Advocate

The eMagazine of the Network of Alcohol and other Drugs Agencies Issue 4: December 2018

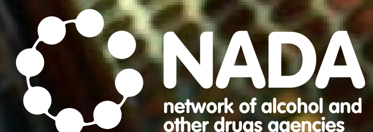
Family matters 3

Peers are professionals 9

Implementing family inclusive practice in AOD and mental health services 13

Support networks

• Family Drug Support • Family Recovery Program
• Odyssey House Victoria • Emerging Minds
• Sydney Drug Education and Counselling Centre
• Lives Lived Well • Open Dialogue • ACON • NUAA



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CEO report

Larry Pierce NADA

This edition of the Advocate focuses on the importance of support networks—networks of services, families, communities and peers—that are crucial in ensuring clients are best supported in the non government AOD sector.

The idea of networks is close to our heart at NADA, for as our name suggests, we believe that it is through a network of services that the best policy and practice outcomes can be achieved.

NADA is proud to be a peak body for the non government AOD sector in NSW, and first and foremost we are a networking agency for our membership. We exist to bring our members together, to assist with shared communication and information exchange, to work through the key issues of the day with the membership and hopefully reflect their views when advocating for the sector. We believe that without our network we are merely a small organisation trying to effect change and promote a set of messages with insufficient evidence behind us. Indeed, it is because we are a network of close to one hundred member agencies that we are listened to, and consulted, by government and other stakeholders. It also means we can provide a collective voice for AOD issues, and at the end of the day, for the clients that access our services.

To further strengthen our network, we have recently renewed our strategic plan. In this document we have outlined our vision for a connected and sustainable non government AOD sector with our purpose to advocate for, strengthen and support our members. And what are the values that underpin our vision and purpose? They are: integrity, respect, inclusion and collaboration. We believe that these values are central to genuine and effective networking—for how can you maintain a network without being respectful, inclusive and collaborating with integrity? NADA's strategic priorities are to advocate for sustainable funding and grant program governance, to promote the strengths of the membership, to assist in building the capacity of our sector and to help support our workforce. None of these priorities can be done well if we don't work with and through our membership networks. It is through this networked approach to these priorities that we can effectively mine the collective practice wisdom of our membership, exchange intelligence and help create linkages.

We believe that it is through a network of services that the best policy and practice outcomes can be achieved.

NADA's value is its networked membership, and our membership gains strength through their participation in that network. Government trusts our representations because they know we speak for the membership and provide the collective voice. Stakeholders value these same things and know that NADA is a good reflection of the collective professionalism of the non government AOD sector. Finally, the staff and the NADA Board of Directors know that through maintaining the network, and sub networks we support, that we can truly reflect and support the needs and priorities of our membership at all the levels we work at. This gives us all strength and clarity of purpose.

The articles in this edition will focus on a range of client support networks developed across our membership and the value this brings to services. I commend this edition to you.

Family matters

My story in the telling has been a long time coming, I experienced such grief, feeling as fragile as a glass that could shatter at any given moment.

Anonymous

Photo cc by nc nd 2.0 International Monetary Fund and Brandon

Our story begins like many others—a teenager struggling with his sexuality, anxiety and depression, turns to an over-the-counter medication to cope, of which he takes up to 60 tablets a day.

Fast forward four years: he has a university degree, excels in his chosen profession and has the prospects of a wonderful career. But he hides a secret—he has an escalating opioid dependence. Several times, unbeknown to us, he has reached out for help, but with little success.

Our world and his implodes one night. He is a nurse on duty, in charge and inexperienced. Not coping. He self-harms with an anaesthetic agent and is found unconscious by work colleagues.

He exits to a private health facility for treatment.

His story is leaked to the press and Channel 7 lead their nightly news with 'Drug addicted nurse steals cancer patient's drugs.'

Weeks later, the police come to our door and escort him to the local station. The hospital has him charged with stealing to the sum of $20 (the cost of the medication), and possession, as he was found unconscious with the medication and a syringe in his hand.

The court, however, were merciful. No conviction was recorded—still it was a very difficult time.

18 months later and he fronts an unbelievably stressful two-day hearing with the Health Care Complaints Commission (HCC) as he was a nurse and the incident happened at work. The outcome was fair but the restrictions were unachievable given his circumstances of depression, unemployment and drug dependence.

Inexplicably Channel 7 see fit to run another story. This time Derryn Hinch names and shames him on a prime-time current affairs program.

> I would like to pause a moment to emphasise the damage this had on his mental health and wellbeing, not to mention mine.

He continued to see-saw between replacement pharmacotherapy and relapse, and at times using alcohol and cannabis. Part of the restrictions placed by the HCC was regular drug screening, yet following these events, he returned with a positive result.

Family matters
continued

Another two years pass—five years since the original transgression—and the HCCC decide to persecute him again, despite the fact he had not worked as a nurse for five years, was not registered and most likely never would be again.

Once again, he was subjected to a two-day tribunal. This time he represented himself, and he did so amazingly well, up against their barrister and lawyer. But yes, this caused him to relapse and he admitted himself once again to a private health facility.

The outcome this time was less than positive, and to add insult to injury he was sent a bill for over $12,000 dollars for the hearing. On protest this was reviewed, and someone saw fit to rescind all costs.

Whilst our story is one of grief, loss and pain and at times felt like persecution, it is also a story of love, hope and forgiveness. My son lost his career, his self-respect and almost his life but he never lost the love and support of his family and those who knew him.

I despaired, how could this happen to such a wonderful young man, who was so kind and caring? How could I fix this? But of course I couldn't, that was his road to follow.

My story in the telling has been a long time coming, I experienced such grief, feeling as fragile as a glass that could shatter at any given moment. Not wanting to tell people what we were going through, I was hyper vigilant and consumed by these events and his struggle. I felt such shame and failure as a parent.

Driving home from work the tears would fall, I wanted to pull into someone's driveway and live their life.

For me, along the way I found Family Drug Support (FDS). I couldn't believe such an organisation existed! FDS gave me hope when I had little, and I began to understand what drug dependence was and the long hard road that is recovery, fraught with relapse and disappointment.

Though this was a horrible time in our lives it was also an opportunity for personal growth, understanding and learning, I attended the FDS Stepping Stones course, became a volunteer on the telephone support line and now facilitate a support group.

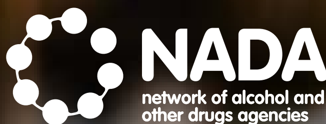
Eight years have passed since that fateful day and many nights, where fear came to visit regularly and rest heavy on my chest.

My son is going well and is still on pharmacotherapy (suboxone), though the fear of relapse is always ever present.

He has finally found the confidence to find employment after being so brutally crushed and made powerless by the system—he has been working this last year as a carer.

In December on his 28th birthday, he became engaged to his long term partner who had stood steadfastly beside him all these long years. We are so grateful for his progress and the courage and strength it took to take control of his life, but without the support of his family this journey to recovery may well have had a very different ending.

Photo cc by nc nd 2.0 steph



2018
annual report

Take a look

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Through the eyes of children

Working with children when there is substance use in the family

Sally Riley
Co-ordinator, Child and Adolescent Program
Family Recovery Program (formally Holyoake)

I have the privilege of working with children who have had some of the most unpredictable and challenging experiences, usually in their first five to 10 years of life.

The first meeting is crucial in establishing a connection. How does a child explain why they need support? How do they explain their 'normal' when often unspoken family rules of 'don't talk', 'don't trust', 'don't feel' are embedded in their beliefs? Involving the parents in the first meeting with non-judgemental compassion is imperative. Gaining their permission for their child to share whatever is necessary with this strange new 'helping person' is a key marker to establishing trust, that I am here to help find the strengths in what is often thought as hopeless.

As a child plays in the therapy room, with gentle discussion around universal themes typical in families with these issues, something shifts. The child's interest peaks and questions slip out in between play. What began as fear can turn quickly to hope. Common fears that emerge from the children include: 'it's my fault', 'I'm not good enough' and 'I have to fix the problems.'

When these children decide they want to join a group with other kids, things often begin to shift—the children appear a little less burdened and parents often report they are surprised by the difference they see in their child.

'I learned that it's not my fault and that I didn't have to keep my feelings inside —that I'm a pretty cool person'.

As the eight-week group starts and children meet others that share similar experiences they learn coping strategies, safe people and how to express difficult things using fun and creative play. After the group these children tell us they feel less scared or sad, are more willing to talk about their worries and see themselves more positively. At the same time their parents report they have less fear around how their child is doing and that their coping strategies have improved. This is best captured in a comment made by a recent group member who said, 'I learned that it's not my fault and that I didn't have to keep my feelings inside—that I'm a pretty cool person.'

Kids in focus

Family work at Odyssey House Victoria

Photo cc by 2.0 Tom Reynolds

Anne Tidyman
Manager Child and Family Services
Odyssey House Victoria

Since 1979, Odyssey House Victoria, an AOD treatment agency, has provided residential services for families with parental substance use problems. During 2002–2004, philanthropic funding allowed for the development of a non-residential family program at community services. Known as Nobody's Clients, the program documented the experiences of parents with problematic substance use and their children, while providing short-term case management to help families meet their needs. Following on from the success of the program, the federal government funded the Counting the Kids program, which ran from 2004–2010, and led to the Kids in Focus program, currently funded until 2020.

Engaging early and building trust

Kids in Focus is a child focused, family centered program which reaches out to families in their own homes. The program uses strength based, trauma informed interventions to addresses both risk and protective factors. The program also delivers the parents under pressure model and helps families to address social isolation through the mirror families practice model and through therapeutic family camps that provide opportunities for social interaction. The critical components of the Kids in Focus program are engagement and building a trusting relationship with families, which means being available and reliable. The program also advocates for families in meetings with other service providers and at court appearances.

The majority of parents engaged with the program have complex trauma histories. Many grew up in homes with problematic parental substance use and experienced childhood physical and sexual abuse. Co-occurring mental health problems and domestic violence frequently feature in their adult lives. These past and current experiences often result in inconsistent, sometimes punitive, neglectful and ineffectual parenting, child protection involvement and the removal of children. These children will often experience multiple placements. The children's own adverse life experiences sometimes lead to social, emotional and behavioural problems and their own substance use problems, yet only a small number of children receive any service when their mother or father enters treatment; when services are provided they tend to be delivered separately. Yet, to be effective, interventions need to simultaneously address parental substance use, attend to parental and child trauma, repair attachment and build resilience in children.

> If the damage is done relationally, then repair has to be done relationally, alongside absolute positive regard with a good dose of reality!

To be most effective, interventions need to commence as early as possible. To this end, Kids in Focus supports women through pregnancy, childbirth, parenting and recovery through a partnership with the Women's Alcohol and Drug Service at the Royal Women's Hospital in Melbourne.

Developing therapeutic relationships

The key lessons learned from various programs delivered over many years, both in community and residential services, is that good assessment is based on a therapeutic relationship, which, in turn, requires a skilled worker. This worker needs to be able to assess interactions between parents and children and to be able to help parents understand that children's behaviour is the language that adults need to hear. The worker needs to know strategies for reparation, as this is where therapeutic intervention occurs. The skill of the clinician is also highly important in assessing child and family wellbeing. This is slow work: building a therapeutic relationship, engagement and assessment take time. Parents can be highly anxious and communicate with the worker only by text messages for the first month or two, which many services would see as lack of engagement and close the case. However, the trauma clients are living is relational and therapy or intervention therefore need to be done relationally, within professional boundaries.

No matter what their history, almost all parents with problematic substance use are socially isolated and lack positive community engagement. In essence, the therapeutic community and Kids in Focus do similar work in different settings: the therapeutic community provides peer support for resident families whereas Kids in Focus helps parents and children establish peer support in the community. Thinking about your own work with families, who do you pull in around the family? Is it the child health nurse? The local community house? The extended family? Whoever it is, work with the family must be led by the family. The family needs to have agency and self-efficacy in order to walk through life differently. If the damage is done relationally, then repair has to be done relationally, alongside absolute positive regard with a good dose of reality!

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Paving ways

Northern Beaches

Belinda Volkov Clinical Coordinator
Sydney Drug Education and Counselling Centre

For the past 45 years, the Sydney Drug Education and Counselling Centre (SDECC, formerly MDECC) has provided AOD treatment for those living within Sydney's Northern Beaches. In 1999 SDECC became a predominately youth specific service which increased the requests from families who were in need of support. SDECC developed the Paving Ways program for parents during this time with guidance from pioneers in the sector such as Tony Trimingham.

Implementing a family inclusive approach was a testing time for the agency. SDECC's challenge was maintaining a youth friendly environment that is also welcoming for parents. SDECC's model reflects the evidence that when families are in crisis and/or conflict that trying to work with them together is generally ineffective. At SDECC young people and parents are given a different counsellor, no clinician works with both young person and parents. Parents are allocated to the Paving Ways group with further support from individual counselling should this be necessary. Young people and parents can access treatment whether the other family member is in the service or not. Our recent data reflects that of those parents who attend the service and whose children are not that approximately 70% of their young people present.

Paving Ways runs as a six week program with parents to provide stabilisation, skills and strategies for managing their young person's behaviour. It is common for parents to present with the goal of 'fixing their child' however our evidence shows that they come away with a more holistic understanding of what they can and can't control as well as develop ways to manage and respond.

Roadmaps

Western NSW

Sue Williamson Coordinator, Lives Lived Well

Roadmaps is an exciting mobile day support rehabilitation program being delivered across Western NSW by the Lyndon Dubbo outreach team, which is part of Lives Lived Well.

The Roadmaps program aims to provide more accessible AOD support to adults living in regional towns. The program uses a community reinforcement approach to help participants find healthy alternatives to drinking and using. This is achieved through goal setting, problem solving, communication skills and increasing healthy activities.

Roadmaps is free and runs for two sessions per week for six weeks. The program helps with AOD dependence, mental health concerns, education, harm reduction and overdose prevention strategies, relapse prevention, access and referral to relevant supports services such as housing and health.

The Roadmaps program has already been successfully completed in Dubbo, Wellington and Gilgandra. A second round of the program is underway at Dubbo, with a further three locations set to host the program in 2018.

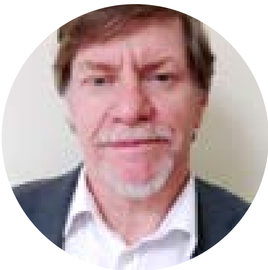
The program has attracted male and female participants ranging in age from 18 years to 50 plus, with 90% being of Aboriginal origin. Participants have nominated primary drugs of concern including methamphetamine, cannabis, pharmaceutical patches and alcohol.

One of the first people to participate in the program was 25 year old John*. John said his decision to take part in Roadmaps was life-changing.

'The support and acceptance I got from the Roadmaps team encouraged me to keep going and the strategies I learned have given me hope for the future,' he said.

'Everyone was shocked and surprised, including me. I just decided I'd had enough of being broke, chasing pot and having all the other hassles. I have given away my bong and other equipment because I don't want to go back.'

**name changed to protect client's privacy*



Peers are professionals

Dr Grenville Rose, adjunct lecturer for the Centre for Social Research in Health, UNSW, advocates for the recognition of peer workers based on the outcomes they achieve.

I work in mental health for my day job and have lived experience of both mental health and AOD issues, but when I was contacted about writing an article on peers in the AOD sector I asked if I was the right person to write about it. The reply I got was one that has worried me for years. 'Mental health is further ahead of AOD in consumer and peer work.'

It worries me because I know how far there is to go in mental health. There are still problems integrating peer workers into programs even in the mental health non government organisations that have philosophies based around individual choice and acknowledging the importance of the voice of lived experience in services. I don't even want to think about the implementation in more clinically oriented services. Even in community managed organisations I believe there is a lack of recognition of the wealth of experience that comes from learning how to overcome your own difficulties and developing your particular strengths. There is an overvaluing of professional qualifications above the knowledge that comes from lived experience. If as outcomes research suggests, even in clinical environments[1], the outcomes produced by peer workers are at least equivalent to the outcomes achieved with professionally qualified people then perhaps it's time to fully recognise the value of having peer workers in an organisation and to value the intersection of professional and lived experience knowledge.

There is a substantial, if controversial, body of research in psychology that states that different therapies yield the same outcome, but that different 'therapists' can get different outcomes. A principal criticism of that theory is that different therapies do get different outcomes with regard to symptom reduction. However, if you include broader measures of quality of life, beyond just reduction of symptoms, those differences between therapies disappear.[2] In AOD, similarly, are we talking only about minimising substance use or are we talking about a better quality of life? The theory proposes that the reason there are no differences between therapies but there are differences between therapists' results is that there are common factors that help people. These common factors include: empathy, alliance, positive regard and congruence.[3] These are all qualities that are so strongly embodied in peer work, both in mental health and AOD.

Peer workers can feel isolated and devalued in their work. They can feel overlooked for promotion and seen as 'only a peer worker', not professionally qualified. This is prejudice, it is not based on the outcomes achieved. The knowledge gained by lived experience should be recognised as equivalent to more formal professional qualifications and the intersection of professional and lived experience knowledge must be explored so we can get better outcomes for the people that access our services.

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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].

The role of children in family inclusive practice

Emerging Minds

Relational recovery research and practice[1,2] has developed in the mental health and AOD sectors to improve client outcomes, understand parents' relationships with their children as a motivator for change, and provide early identification and prevention of risks to mental health for Australia's children.

31% of Australian children currently live in a household with someone who drinks alcohol at risky levels, while 22% are adversely affected in some way by this drinking.[3] Despite what we know about involving children in parents' AOD treatment there remains significant structural and individual challenges for practitioners.

Supporting child focused practice

In 2018, Emerging Minds conducted a needs analysis of AOD professionals and determined the major contributing factors in practitioners' ability to engage in child focused practice were:

- clear organisation expectations regarding child focused and child inclusive practice included in service frameworks, assessment protocols, practice policies and case reviews
- access to reflective supervision supporting the development of child focused micro-skills
- the ability to build rapport with parents with a long history of being judged or stigmatised
- the confidence to have child focused conversations with parents who have previous or current experience with child protection systems
- access to child specific data regarding the number of family focused plans and children's involvement in decisions about their parents' treatment
- the ability of practitioners to reflect on child focused practice if this is not core business or fall outside of their 'core business.'

Where there is a lack of clarity about child focused practice, practitioners discussed a lack of confidence in having meaningful conversations with parents, and a reluctance to involve children as stakeholders in their parent's treatment.

Inclusion of children in your practice with parents

Children whose parents are experiencing AOD issues are often attuned to their parent's behaviours and can offer unique insights. They are also the individuals with the most to lose and gain from their parent's engagement in AOD treatment. Including children in your practice with their parents not only promotes their safety and care and allows them to participate in decisions that affect their lives, but it can further enhance parents' engagement and success in treatment.

Practice considerations

We invite you to consider your own practice and how your organisation supports child focused and child and family inclusive practice. Does your organisation:

- have intake and assessment processes that capture all clients' parenting and family status
- consider the ways in which parents' AOD use could be impacting children's social and emotional wellbeing as part of the intake and assessment process
- have specific practice positions, policies and processes which support child and family focused practice
- have mechanisms to support interviews with children or families, where safe and appropriate
- train practitioners to discuss sensitive topics with clients, particularly where those conversations might apply to previous, current or potential child protection notifications?

Emerging Minds

The Emerging Minds: National Workforce Centre for Child Mental Health works with practitioners to support a focus on the social and emotional wellbeing of children in adult focused services. The centre's child mental health workforce consultants can partner with AOD practitioners and organisations to develop resources to support workforce development and practice change. These services are provided free of charge and consultancy is provided at a pace that meets your organisation's needs. This work also recognises models of good practice existing within the AOD sector and seeks to understand what supports this work and the improvements on client outcomes when practicing in a family inclusive way. Visit emergingminds.com.au to learn more and access a wealth of resources.

References overleaf

We asked you...

How can we better engage with Aboriginal families?

At the service level, you suggested:

Focus on what's going on with the family and not just the individual.

Recognise the family, and strengths and resilience within Aboriginal families.

Connect with community members as there may be existing networks, services and resources that services can piggyback on.

At a practice level, you said:

'Waiting' can be a deterrence—offer opportunities for immediate engagement.

Families will often check in or call—take that opportunity to directly link them in with other help your service may offer.

Ask for advice from your Aboriginal colleagues.

Families can often call in intense moments. Workers can help and make themselves available to talk, take time to build rapport and provide opportunity for families to drop in.

Thank you Yerin Aboriginal Health Services, Illawarra Aboriginal Medical Service and Tharawal Aboriginal Corporation

The role of children in family inclusive practice

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Open dialogue

Professor Niels Buus and **Dr Steven Mayers**

St Vincent's Open Dialogue Initiative

When people experience repeated trauma and distress they learn to cope in different ways. These coping mechanisms, such as AOD use, are sometimes referred to as 'symptoms' and the person's story that led to this point can be downplayed. Current approaches to supporting people experiencing distress often serves to isolate them from their support network and locate the problem within the person. For a number of years, various service user groups and professionals have sought alternative ways of supporting people in crisis, regardless of how their distress might manifest.

Originating in Finland, Open Dialogue is a person oriented approach, which aims to mobilise psychosocial resources around a person by engaging the person, the family, and the individual's social network in a series of treatment meetings. It was originally developed as an approach to mental health crisis intervention for early psychosis and to ongoing care for people experiencing a psychosocial crisis. Now, it is implemented as an approach to social recovery for people dealing with a variety of different mental health and social health problems, both acute and persisting.

There is currently no formal manual for Open Dialogue and interventions are based on the following seven general principles which can be modified to fit in differing contexts: 1) Responsiveness. 2) A social network perspective. 3) Flexibility and mobility. 4) Responsibility. 5) Psychological continuity. 6) Tolerance of uncertainty. 7) Dialogism.

Evaluations of the effects of Open Dialogue in Finland are encouraging, demonstrating improved clinical and functional outcomes after five years. On the basis of a register based cohort study, Seikkula and colleagues found that the group receiving Open Dialogue required fewer days of hospitalisation (an average of 36 days) than the comparison group receiving treatment as usual (an average of 117 days). Furthermore, they found improved employment status, with 83% of the intervention group studying, working, or job seeking in contrast to 30% in the comparison group.

The humanistic Open Dialogue approach, including Peer-supported Open Dialogue, has the capacity to reduce the alienation of service users and their families by avoiding paternalistic decisions and interventions. For many people and their families, contact with services can be very disruptive, confrontational and even traumatising. It is very likely that families that are met by an open and genuine approach will start to make better use of health care services, with improved outcomes for patients and less utilisation of limited resources.

How can my organisation learn more?

Open Dialogue is currently being modified and implemented in different ways in health and social care teams in NSW and there are plans to implement the approach in AOD services in the inner Sydney region. Professor Niels Buus and Dr Steven Mayers, who are facilitating this process, would like to extend an invitation people working in services providing support. We will provide opportunity for you to learn more about these approaches and to consider how they might be implemented into the services in which you work. Building on the success of the previous implementations of the model we would like to share our experiences and learn from yours. If you are interested in attending a two-hour workshop in relation to this then please email Suzie Hudson or phone (02) 8113 1309.

Translating research into practice

Implementing family inclusive practice in AOD and mental health services

Naomi Rottem Manager of Community Services and **Michelle Wills** Project Coordinator
The Bouverie Centre, a research centre of Latrobe University

Problematic substance use impacts all aspects of a person's life, including their family relationships. These impacts can also be reciprocal; that is, family relationships can be a source of stress which can be a trigger for some people to engage in substance use. There is a significant body of evidence to indicate that including families in the treatment of people with problematic substance use can improve retention in treatment, treatment outcomes, and the wellbeing of family members or significant others. Despite this, many services still struggle to routinely incorporate family members in the treatment.[1] This article will describe The Catchment Beacon Project, an action research project undertaken by The Bouverie Centre, and some key findings that may provide useful insights to assist services in implementing family inclusive practices.

In 2014, The Bouverie Centre received funding from the Victorian Government to implement a coordinated project over two years to improve the capacity of AOD and mental health services to work with families. This project, known as the Catchment Beacon Project, brought together services located in two geographic locations or 'catchments' (one in metropolitan Melbourne, and one in regional Victoria) around this shared endeavour, and incorporated an action research component that aimed to explore the following questions:

- Which family inclusive approaches would best meet the needs of clients, families and services?
- How would practice change best be achieved?

The first phase of our project involved engaging service managers, a strategy informed by the implementation science literature,[2] that aims to establish an authorising environment for change to occur. Once engaged, managers were then asked to recruit practitioners and people with lived experience (service users and family members) to be involved in a consultation forum that would drive the direction of the project.

These forums were a novel and important component of the initiative. Two were held—one in each catchment. The process of conducting the forums was informed by concepts from the experience based design methodology.[3]

In total, 59 participants were involved, including 26 practitioners and 33 people with lived experience. Participants were divided into small groups; one comprised of service users, one of family members, and one of practitioners. Groups were invited to share their experience of family inclusion in services at various points of their 'journey of care' and to make recommendations for how this experience could be improved. The groups reported back themes to the larger group.

Next, participants were provided with information about a range of different family interventions, including information about their evidence base and a video demonstration of the approach. They were then divided into service-based groups comprised of practitioners and people with lived experience, and asked about their views on which approaches would be most appropriate for use in their service. Interestingly, most of the groups in both catchments came to the same view, that single session family consultation (SSFC) would be the preferred model of family intervention.

> Hearing directly from clients and families about what they had been through, and how they had experienced services, helped practitioners develop a greater appreciation for their needs.

This unified view amongst service providers and people with lived experience provided a clear direction for the project. Hearing directly from clients and families about what they had been through, and how they had experienced services, helped practitioners develop a greater appreciation for their needs. We speculate that this helped to increase practitioners' acceptance of the need to incorporate family interventions in their work, and their willingness to take up new practices.

Catchment and service based implementation plans were developed in collaboration with catchment steering groups, and included practice enquiry groups (PEGs), training, and booster sessions. Implementation support was provided to the services involved, via monthly steering group and PEG meetings in each catchment, and these groups also functioned as a vehicle for both qualitative and quantitative data collection.

A total of 154 practitioners from 10 different agencies were trained in SSFC, with 27 of these also attending booster training about managing conflict in family sessions. All participants were asked to keep record of their efforts to engage families in their work with service users. This

Translating research into practice

continued

information was collected by practice champions and reported back via the PEG meetings. At times this process of data collection was challenging, as it required persistent efforts from the practice champions, and it also revealed slow uptake in practice. While this was not unexpected, it was at times disheartening, and so it was important to understand the complexities and barriers that were being experienced and respond to these by taking appropriate action. In this way, the research process became an implementation tool, which helped keep project momentum going;

'It pushed us all to come together, encouraged us, it gave us deadlines and goals and accountability.'

Over time, the data revealed an increased uptake in family inclusive practice following participants' involvement in the training as reflected by the number of:

1. discussions practitioners had with clients about involving their family
2. invitations extended to families to participate in meetings with clients
3. consultations involving the client and family together
4. consultations with individual family members.

'There's been a real shift in mentality around how we think about working with families... taking that next step from being family inclusive and providing information to families, to actually sort of actively working with them and moving towards that more collaborative approach.'.

'...we've been noticing lately that we have a lot more family members accompany our clients when they come in for their assessments because we've talked to them, we've explained to them the process, we've told them that its an option'.

Other methods of data collection included:

- pre and post surveys completed by training participants, the results of which indicated that statistically significant gains in confidence occurred following completion of the training. This related to both family sensitive practice generally and to facilitating family meetings
- interviews with both managers and practice champions at the end of the project, which elicited valuable information about barriers and enablers to change, and their experience of involvement in the project.

For services that are considering adopting family inclusive practice in their work, this research provides some valuable insights:

- For family inclusive practice to be embedded sustainably within services, it must be supported at every level. Having management engaged and actively endorsing and monitoring practice change, and ensuring that family inclusive practice is clearly articulated in all relevant service documentation is vital.
- Opportunities for practitioners and people with lived experience to work collaboratively in a co-design process are useful mechanisms to ensure relevance and increase staff buy-in.
- Having all levels of staff and management participate in research around implementing new practice can foster a healthy sense of curiosity and keep the momentum for change going.
- While the inclusion of sustained implementation support is more resource intensive than providing training alone, it is more likely to embed family inclusive practice in the long-term.

'It's a big time commitment... but I think the advantages outweigh the time commitment in the long run'. (practitioner)

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The Bouverie Centre, From Individual to Families: A client centred framework for involving families https://www.bouverie.org.au/images/uploads/Bouverie_Centre_Framework.pdf

Support networks for LGBTI people

You must ask the question first

Genevieve Whitlam and **Sarah Lambert**

ACON

How many LGBTI clients does your service provide support to? Do you know what supports options are available for them? The LGBTI population makes up around 11% of the Australian population.[1] There may be some geographic variation surrounding this figure, however it gives service providers a sense of the proportion of their clients that identify as such (openly or not).

It has not yet become standard practice for services to ask clients whether they identify as part of the LGBTI community. Some argue that asking about sexual orientation will be met with reluctance or cause offence. However, when surveying people aged over 45 years, the Sax Institute found a greater reluctance to answer questions related to income than sexuality.[2]

By asking clients about their gender and sexuality, we:

- signal to LGBTI people that this is an inclusive service
- provide opportunity to disclose gender and sexual identity
- enable services to identify LGBTI clients and provide client centred practice
- build the evidence about LGBTI health, behaviours, service need and access.

Through consultation with LGBTI communities and health researchers ACON has developed the following indicators. We recommend the use of these questions in all health/human services data collection and research where applicable. NADAbase also includes questions that relate to sexual orientation and gender diversity after consultation with us.

SEXUAL ORIENTATION	INTERSEX STATUS
Do you consider yourself to be: ☐ Lesbian, gay or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Queer ☐ Different identity (please state)	Were you born with a variation of sex characteristics? (this is sometimes called 'intersex') ☐ Yes ☐ No ☐ Prefer not to answer

GENDER	
Which of the following best describes your current gender identity? ☐ Male ☐ Female ☐ Non-binary/gender fluid ☐ Different identity	What sex were you assigned with at birth (i.e. what was specified on your original birth certificate)? ☐ Male ☐ Female

LGBTI people experience higher rates of harmful AOD use, mental health issues, suicidal ideation and suicide than the general population. This is not because of their LGBTI status, but because of 'minority stress', the accumulating effects of discrimination and stigma.

Community connectedness and support networks for LGBTI people are understood in terms of chosen family (non-biological close friends), community participation and perceived exclusion to community. Like other cultural groups LGBTI communities enjoy peer social groups, sporting teams and interest groups. Community connectedness is invaluable to 'coming out' processes, reducing internalised homophobia, enabling positive social comparisons and improving mental health and wellbeing.[3] However some people within the LGBTI community may feel less connected, including bisexual people and people at the intersections of race/ethnicity, gender and sexuality.[4]

This brings us back to the importance of a consistent approach to asking clients about their gender and sexuality. When we provide opportunity for an individual to disclose their gender and sexuality, we will better understand our clients, their context and build opportunities for delivering a truly client-centred service.

ACON offers a variety of clinical services and peer led initiatives aimed at improving community connectedness and support networks including counselling, care coordination, a community visitors scheme, support for older people, peers support and workshops for different groups. See our website or check Pivot Point. To make a referral, call 02 9206 2000 or email intake@acon.org.au.

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4. ibid

Useful resources

Resources

- Tools for change: A new way of working with families and carers
- Factsheets: Navigate the child protection system

Network of Alcohol and other Drugs Agencies nada.org.au

- Not my family, never my child: what to do if someone you love is a drug user
- Stepping stones workbook: Guiding families through the journey of coping with drug and alcohol use

Family Drug Support fds.org.au

- Parent and family drug support: information and support pack for Aboriginal parents and families
- Working with families with substance misuse problems: community reinforcement and family training manual

Australian Indigenous HealthInfoNet—Alcohol and Other Drugs Knowledge Centre aodknowledgecentre.ecu.edu.au

- Domestic and family violence tools for alcohol and other drug settings

Alcohol Tobacco and Other Drug Association ACT
atoda.org.au

Links

NSW Family and Community Services
Promotes the safety and wellbeing of children and young people and works to build stronger families and communities.
Telephone: 132 111
facs.nsw.gov.au/families

Drug and Alcohol Multicultural Education Centre
Primary focus is to bridge the service gap by assisting and supporting service providers to make a difference to the way they access and service culturally and linguistically diverse clients.
Telephone: 02 9699 3552
damec.org.au

NSW Users and AIDS Association Inc
Provides education, practical support, information and advocacy to users of illicit drugs, their friends and allies.
Telephone: 1800 644 413
nuaa.org.au

Druginfo
Information for the community with a collection of plain language books and factsheets held in NSW public libraries and public programs delivered by public library staff.
druginfo.sl.nsw.gov.au

Say it out Loud
ACON
Say it Out Loud encourages people from LGBTIQ communities to start talking LGBTIQ domestic and family violence
sayitoutloud.org.au

Carers NSW
Provides a range of support and information services, and lobbies on behalf of carers in NSW.
Telephone: 1800 242 636
www.carersnsw.org.au

Supporting the supporters

Dr Suzie Hudson Clinical Director, NADA

Families come in various shapes and sizes, and when it comes to inclusive practice in AOD treatment, they can include anyone who cares for, and is concerned about someone else's AOD use. AOD services are well placed to support the supporters—even our data collection demonstrates this when it asks you to nominate whether you are engaging with a client who identifies their *own use* as being why they reached out for help, or whether it was someone else's use (denoted by *other's use*).

It is never easy to receive a phone call from a distressed family member or partner; they are often looking for answers which we are unable to give, or incredibly worried about the potential outcomes of continued substance use which brings with it lots of emotion. However, there is much that we can do that helps:

- **validate** their experience, give them some space to express their concerns and fears
- **educate** them with some basic information if they are seeking it, such as what effects substances may have, what is AOD treatment and how does it work
- **facilitate** links to additional supports that may assist such as support phone lines, peer support groups like those offered by Family Drug Support or counselling.

Demystifying the effects of AOD, providing information on the treatment system is extremely useful and can assist in more realistic expectations of what can be provided, and what the boundaries or limitations are.

There is good evidence to suggest that being inclusive of families and significant others can assist in sustaining positive outcomes form treatment for clients and support the wellbeing of both clients and those who care about them. We know that the reality of AOD treatment is that it is that it is time limited—whether it's the counselling session that comes to an end after 60 minutes, the group session that wraps up for the day, the withdrawal management episode that is completed or the conclusion of a residential rehabilitation program. So how do we ensure that the support continues out in the community for all those being impacted?

Ask questions of consumers and clients that invite them to explore previous or current support networks, and revisit these areas throughout the treatment episode:

- *'Is there someone in your life that supports you? Or that might be supportive of this step you are taking?'*
- *'What kinds of information might assist the person who cares for you to understand what you are experiencing—is that something we can assist with?'*
- *'What might a supportive network look like for you? Is this something you have experienced in the past? What can we do to build that?'*

When engaging with significant others build on the strengths that are there in their relationship with the person they are concerned about:

- *'How might you describe the connection you have with the person you have concerns about?'*
- *'Are there things that support you now that help with staying connected to the person you are concerned about, despite the worries you have for them?'*
- *'Are there other things that might further assist with maintaining your connection/support of the person you are concerned about?'*

Be open and curious to the importance of cultural backgrounds and the meaning of family for different people. Link in with Aboriginal Community Controlled Services—there is much we can learn from Aboriginal workers about the significance of family connection and the role it can play. Similarly, taking the time to find out about possible support networks with different culturally and linguistically diverse groups can enhance the treatment being provided and offer insights into some of the challenges that stigma can place on individuals and those who care for them.

The language we use is important and improving communication within a household to ensure everyone is safe and feels understood can assist in alleviating distress. Good communication also ensures that privacy and confidentiality are not a barrier to supporting families and significant others. There are things you and your organisation can do right now to improve family and significant other inclusive practices—for more information check NADA's Tools for change kit that includes an organisational audit tool that will identify areas you can get started with.

Working with statutory child protection agencies

Michelle Ridley Clinical Consultant, NADA

Protecting children is everyone's responsibility. Just as a health system is more than hospitals, so a system for the protection of children is more than a statutory child protection service.[1]

AOD services and statutory child protection agencies have traditionally experienced difficult working relationships. Our sectors have worked independently, largely due to different organisational cultures, views, language and policies. For AOD services working with clients who have current or past child protection involvement, it can be difficult to comprehend the system and how and why decisions are made.

Child protection services are child focussed, usually requiring parents to engage with services in a mandated capacity, often requesting parents achieve abstinence in very short timeframes to address parenting and child protection risks. While AOD services traditionally are adult focussed, requiring willingness on behalf of the parent to engage in treatment, using a harm minimisation approach that does not necessarily mean abstinence, and allows for longer time to achieve treatment goals. These diverging views and practices often make it difficult for AOD and child protection services (e.g., FACS) to work in collaboration.

AOD services generally take on an advocacy role for the parent when working with child protection and we do this to ensure our client's situation and needs are being heard. Conversely, if we advocate in an adversarial and confrontational manner, this can create interagency conflict and cause services to be reluctant to work collaboratively.[2] When reflecting on my own past practice in frontline AOD roles, I recall advocating strongly on behalf of my clients, and now reflecting on these times that I took an adversarial stance, and acknowledge that this type of advocacy was most likely not that helpful for my client. Research and practice advice suggest we can reduce this perceived conflict and barriers between child protection and AOD services, through a common understanding and language.[3]

For AOD services to work in partnership with child protection we need to have an understanding of the child protection system. While child protection agencies need to understand drug treatment and respect the expertise of AOD service providers and the challenges for parents with long term problematic drug use, that is often related to histories of significant trauma and current contexts of family and domestic violence and other vulnerabilities.

Understanding our own values and beliefs and biases also helps in working together, as a clear understanding can allow us to find common ground and reduce the sometimes defensive reaction from each service.[4]

Resources to enhance collaborative practice

NADA has developed fact sheets to help you navigate the child protection system and Family and Community Services (FACS). The first fact sheet provides an overview of the roles and responsibilities of FACS and its staff, whilst the second describes the practice framework, approaches and systems of FACS.

Working together for families—Child protection in the AOD service context This resource [PDF] provides AOD services with essential knowledge about child protection processes and aims to enhance the working relationships between AOD services and child protection services involved with women with children.

For kids' sake this resource [PDF] is designed to build building knowledge and strategies for AOD interventions that are sensitive to the needs of, and involve, families and children.

Top ten tips for dealing with FACS this booklet [PDF] has been developed by NSW Women's Legal Service to help women and families deal with the government services in charge of keeping children safe.

A final suggestion for supporting your client if you believe they are being unfairly treated by FACS after all your attempts to work collaboratively, is to report their situation to the FACS Complaints Unit. This unit is located in their central office and is separate from the local office that is working with your client and their children.

If you'd like further advice, please contact Michelle Ridley michelle@nada.org.au.

References overleaf

Families and significant others

Workshops

NADA has hosted several state wide workshops in collaboration with the NSW Ministry of Health, Family Drug Support and Local Health Districts. The workshops explored family inclusive practices and presented an opportunity for services to reflect on what they are doing to engage families and significant others, and identify areas for improvement.

What we learned

- Engaging families and significant others is an essential part of a comprehensive response to working with people with AOD issues.
- The language we use is important and we need to be mindful of the terminology used when discussing family and support networks with clients and families/significant others.
- Services can be open to listening to family members and significant others without breaching confidentiality and privacy.
- Actively listening and subsequently considering the family dynamics and the other impacts the situation can create (e.g. fear, isolation, anger, powerlessness) is helpful for the family/significant other.
- Have early discussions with clients to establish family inclusion and create opportunities to again raise this throughout the treatment process and to clarify boundaries.
- Providing supported and warm referrals for family members and significant others that come into contact with your service can be a part of service delivery and captured within client notes and as part of the N/MDS and MDS.

What you said

'...the day provided a good opportunity to reflect on how 'family inclusive' our service is and consider it—the implications, the weaknesses, the benefits, the costs (resources & otherwise)—particularly from the perspective of the family. Sort of like jumping over the fence and seeing what we do from the other (family) side.'
Local Health District worker

'It was good to listen to (family members) stories, the trauma (emotional), the struggles and the barriers the person, family members travelled through their life—they had great information to pass onto us.'
NGO worker

'...validate, educate, facilitate model. Reminder that therapeutic relationship is key to this work.'
NADA member

Working with statutory child protection agencies

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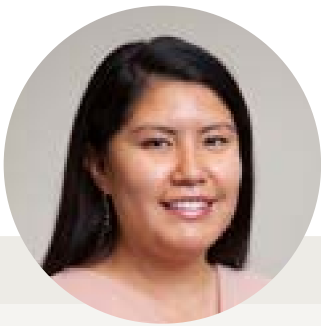

Join us for morning tea

Building relationships and support pathways

Rubieth Montecinos Program Manager

The families and significant others of clients face numerous barriers to engage with AOD services. An effective way to reduce these barriers is to form collaborative relationships with a wide range of community groups and services to build effective and appropriate referral pathways.

Services may begin by investigating available referral options. For example, they can map local and regional service providers or review directories from local councils or state government websites. Another option is to join a local network mailing list. Once relevant services are identified, then start collecting information about what programs or services they provide, their target groups, and capacity for engagement.

The next step is to begin engaging service providers. A practical way to do this is to invite them to relevant meetings; these may be events for the community, or meetings to exchange information about your respective services. It could be a simple as hosting a morning tea! Another option is to include local agencies in activities or learning opportunities, for example, professional development for staff.

How do you build an effective relationship with local services and agencies?

- Treat external providers as partners. This means working closely together and giving each other feedback on how the relationship is working. This can be positive feedback and feedback that highlights issues that need to be worked on.
- Ensure staff are well informed about external service partnerships and have processes in place internally to ensure that everyone understands their role.
- Check in with local services and find out if there are ways to improve your referral pathways. Over time that communication will build and develop into a great working relationship.

How do you tell if a relationship is effective?

Effective working relationships are generally achieved when the respective parties:

- are clear of the goals and responsibilities of each party
- engage in activities to help each party understand the perspective of the other
- have realistic expectations of each other and what can and cannot be undertaken
- have an appreciation (and some empathy) of the pressures each other faces
- have clear points of contact between respective organisations who can troubleshoot any difficulties.

Relationship building isn't rocket science, but it can be just as powerful! Simple ensure you know what services are available and understand that it may take time for that relationship to develop. Ongoing and regular communication and information sharing help to develop effective working relationships. In turn, these produce positive outcomes for clients and their families and significant others.

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NUAA

Peers and Consumers Forum

NUAA's inaugural Peer and Consumers forum was held at the Teachers Federation Building in Sydney, on 5–6 September 2018. The forum aimed to provide opportunities for peers to speak up and be heard, to network and provide development in their roles. We targeted people who identify as peers in a variety of roles in the community of people who use drugs including: those contributing as volunteers, people in front-line peer support roles and peers in management and leadership roles.

The forum emphasised peer support and inclusivity; diverse communities engaged including festival, Aboriginal, peers engaged in hepatitis C (HCV) support work and those in AOD settings. The forum also aimed to increase linkages between services and engaged peers and to increase the visibility and understanding of peer work among service providers. We considered an academic program of formal presentations to be inappropriate and opted to have an open dialogue with expert panellists participating along with audience members.

To our knowledge, this forum—organised by and aimed squarely at peers and consumers—was the first of its type in the world. It was a significant challenge and opportunity for NUAA as we were, as an organisation, breaking new ground and stepping outside our previous experience.

We provided free registrations to anyone requesting one and travel support to as many regional peers as possible. Half of the registrants identified as being peers. On the day, 70% of attendees attended free of charge and eight participants travelled from outside of Sydney. A total of 120 people attended the forum.

Annie Madden, co-founder of Harm Reduction Australia

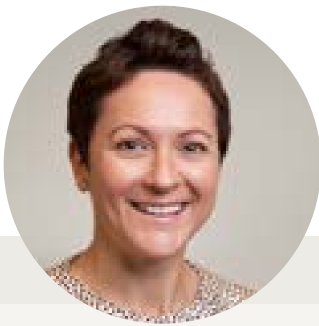
Overall, the forum was an extremely positive experience for participants with over 80% of participants rating it 'excellent' or 'very good'. Informal feedback received during the forum was positive, with the welcoming vibe particularly outstanding. The main aim of NUAA and the forum, to provide a supportive, welcoming opportunity for peers to network and have their voices heard, was achieved.

The Peers and Consumers Forum took place with the generous support of Central Eastern Sydney PHN, WentWest PHN, NADA, Sydney LHD and the NSW Ministry of Health.

Magistrates Early Referral Into Treatment (MERIT)

The MERIT program provides a referral pathway away from the criminal justice system for eligible clients. Brush up on MERIT with this online tutorial.

Learn online



NADAbase

Cassandra McNamara Program Manager—Data Systems, NADA

Reporting

The annual 2017/18 National Minimum Data Set for AODTS was submitted to AIHW on 30 November 2018 on behalf of members who are funded by the PHN/Department of Commonwealth. If you have questions please contact Suzie Hudson or Cassandra McNamara.

What's been happening?

NADA held the inaugural NADAbase Administrators Forum on 12 November. On the day we heard from Dr Michelle Cretikos, Director, Centre for Population Health, Ministry of Health on Service Information and Reporting for NSW AOD Services; Gemma Campton, The Glen, who shared insights on data informed program evaluation; and from NADA, Michelle Ridley, Clinical Consultant and Fiona Poeder, Consumer Project Coordinator, who discussed data collection from a consumer's perspective, including protecting consumer privacy and confidentiality. Thank you to our speakers and the NADAbase administrators in attendance. If would like to receive information on the day's discussions, please contact NADAbase support.

Now live

'NADAbase data snapshot for'' 2015/16 and 2016/17 providing client demographic and outcome data is now available for members to view.

What's coming up?

We are looking for volunteers to join the National Minimum Data Set AODTS pilot training being held on Monday 10 December 2019 in Sydney. If you interested in taking part in this pilot training session or would like more information, please contact Suzie Hudson.

NADA will be releasing the NADAbase data dictionary in early December. The NADAbase data dictionary provides data specifications for data elements added to NADAbase outside of the National Minimum Data Set items. This includes data specifications for items such as client outcome measures, sexuality and risk screeners. The data dictionary will be released on the NADA website and made available to all members.

NADA events

10 Dec

AODTS National Minimum Data Set Training (pilot)

Do you enter AOD treatment NMDS data? Do you find some elements confusing? How accurate is your data? Come along and learn all the ins and outs of the National Minimum Data Set for Alcohol and other Drug Treatment—it will be fun... promise!

12 Feb

Introduction to NADAbase training

Are you new to NADAbase? Or would you like a NADAbase refresh? You can gain an understanding with the online tutorial, but also through this course, an introduction to NADAbase.

Register now

Profile

NADA board member

Catherine (Cate) Hewett
CEO, Kamira

How long have you been associated with NADA?

I attended my first NADA meeting at William Booth, I think, in 1995. I was a newly graduated psychologist and passionate about my chosen AOD career path.

What does an average day look like for you?

I begin with a walk along the beach with my favourite pet Eddie, then meet my partner for coffee and watch the sun rise. Fast forward to work, taking time to touch base with staff and help with any pressing issues first, before sneaking into the residential facility. I enjoy a bit of small talk and remind the amazing women who enter the program that I am one of their biggest fans. Everything that happens beyond that is typical of a CEO—responding to requests and requirements of the outside forces necessary to ensure Kamira remains a leader in the treatment of women and their children experiencing problematic AOD use.

What experiences do you bring to the NADA board?

I bring a broad currency in the AOD sector, specific to women, combined with a wealth of historical experience. I have spent weeks immersed in women's programs internationally and shorter visits within Australia. I have presented at conferences in Australia, New Zealand, Rome and Lisbon. I have also been able to experience treatment options for Indigenous and multicultural populations.

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

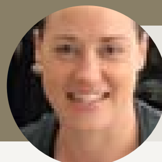
I like to ensure that the board of NADA remain the conduit between clients emerging needs, quality in treatment, the membership needs, NADA staff projects, and the direction in which this ship sails. I am an active member of the Women's Network and hope that by being on the board I can ensure that the leaders in treatment for women have a voice at all levels.

What else are you currently involved in?

I'm involved in establishing an all women's Etchel Sailing team at Gosford—let's just say we can only go up from our current ranking but we're up for it!

A day in the life of...

Sector worker profile



Clare Mayoh Case Manager
Mission Australia Kings Cross Youth Services
The Crossing

How long have you been working with your organisation?

Six years.

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

I made a career change about 10 years ago and began working in the community sector with youth. I have worked in a number of residential programs, and then moved into case management work at Mission Australia.

What does an average work day involve for you?

Because we work in an outreach capacity and with a wide range of youth, no day is the same. We provide assertive outreach in the community which may be case planning, supporting a young person to connect with services and attend appointments, providing practical assistance with living skills, helping people set up their homes, advocacy with other services and informal counselling and then catching up with admin work back in the office.

What is the best thing about your job?

Working with young people and supporting them to achieve their goals and build their confidence and independence. As we work long term with our clients, we get to build a strong working relationship during this time and see great outcomes for the young people we work with over the years.

What is one thing you would like to see different in the non government AOD sector? What needs to change to get there?

I would like to see better collaboration between the mental health sector and the AOD sector. We have so many young people we work who have co-existing mental health and AOD issues. They often face barriers to accessing appropriate services, fall between the gaps and get bounced around the system. I think we need to look at where these gaps and barriers are, and programs need to be developed and funded to better support this.

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

Great supervision, a workplace that promotes self-care and a supportive and flexible team culture is important. Leaving work on time and getting some exercise in helps too!

Keep informed with quarterly updates from the Women's AOD Services Network, the Youth AOD Services Network, the NADA Practice Leadership Group and CMHDARN.

NADA
network updates

Women's AOD Services Network

The Women's Network has had a busy year of information sharing, gathering and exchanging learnings within the network. The network continued to host meetings at network member sites, with the latest meeting held in October 2018 in Orange where they toured the Lyndon Womens Program and the programs on offer.

The meeting also enabled the network to discuss several topics, including:

- recruitment and workforce availability
- access to childcare outside of treatment
- working with Centrelink and the Job Network
- advocacy for women's services

NADA thanks the network for raising these topics and has provided some advice and support to the network where possible.

The network will continue to further advance initiatives and activities that have been in development throughout the year and looks forward to sharing these with the sector in 2019.

Youth AOD Services Network

In November 2018, the Youth AOD Services Network participated in a workshop on 'DNA-V: A new model for positive development at any age,' facilitated by Joseph Ciarrochi.

Joseph Ciarrochi is a professor at the Institute for Positive Psychology and Education at the Australian Catholic University. His research focuses on understanding and promoting flexible strength, the ability to use psychological skills in a way that promotes personal growth and builds vitality and valued action.

Feedback was positive, with respondents commending the facilitator for being informative, engaging and entertaining.

NADA network updates
continued

CMHDARN seeding grants

NADA would like to highlight some key research that has been undertaken by our members.

Drug and Alcohol Multicultural Education Centre Power of programs: Finding, adapting and implementing evidence-based CALD-client focused evaluation strategies in DAMEC's brief therapeutic and community development programs.

Family Drug Support Problematic drug use and family coping: Designing a qualitative study to explore long term coping in family members adversely affected by another's drug use.

Kathleen York House A review of evidence to inform substance use disorders treatment services for pregnant women.

Lyndon Community Barriers and enablers of ATSI cultural inclusion in a rural mainstream AOD service.

Positive Life NSW Post incarceration health needs of the gay, lesbian and trans community in Sydney—a pilot study.

NADA Practice Leadership Group

The NADA Practice Leadership Group (NPLG) met for their quarterly meeting in September 2018 where new members of the NPLG met and quickly dove into it. Work is being done around progressing the recommendations from the withdrawal management paper, salary benchmarking for common positions within the AOD sector, and the NPLG is at the early stages of planning for an access and equity forum.

The following messages arose from the meeting:

- NPLG advocates for streamlining and standardising forms for easier access and greater equity for clients.
- NPLG places importance on investing more in the sector and for consideration around the need for a focus on workforce development and increasing workforce.
- NPLG finds it vitally important that the sector think about a staff exchange and how that would work to provide an immersion experience for staff to understand the different treatment types within the AOD sector.

CMHDARN

CMHDARN recently accepted expressions of interest for a second round of Seeding Grants for 2018/19. A panel will review these expressions of interest and applicants will be notified shortly.

Apply now for a research mentor. The CMHDARN community research mentoring program aims to increase mentee confidence, knowledge and skills in the areas of research, and further develop a research culture within community managed organisations. Applications close 11 December 2018.

Email the research network coordinator to sign up to the CMHDARN mailing list. The 'Research ethics consultation committee' are happy to assist in reviewing human research enquiries within the mental health and AOD communities. If you're an aspiring researcher and want some support in this context, contact us now.

Member profile

Family Drug Support

Over the past 21 years, Family Drug Support (FDS) has built and developed a model for supporting families impacted by a family member's AOD issues by listening and talking to thousands of families and undertaking focus testing.

We started by establishing open support groups, then telephone support followed by our interactive experiential programs, Stepping Stones and Stepping Forward.

It is our experience that whatever the drug—families often do not reach out for help until the impact has escalated to a problematic extent. At this point in time families feel helpless, isolated and are struggling with how to manage. The stigma associated with drug use impacts not only on the person who uses drugs but also the family. Unhelpful labels and concepts such as 'junkie', 'addict', 'clean', 'rock bottom' and 'enabling' add to their confusion and dilemma on how to deal with the problem.

FDS trains its workers to engage with family members in a calm and supportive manner which often allows for a de-escalation of panic and reactivity. Our workers are also trained to be fully familiar with stages of change model for the person who uses drugs, developed by Prochaska and Di Clemente in the 1980s.

We also train our workers in the families stages of change model which Tony Trimingham developed in 2000 with two colleagues from Western Australia. The stages for families include denial, emotion, masculine and or feminine control, chaos and coping.

Our model emphasises the normality of what they are experiencing, provides tips on strategies for coping and allows them to make their own decisions on how to proceed or deal with dilemmas.

FDS also educates families with the concept of harm reduction with the aim of keeping their family member alive and safe through harm reduction strategies, encouraging people to develop coping skills.

The 24/7 Support Line continues to be a core activity of FDS, with numbers growing from around 5,800 in 1998-99 to over 40,000 in 2016–17. Other FDS service include open support groups in 38 locations around Australia, bereavement support, the Stepping Stones experiential course and Stepping Forward education and interactive sessions for families, friends and workers. Our Bridging the Divide project works collaboratively with treatment services to upskill workers in family support needs and provide pathways to support family members of people in treatment. FDS has a number of publications including our *Guide to coping*, *FDS Insight* newsletter, information brochures and Tony Trimingham's book *Not my family never my child*.

To learn more about Family Drug Support, phone (02) 4782 9222, visit www.fds.org.au or email admin@fds.ngo.org.au.

NADA Practice Leadership Group

Meet a member

Jessica Burgess Psychologist, Mission Australia Junaa Buwa! and 360 Outreach

How long have you been working with your organisation? How long have you been a part of the NPLG?
I am employed as a psychologist with the Junaa Buwa! youth resi-rehab with Mission Australia and the early intervention, 360 Outreach program. I joined the NPLG this year and am excited to be a part of it.

What has the NPLG been working on lately?
The NPLG is providing workshops to better services i.e., open dialogue trainings, focusing on developing access and equity amongst services, improving client feedback and outcomes, and improving the overall wellbeing of the workforce.

What are your areas of interest/experience—in terms of practice, clinical approaches and research?
I am a registered psychologist and have been working in the AOD sector for three years. I provide individual and group counselling/therapy to 13 to 18 year olds whose substance use is contributing to their offending behaviour. Through 360 Outreach, I also provide support, guidance to a team of youth workers and case managers, and counselling to vulnerable young people to assist with managing comorbid mental health and substance use.

What do you find works for you in terms of self-care?
I value variety, therefore during each week I prioritise exercise through Crossfit and Latin dancing, connecting with friends and family, meditating, church, and connecting with nature.

What support can you offer to NADA members in terms of advice?
I can provide support and suggestions about how to work with at risk young people, and how to use interventions such mindfulness/ACT, CBT and DBT. I can also advise around harm reduction, non-clinical withdrawal support, and behavioural challenges.

Celebrating 40 years

On Monday 19 November 2018, NADA celebrated its 40th anniversary at the annual general meeting. A presentation to acknowledge our 40 years as a network was attended by members as well as stakeholders from the Australian and NSW Government health department, PHNs and LHDs. A panel reflected on the past, whilst current members and a consumer representative talked about some of the key issues and areas to develop in the future.

We thank our panellists:

- Peter Connie, former NADA Executive Officer
- James Pitts, former NADA board member and former CEO of Odyssey House
- Larry Pierce, the current NADA CEO
- Belinda Volkov, Sydney Drug Education and Counselling Centre, and member of the NADA Practice Leadership Group
- Grace Ivy Rullis, Haymarket Foundation and member of the NADA Practice Leadership Group
- Benjamin Steele, Consumer representative.

View the member video shown on the day.

What we're working on

Program update

Worker wellbeing

NADA has a long history of supporting its members through workforce development. This has taken various forms throughout the years, from the provision of small training grants to the development of specific resources, and research work with our membership. A new key area of work for NADA aims to support worker wellbeing.

Here's what's been happening:

- We undertook a survey in partnership with NCETA and Matua Raki to examine the health and wellbeing of the AOD/addictions workforce in NSW and New Zealand. While most workers appeared to be faring well, issues around job security and other work related aspects were apparent. To learn more, visit our worker wellbeing page.
- We launched our new workplace wellbeing for managers workshop at our conference. We hope to run this training again in early 2019. Keep an eye out for details on our events page.
- We published a special 'Worker wellbeing' edition of the Advocate. The issue looks at the art and science of wellbeing, the ethics of self care and the wellbeing of AOD workers in NSW, and more. Read the issue [PDF].

Contact sianne@nada.org.au to learn more.

Family and significant other inclusive practice workshops

NADA will deliver another two workshops during December in Coffs Harbour and Port Macquarie—we hope to see you there! We have been traveling around NSW and have delivered seven workshops to date with overwhelmingly positive feedback. The beauty of these workshops has been our collaborative approach with partners Family Drug Support and the Local Health District staff from each region. In addition each workshop has had excellent input from NADA members and staff from Aboriginal Community Controlled service providers which has enhanced the quality of the information being provided and helped tailor the workshops to local needs. We will soon take the content delivered in these workshops and develop a facilitator guide so you can run one in your service, or engage with the eLearning modules which will be available in June 2019.

Contact rubi@nada.org.au or suzie@nada.org.au.

Consumer engagement project

NADA's project to increase service and clients' capacity for consumer engagement began with the selection of pilot sites comprising four residential services and one withdrawal unit. Four consumers, previously trained through NUAA's Consumer Academy have been supported to become workshop co-facilitators. They delivered training to the sites' staff and service participants. Evaluation assessments are in train. Activity plans are being implemented for each site, with most including the establishment of consumer advisory groups to lead the execution of the plan.

NADA is practicing what we preach through the Consumer Engagement Project. We have:

- engaged a consumer to become a member of the NADA Board of Directors
- consulted with consumers to provide input to inform NADA's 2019-2022 Strategic Plan
- developed a consumer participation audit tool for NADA members
- reviewed and updated our Consumer Participation Policy.

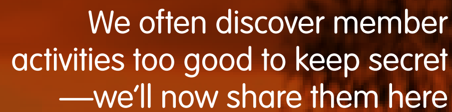
Contact fiona@nada.org.au to learn more.

Continuing coordinated care

The Continuing Coordinated Care (CCC) program improves sustainable continuing care pathways and wrap around services for people experiencing AOD issues and complex needs. This program provides longer term, holistic support to assist client's access and remain connected to services and other networks, to help improve their overall health and wellbeing.

To date:

- The CCC program providers have recruited their staff.
- The CCC clinical consultant, employed by NADA, is supporting the providers to navigate the service system through systemic advocacy, liaison, training and advice.
- The CCC clinical consultant organised a two-day forum so the CCC workers could meet, network and engage in professional development. Topics included motivational interviewing, stigma and discrimination, consumer involvement, family inclusive practice, working with people involved with the criminal justice system and worker wellbeing.



Clever ideas unearthed

Some services seek to engage the families of clients through informal gatherings, and Canberra Recovery Services is one such example. At this service families are invited to weekly roast meals, weekend activities and picturesque walks. Staff members also invite their families to join in.

What's so clever about that?
The service sets the tone with community shared meals. Allowing the families use of the abundant space—a courtyard, basketball court and garden—means they spend quality time together. Staff work hard to create a safe environment which they believe is worth the effort. Family members agree—they enjoy the atmosphere, privacy and trust—and return often.

Contact Canberra Recovery Services.

Photo cc by nc 2.0 Stuart Seeger

What we're working on

continued

To learn more about the CCC program in your area, refer to the organisations below who are delivering the program across NSW:
The Buttery—AOD CCC Program
Mission Australia North Sydney CCC Program
Mission Australia Western and Far West CCC Program
St Vincent de Paul's CCC Program

Or contact the CCC clinical consultant, michelle@nada.org.au.

Training grants

Supported by the NSW Ministry of Health, the training grants program has been an integral part of NADA's activities for several years. Two training grant rounds are held each financial year.

The current round, which supports funding for training in the July—December 2018 period, was very popular. While we were unable to support all applications for funding, we were pleased to be able to approve 24 grant applications either in whole or in part.

Training programs that are proving popular with our members include those around trauma informed care and practice, acceptance and commitment therapy and dialectical behaviour therapy.

The next training grant round opens for applications in December 2018 (for training which will occur between January and June 2019). Visit the grants and subsidies page on the NADA website to view the program guidelines and find out how to apply.

Contact victoria@nada.org.au for more information.

NADA highlights

Photo by Kris Ashpole

Policy and submissions

- NADA provided a brief to the NSW Shadow Health Minister, Hon. Walt Secord in support of a NSW drug summit and enhancing the capacity and sustainability of the NSW AOD workforce
- NADA endorsed a media release from Just Reinvest NSW calling on the Federal Government to provide a formal response to the recommendations contained in the Australian Law Reform Commission's Pathways to Justice report
- AOD Peaks Network provided Shadow Health Minister, Hon. Catherine King MP, with a list of national priority areas

Advocacy and representation

- NADA held a joint forum with the NSW Ministry of Health, with residential rehabilitation providers to consult on pathways to treatment, standardised KPIs, and a consultation on a review of the Drug & Alcohol Treatment Guidelines for Residential Settings. A communique has been provided back to sector on the outcomes
- NADA and AOD Peaks Network met with the Department of Health, the Department of Social Services, the Department of Prime Minister and Cabinet regarding a range of issues on behalf of the sector. A Sector Watch Update was provided on the outcomes
- NADA asked a question on responding to unmet treatment need at The Great Debate on Health in NSW held by the PHAA
- Ministerial meetings: NSW Minister for Health, Hon Brad Hazzard MP, and NSW Shadow Health Minister, Hon Walt Secord MLC
- NADA is participating in the Ministerial Advisory Group (MAG) on Vulnerable Children, Young People and Families that involves meeting monthly with the Hon. Pru Goward MP to discuss ways to improve whole of life outcomes for children and young people
- NADA participated in workshops for Their Futures Matter (TFM) Access System Redesign, which is a key initiative for TFM and the NSW Government to develop evidence based, multi-agency system that enables vulnerable children, young people and families to access suitable supports and services in a timely manner
- NADA attended the National Treatment Framework consultation
- NADA attended the AODTS NMDS working group and provided an update on data collection in the NGO specialist AOD treatment sector

Sector development

- NADA held workshops on family inclusive practice, hepatitis C, Aboriginal cultural awareness and practice methods to engage clients using feedback informed treatment by Scott D. Miller PhD
- NADA held a Continuing Coordinated Care (CCC) forum so CCC workers could network and engage in professional development

Contact NADA

Phone 02 9698 8669
Post PO Box 1266
Potts Point
NSW 1335

Larry Pierce
Chief Executive Officer
(02) 8113 1311

Robert Stirling
Deputy Chief Executive Officer
(02) 8113 1320

Suzie Hudson
Clinical Director
(02) 8113 1309

Michelle Ridley
Clinical Consultant
(02) 8113 1306

Sianne Hodge
Program Manager
(02) 8113 1317

Cassandra McNamara
Program Manager—Data Systems
(02) 8113 1319

Rubi Montecinos
Program Manager
(02) 8113 1312

Fiona Poeder
Consumer Project Coordinator
(02) 8113 1324

Victoria Lopis
Project Officer
(02) 8113 1308

Ana Katerina de Jesus
Project Officer
(02) 8113 1308

Sharon Lee
Communications Officer
(02) 8113 1315

Maricar Navarro
Office Coordinator
(02) 8113 1305

Feedback **Training grants**