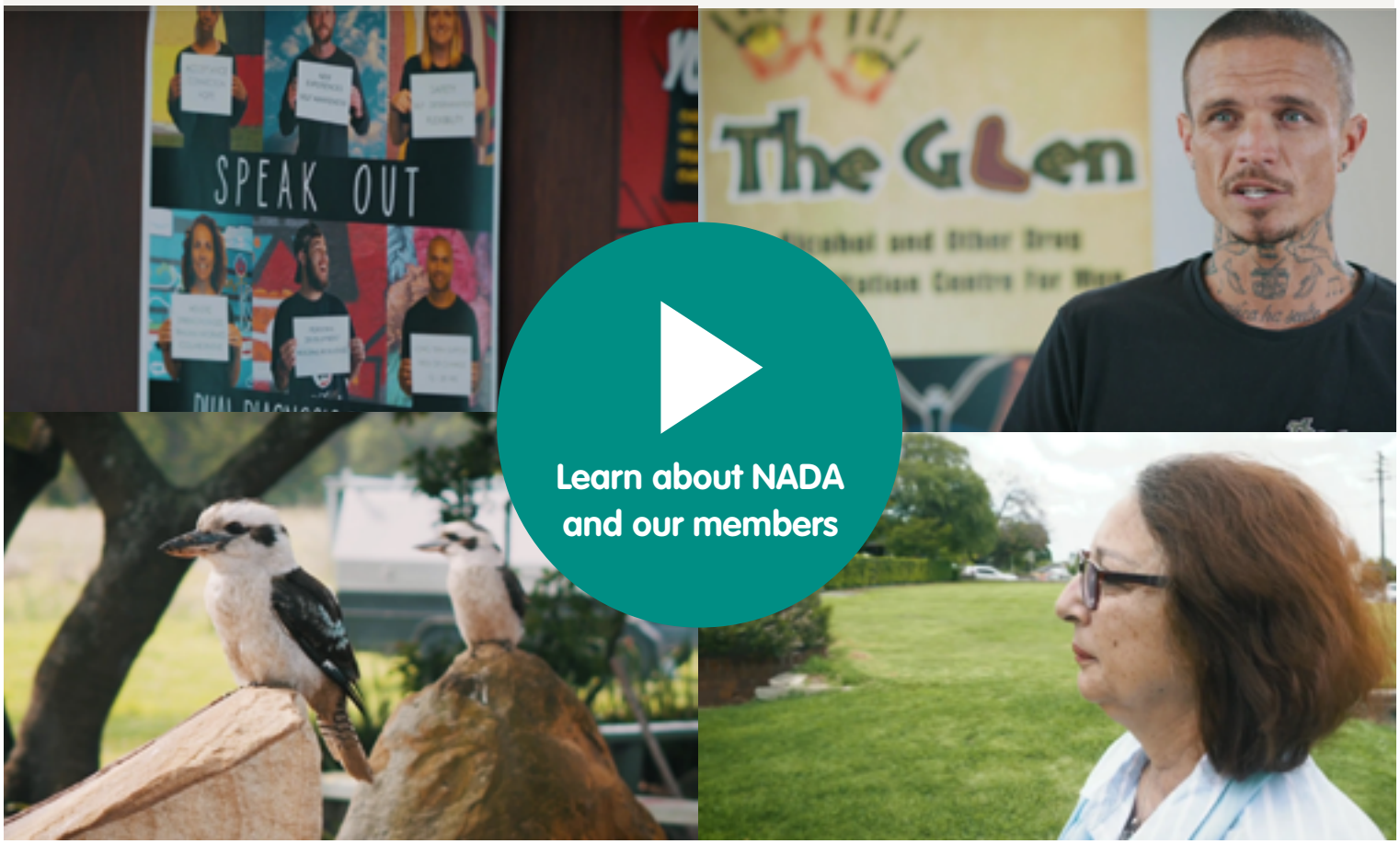
How long have you been working with your organisation? How long have you been a part of the NPLG?
I have been working at University of Wollongong since 2011, and I've been a member of the NPLG since 2015.

What has the NPLG been working on lately?
The NPLG held a really productive meeting with the Ministry of Health earlier this year. This provided an opportunity to showcase the role of the non government AOD sector. In particular, the NPLG was able to highlight the tremendous role that the sector has played in establishing the NADAbase.

What are your areas of interest/experience—in terms of practice, clinical approaches and research?
I'm interested in research that helps to improve the quality of care that is available to people accessing AOD and/or mental health services. This includes examining new types of interventions, improving the way that outcome data is used, and helping to understand and improve the experience of people accessing treatment.

What do you find works for you in terms of self-care?
I'm lucky, I work with a group of really supportive colleagues and students. I think that really helps to make work enjoyable. Outside of work, I do my best to spend time with family, keep exercising, and listening to lots of music.

What support can you offer to NADA members in terms of advice?
I think all of the members of the NPLG would be very happy to talk to NADA members. I wouldn't hesitate to contact any of us. I'd be more than happy to brainstorm research ideas or give feedback on grant applications —whatever is helpful. Feel free to shoot me an email: pkelly@uow.edu.au.



Advocacy highlights

Policy and submissions

- The AOD Peaks Network wrote to the Australian Government Health Minister providing the results of the member COVID-19 impact survey, highlighting the agility of the non government AOD sector. We requested the Minister consider the financial implications of the pandemic, as well as the uncertainty resulting from the freeze on indexation and the cessation of ERO supplement.
- NADA and the NSW health peaks have sent a letter to NSW Ministry of Health seeking clarification on the Supplementation and Indexation under the NSW Ministry of Health NGO Ministerial Grants Program.
- NADA wrote to the NSW Health Minister providing the results of the member COVID-19 impact survey requesting an additional 1.5% of members funding agreements amounts be applied to support responses to COVID-19 for items such as PPE and technology costs.
- A joint media release by ADARRN and NADA called on the NSW Government to start implementing the recommendations from the Special Commission of Inquiry into the Drug 'Ice' to see more resources given to Aboriginal community controlled organisations.
- NADA provided a submission to the parliamentary inquiry into family, domestic and sexual violence, and feedback on the AADC submission.
- Submission from a coalition of Australian AOD services calling on governments to respond with policy changes and additional funding to enable COVID-19 enhancements on an ongoing basis.
- NADA is supporting the campaign by ACOSS to raise the rate.
- NADA contributed to consultation on the trial of eight adult mental health centres across Australia; the NSW centre will be located in Penrith.

Advocacy and representation

- NADA has been representing members on a range of COVID-19 meeting structures: NSW Ministry of COVID-19 Clinical Council, NGO Community of Practice, AOD Community of Practice.
- Key meetings: Australian Government Department of Health, NSW Ministry of Health, NSW Department of Communities and Justice, NSW Council of Social Services.
- NADA has been involved in the Expert Panel for the review of the Co-morbidity Guidelines for AOD and Mental Health 3rd Edition
- NADA is part of the steering committee and working group tasked with informing the development and delivery of a workforce development package and implementation strategy for the *NSW Clinical Care Standards: Alcohol and Other Drug Treatment*.
- NADA is part of the steering committee overseeing the Take Home Naloxone program and participated in the pilot of its training program.

Information on NADA's policy and advocacy work, including Sector Watch and the meetings where NADA represents its members, is available on the NADA website.

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Feedback **Training grants**

Photo by Kris Ashpole