Advocate

The eMagazine of the Network of Alcohol and other Drugs Agencies Issue 4: December 2019

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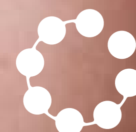
Emotions

• Yerin • La Trobe University
• Triple Care Farm • The Recovery Point



NADA
network of alcohol and other drugs agencies

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CEO report

Larry Pierce — NADA

This edition of the Advocate explores the theme *emotions*, a topic that is central to the AOD field; I would like to consider this topic at the broader social and policy level.

I am pleased to note that in a recent series published in *The Lancet*, researchers from the National Drug and Alcohol Research Centre (NDARC) urge policymakers (read: our politicians) to dump morally charged punitive measures from our current policy approach and instead, turn to the evidence to reduce drug related harm. Most pointedly I note the editors, Dr Pam Das and Dr Richard Horton in an accompanying comment piece, wrote, 'Policies that might improve the lives of people with health problems relating to drug use are not seen as substantial vote winners.'

I wonder about this statement in the context of the Australian Government's recent proposal to drug test welfare recipients. The Prime Minister has declared that the ordinary Australian do not want to see their taxes used for welfare payments made to 'people who are using it on drugs'. This casts the trial as a moral and social imperative. And so too, our Premier's negative response to the calls to provide pill testing at music festivals and related drug law reforms to lessen the negative impact these laws have on people who use drugs.

Based on the evidence, the policy approach of 'get tough on drugs' and punish people who use them does not seem to be working to reduce harms, and may in fact be increasing them.

The point that the NDARC above mentioned article made is that the political approach to drugs and drug policy that rely on moral and social prejudices is failing to help with the development of sound evidence based drug policy and program development.

So, what underpins the government's response to drug policy, if it is not the evidence? News media plays a crucial role in shaping policy decisions. They influence the type of public debate that occurs: they control what is said, by whom and the optimum solutions. Not only that, but the negative and fearsome framing of AOD issues by sections of the media and popular culture inform the community's beliefs. Media's representations strongly influence attitudes and opinions, because many in the community are quite unfamiliar with illicit drugs.

And so, government leaders tend to respond with negativity to evidence based drug policy and approaches.

News media plays a crucial role in shaping policy decisions. They influence the type of public debate that occurs: they control what is said, by whom and the optimum solutions.

I say it is time to stop reacting emotionally to drug use issues. It is time to recognise the human rights of people who use drugs and offer them the same support and protection through evidence based solutions and interventions we offer to anyone, and all.

One way to reduce fear and blame is to improve knowledge and attitudes about illicit drugs and the people who use them, and knowledge and understanding about substance use and recovery. Researchers, again, are leading—see the online resources described in the 'research into practice' article.

I know from member feedback that you too, would like to address stigma and discrimination. Let's discuss what we can do together, as a sector—come along to the NADA Conference 2020 in June.

NADA Conference 2020

Enhancing connections

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Join us at NADA Conference 2020: Enhancing connections

This conference will attract delegates from across NSW, the broader Australian AOD treatment sector and other health and human services. Showcasing interventions designed to improve outcomes for clients, this event will inform with new ideas, engage with the evidence base and provide networking opportunities.

Early bird registrations open 1 February 2020.

NADA Conference 2020

Enhancing connections

4-5 June 2020 | Sydney

#NADA2020

Abstracts are now open

NADA invites abstract submissions for oral papers, workshops, panel presentations and poster presentations for the **NADA Conference 2020: Enhancing connections**.

This is an opportunity for you to showcase your innovative practice and research addressing the diverse needs of people accessing AOD services. We encourage workers and services across all sectors to submit an abstract as the focus of this conference is building connections and collaborations. Interactive sessions are encouraged to maximise opportunities for conference participants to exchange practice and experience.

- Abstracts are welcome from all sectors across Australia and internationally.
- Abstracts must be submitted by **Monday 9 March** at 5pm AEDT (Australian Eastern Daylight Time). No extensions to the deadline will be granted.
- All enquiries should be sent to conference@nada.org.au.

See format and submission guidelines

Announcing keynote speakers

Karen Urbanoski holds the Tier 2 Canada Research Chair in Substance Use, Addictions and Health Services Research. Her keynote will discuss ways services can enhance access to AOD treatment among the population in need.

Daryl Chow is a psychologist, trainer and author of *The First Kiss: Undoing the intake model and igniting first sessions psychotherapy*. His keynote will explore ways to enhance engagement with clients and improve outcomes.

Paul Barry is a respected journalist, presenting ABC TV's Media Watch, Australia's leading forum for media analysis. Paul's keynote will explore AOD, stigma and the media and he will facilitate a panel discussion about this important topic and ways to work with the media.

Dr Stephen Bright is senior lecturer of addiction at Edith Cowan University. His interests include drug policy, psychedelics, and AOD in the media. Stephen will be part of the panel on AOD and the media and he will also present on psychedelics and treatment.

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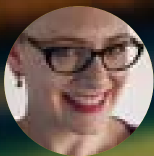
More to come. Keep up-to-date at
www.nadaconference.org.au

Attachment theory



By Resli Büchel NADA

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The first 1000 days

There is mounting evidence that the first 1000 days of life have a profound impact on an individual's biological, neurological and psychological development—more so than any other stage of life. Starting at conception, up to the age of three, an infant is constantly interacting with their environment, taking cues from their parent's physical and mental state to guide how they respond to the world around them.[1]

While this powerful process is vital for each of us to learn and grow into functional and integrated adults, it can be a double-edged sword.[1] In the short-term, being able to adapt to difficult circumstances may be helpful for children who are exposed to adverse environments, such as abuse and neglect. However, these 'adaptations' frequently lead to problems in the long-term.[1,2] This can include physical illness (e.g. heart disease and diabetes), mental health issues (e.g. depression, schizophrenia), and lifestyle challenges, such as poverty, obesity and difficulty forming relationships or healthy 'attachments'.[1,2]

Attachment theory

First described by British psychologist, John Bowlby, during the 1950s, attachment theory focuses on the nature of the parent-child relationship, how well they bond, and how this influences the child's development. Bowlby saw the importance of an infant having a consistent and caring connection with a parent during the early years of life and observed the problems in relationships experienced by adults who did not have this kind of connection as children.[3]

For example, a child who is encouraged to seek closeness and comfort from their parent when they feel upset or threatened, and who feels safe to do this, will establish healthy 'secure' attachment-style and carry this into their adult relationships. However, a child who is unable to be comforted in this way—because their parent is physically or emotionally absent—or who feels unsafe with their abusive or neglectful parent, is likely to develop a 'disordered' or maladapted attachment style, leading to difficulty forming healthy relationships as an adult.[2,3]

Attachment and AOD

As anyone working within the AOD sector will attest, growing up in a dysfunctional caregiving environment can have significant negative effects on a child's emotional and relational development and is a key factor in the 'transgenerational transmission of risk factors'.[2] In other words, growing up in a household affected by parental substance use will often lead to substance use as an adult and underlying 'attachment' (or relationship) problems.

Attachment theory

continued

Further to this, some experts consider AOD dependence to be an attachment disorder in and of itself, whereby 'drugs are used to compensate an alienated sense of self, to manage fearful and anxious mental states about self and others, to regulate emotions and restore comfort, and to find an alternative to attachment functions usually realized through relationships, as a result of attachment disruptions in infancy'.[3]

However, it should be acknowledged that several studies show a lack of clear association between substance use and poor parent–child attachment, demonstrating that substance use alone does not always compromise parenting, and that it is possible for a healthy relationship to be maintained between a child and a parent who uses substances.[3]

Whether or not you ascribe value to attachment theory or to the disease model of addiction, it can't be denied that treatment models based on the disruption of attachment have been used successfully in the clinical context over the past few decades, and that attachment theory represents a useful framework for working with adults and children within AOD services.[3]

There is a growing body of evidence showing the effectiveness of interventions based on attachment principles for mothers and children in AOD treatment settings, both as outpatients and within residential services. It also appears that, parents who are exposed to attachment based interventions (such as Theraplay) can successfully apply their newly acquired parenting knowledge and skills to children who are not present in residential treatment or who are in out-of-home care.[3]

Theraplay

Theraplay is a child and family therapy focused on building and enhancing attachment between a parent and child. Trained Theraplay practitioners use natural patterns of play and parent-child interactions to build self-esteem, trust and secure attachment. Unlike many contemporary paediatric therapy models, the use of touch is integral to Theraplay.[5]

'Touch is a normal, healthy part of all parent-child interaction. Physical touch can relieve stress, decrease anxiety and depression and increase comfort. Loving touch [produces] oxytocin and releases endogenous opioids, which are known to solidify infant-mother bonds.'[5]

Various kinds of touch (e.g. structuring, engaging, nurturing, calming) are used as part of Theraplay treatment, with the goal being to touch carefully and respectfully, and only to meet the needs and safety of the child, with a full recognition of the effect that touch has on the child.[5]

Research shows that Theraplay is effective for working with children with developmental disability and autism spectrum disorder, as well as for children who have experienced trauma and/or are at risk of abuse or neglect. It is recognised as an evidence based treatment modality by the U.S. Substance Abuse and Mental Health Services Administration and is currently used by NADA member Phoebe House, as part of their inpatient program for mothers and children.

More information about Theraplay methods, services and training dates is available at theraplay.org.

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.

Theraplay at Phoebe House

How does Theraplay fit in with your overall program at Phoebe House?
Theraplay and family therapy concepts are implemented throughout our program, especially in our Children's Centre. Our activities are based on natural patterns of playful healthy parent-child interaction and are personal, physical and fun. We also use Theraplay assessment tools (e.g. MIM assessment*) to develop plans for mothers and their children in four key areas: structure, engagement, challenge and nurture. These essential qualities are reflected throughout our program.

What are you seeing as the key benefits for children and their mothers engaged in Theraplay?
Theraplay is a non-threatening, safe and nurturing way to restore and enhance parent-child relationships. By playing, nurturing and attuning in Theraplay, new positive moments occur between parent and child that help them learn to experience the joy of shared companionship. We capture these moments on video and in photographs and they are used to further build the relationship between mother and child.

We find Theraplay particularly useful for parents who struggle to regulate their emotions and who lack confidence in parenting. The activities help mothers identify their individual strengths and weaknesses. This is especially important when trauma, abuse and separation have been a part of their journey which, unfortunately, is common among our residents and their children.

How do you find the focus on 'touch'?
The Theraplay framework acknowledges that 'physical touch can relieve stress, decrease anxiety and depression and increase comfort'.[6,7] This also informs our practice at Phoebe House and we find that families who experience trauma often lose the capacity to play or feel that play is not appropriate in their situation. We act to reframe this thought and encourage touch and play between mother and child.

Play can serve as a less intense form of affection for a child who fends off adult caregiving following trauma. However, we are extremely cautious with children who have experienced inappropriate touch and we approach them with great respect. It is essential that these children, especially, learn to have good touch experiences as part of the healing process.

Do the skills learned through Theraplay during the residential program have an effect on parent-child relationships outside of Phoebe House?
Theraplay is early in its conception at Phoebe House and while we've seen positive results from the mothers who are engaging in activities in-house, we are yet to see the effects of Theraplay on these relationships outside the program. Nevertheless, we are presently engaged with numerous residents in assisting them to implement specific play activities with their children who are not residing at Phoebe House. This has seen some good results thus far and it is hoped our residents continue this in their future lives with their children.

*Further information on the MIM (Marschak Interaction Method) assessment is available at www.theraplay.org/the-mim-assessment

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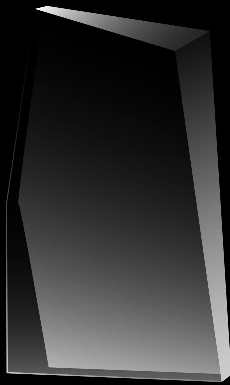

AOD AWARDS
for the
NSW NON GOVERNMENT SECTOR

'Coral Hennessy winning the NADA 2018 First Nations Award has opened many doors for our organisation. Being recognised as a leader in the field has provided us with opportunities to meet with more high profile supporters, philanthropic trusts and funders.'
Alex Lee
Deputy CEO, The Glen Centre

Showcase your service.
Recognise staff's work.

Time to start thinking about your application
The awards acknowledge the significant contribution of the sector in reducing AOD related harms to NSW communities through leadership, program design and delivery, and a dedicated workforce.

Applications open 30 January 2020.

Award categories

Excellence in treatment
This award recognises excellence and/or innovation in treatment to prevent and/or reduce alcohol and other drug related harms. This includes the delivery of services, quality and safety, programs and initiatives for individuals or specific populations.

Excellence in health promotion and/or harm reduction
This award recognises excellence and/or innovation to prevent and/or reduce alcohol and other drug related harms. This includes health promotion, harm reduction, community development, prevention and consumer engagement or peer worker activities.

Excellence in research and evaluation
This award recognises individuals or organisations that contributed to building the evidence base for practices to prevent and/or reduce alcohol and other drug related harms.

Outstanding contribution award (Individual applicants only)
This award recognises the significant contribution of an individual working in the non government alcohol and other drugs sector.

First Nations Award—Improving AOD outcomes for Aboriginal peoples
This award recognises the significant contribution of an Aboriginal and/or Torres Strait Islander individual, organisation or program that has made a significant and/or meaningful commitment and contribution to preventing and/or minimising alcohol and other drug related harms in Aboriginal and Torres Strait Islander communities.

Emotion regulation

By Suzie Hudson NADA

Our emotions can sometimes overwhelm us, but those who have experienced significant trauma have often had limited help to develop emotion regulation. Therefore, it is important for all of us to recognise that emotions are a part of life, and when our clients are presenting with strong emotions, to respond with empathy and care.

A couple of concepts that are useful in understanding how people develop effective emotion regulation include attachment and the fight, flight or freeze response.

What is attachment?

Attachment theory describes the significance of relationships and emotional bonds. It suggests that the earliest attachments experienced as part of early childhood can lay the foundations for future experiences.[1,2] When a parent is emotionally available and attached to their child, they help provide elements of emotion regulation. An example of this is soothing—one of the key strategies for emotion regulation. A child is distressed, and their parent soothes them via touch, voice and attention, and the outcome is that the child feels calmer and is learns the things that work to respond to distress.

It is not uncommon for people who reach out for AOD treatment have had caregivers that were emotionally unavailable to provide soothing responses. The outcome from this, can be that they did not have the opportunity to receive soothing and/or to develop this emotion regulation skill. An absence of early attachment can make it more challenging for a person to reach other developmental milestones, and any kind of learning can be almost impossible if a person is in distress, or unable to regulate their emotions.

Watch this video

Fight, flight or freeze

Fight, flight or freeze describes the specific situations in which emotion regulation is not enacted and higher cognitive functioning such as reasoning, problems solving, or reflective thinking cannot be applied, and effectively a person is in 'survival mode'.

Another way to understand fight, flight or freeze is 'the window of tolerance'. When you are in your window of tolerance, you feel like you can deal with whatever is happening in your life.[3] The things that impact this window of tolerance is either hyperarousal (being overwhelmed by your emotions in survival mode—fight or flight) or hypo arousal (numbed or paralysed by the situation and emotions—freeze).

Practice tip

A useful metaphor to explain what is happening in fight, flight or freeze

Picture a set of scales. On one side of the scales is the fight, flight or freeze responses, the survival state of the body, and on the other side of the scales, are the higher thinking and reasoning sides of the body. When under threat all people will dive into the fight, flight or freeze mode making the reasoning side of the scales out of reach. If a person has no emotional regulation skills they can access, they may stay in that state for a prolonged period, which means all those reasoning skills are also out of reach.

Watch this video

Substance use

Substance use can affect our physical and emotional state and many substances are effective pain relievers. It makes sense then, that for many people substance use can be one of the strategies that they employ to regulate their emotions—even if it is not always effective in the long term.

Practice tip

A practice tip when working alongside people is to acknowledge all the strategies they have used in the past to help regulate their emotions and then work to add to their 'menu of strategies'. This validates a person's efforts to do the best they can with what they have available.

Dialectical behavioural therapy

The act of emotion regulation is one of the four key focuses of dialectical behavioural therapy (DBT), a process of understanding that painful or distressing feelings/emotions are a normal part of life and are not inherently harmful. As with other therapeutic approaches, the focus is moving towards an acceptance of painful emotions and applying skills that can reduce the distress in order for a person to have improved quality of life. There are a number of resources that focus specifically on emotion regulation—all based on common target areas:

Common target areas	Examples
Physical environments	Safe and welcoming environments help with emotion regulation
Emotional literacy	How to identify and describe different emotions, linking them with the physical expression: emotion charts (The Centre for Youth AOD Practice Development)
Self-soothing	Comforting and being kind to yourself: self-soothing strategies (Blue Knot)
Mindfulness	Breathing techniques, meditation, visualisations: mindfulness techniques (Smiling Mind)
Distress tolerance or acceptance	Learning to accept distress: distress tolerance scale (Simons and Gaher, 2005)
Taking care of physical needs	Yoga, exercise, walking, physical health needs (Comorbidity guidelines)
Responding to negative self-talk or negative thinking	Hear the judgements about the emotions and respond to them, challenge them, explore them: addressing negative self-talk (Reachout.com.au)
Engaging in activities that build a sense of achievement or positive experience	Connecting with others, consumer participation

Resources

- **Emotion Regulation and Impulse Control** (ERIC) is a psychological skills based program designed to promote healthy social and emotional development for all young people by cultivating helpful emotion regulation and impulse control skills. Read more about ERIC in this Advocate article [PDF].
- **DBT regulator** helps people with their substance use by building on their ability to identify and manage their emotions, communicate effectively with others, and to get through tough times without making them worse. The skills presented here are modified from DBT and can also help people with other aspects of their lives; not just substance use. Download the workbook [PDF].
- **How experiences of trauma impacts the window of tolerance** The National Institute for the Clinical Application for Behavioural Medicine developed a chart for displaying how clients are best able to cope with stressors and triggers when they're operating within their window of tolerance—and the impact of traumatic experience that can narrow this window, leading to states of either hyper- or hypo-arousal. See the window of tolerance graphic.

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Will you stand by me?

Triple Care Farm's senior psychologist, Lauren Mullaney shares her thoughts on loneliness and connection, and what this means for people who work in the AOD sector.

My starting point for this article was on the concept of loneliness, and what this may mean to us as AOD treatment providers, working with people who may be experiencing this. However, quite fittingly, as I sat down to write this article, the song *Stand by me* came onto my playlist and it got me thinking on a slightly different track. You know the one by Ben E. King? *If the sky we look upon should tumble and fall, or the mountains should crumble to the sea... I won't cry... no I won't shed a tear... just as long, as you stand, stand by me.* As songs go, I think it still holds up; but alas! We definitely aren't here to talk about my music choices.

If I can use the analogy, I think it speaks to a wider theme. That is, even in the darkest of moments, when the skies are tumbling and the mountains are crumbling, if we perceive someone to be in our corner we might feel able to face what it is that we need to face. Whether that be our own emotions, thoughts or behaviours. Interestingly though, it really doesn't matter how many people are actually in our corner, but rather how many we think are in our corner.

If we go back to basics, the feelings of belonging rank pretty high with us as humans. If we revisit Maslow's Hierarchy of Needs[1] we can see that Maslow postulates that the need for love and belonging come directly after our basic physiological and security needs. Now I can't speak for others, but anecdotally I hear from the people entering our service that they are often faced with a loss of self and feelings of isolation/disconnection when seeking treatment for substance misuse. Completing treatment and making some change can further contribute to feelings of seclusion and feelings of isolation from whom, and what is known.

As treatment providers, sometimes there may be expectations that are given to the people entering our services that unknowingly further increase the feeling of disconnection. Sometimes we may ask that people change their connections to the people or the community that they come from in order to remain 'drug free'. We may also have power imbalances[2] that play out that promote a sense of disconnection (i.e. staff aren't really here for me, but rather because it's their job, they get paid to care, etc.) Hopefully, this isn't the sentiment that underpins our work, but again, if the perception is there that it is; we have to work extra hard to navigate this! So, my question... when the land is dark and the moon is the only light we see, do we as services unwittingly contribute to feelings of isolation and disconnection? For instance:

- Do we have policies and procedures (or practice) that limit staff's ability to build rapport and connect with the people in our services? Or, do we have a feedback informed culture that allows people to give us feedback if we aren't getting it right?
- Are there policies and procedures that limit people's abilities to access and speak to their loved ones/ community when they are accessing treatment?
- Are we including communities and their loves ones in treatment provision and planning where possible/ appropriate (once consent has been obtained)? Or, do we ask people to cut ties with what and who they know, and is this realistic and sustainable for them long term?
- If using substances has provided a connection for a person, what happens when it stops? Are we able to support people to navigate this and build alternate strategies?
- For people that are isolated in their communities and don't identify with any protective factors, are we able to support them to link in with others?
- Do we make assumptions about people's level of support, or do we know how the person perceives these connections instead?

I am probably not telling you anything you don't already know... but sometimes, it is useful to remind ourselves and revisit our practices and check in around what we do. We want to be extra clear in not just our thoughts and words, but in our actions and in what we implicitly imply. For it is our actions that say *whenever you are in trouble, won't you stand by me, no please don't be afraid.*

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Shame

Addressing shame to increase access to treatment

Fabian, Consumer Advocate and **Resli Büchel,** NADA

We have all experienced it. That moment when you freeze, hang your head and avert your eyes. Your heart starts racing and you may even break into a sweat. You believe that you have done something foolish or wrong, that you have failed in some way, or even that you are a bad person. You want to withdraw, hide or disappear. You are feeling shame.

Different to guilt, which is a right or wrong judgement about your behaviour, shame is a more expansive negative feeling about yourself. Shame has been described as a 'failure of being', 'global self-condemnation',[1] and most people will do anything to avoid feeling it.

While shame is an appropriate and functional emotion for all individuals to feel at certain times, some people may develop a deep and ongoing sense of shame, seeing themselves as unworthy or inferior. Sometimes referred to as 'toxic shame',[2] this kind of deep self-loathing is often related to abuse or neglect during early childhood, and is strongly associated with depression and substance use issues.

For some people, the combination of shame and substance use can ultimately lead to a risky cycle—while their drug use and related behaviours cause feelings of shame to intensify, their need to use substances increases in an attempt to conceal their drug use and reality from themselves and others.[3] This cycle of shame can cause individuals to feel isolated and be a barrier to accessing AOD treatment and other forms of support.

Shame can keep a person quiet, hiding the truth about their circumstances and struggles. It can also reinforce a sense of powerlessness and hopelessness, making dreams of change and recovery feel impossible.[3] Feelings of shame can come from the stigma associated with drug use issues and AOD treatment. Stigma can be described as being shamed or marked because of unwanted differences, and can be a barrier to a wide range of opportunities, including access to health care such as drug treatment. In very real terms, shame acts as an obstacle to an individual seeking help.

To understand more about shame and stigma, we talked to Fabian, a consumer of drug treatment.

Did feelings of shame and stigma effect you from accessing alcohol and other drug services or other support? I was initially reluctant to seek out treatment for my drug and alcohol use. I would hear stories about other people that have tried to seek out treatment and were either judged or made to feel inferior. Because of this I didn't seek treatment until I was at rock bottom in my life. I had been self-medicating for depression and anxiety and was scared that I would not be treated fairly. It wasn't until I started talking to a psychologist about my mental illness that I was able to talk about my drug and alcohol use more freely and therefore seek out treatment.

How can AOD workers and services reduce barriers for people to access treatment because of feelings of shame and stigma? Employ more people that have lived experience. This will help the services hear stories about what people have gone through and what they have done to overcome the barriers.

Health literacy is something that is being talked about more and it is important to consider so that AOD workers and services can educate people more about their health and drug use. Thinking about health literacy and what language to use when trying to educate people about their health is vital for supporting change.

More choice about treatment. Choice is lacking in the sector. It would be great if workers recognise that by giving the client more choice about what treatment will work for them, they will feel more control of their own journey.

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How can we reduce fear of services

Fear is the worry, panic or dread that we feel when we sense danger. Some of us fear flying, public speaking or spiders. People can also fear treatment or health services and the interventions they provide, as a result of previous negative experiences, such as being stigmatised and/or discriminated against. A lack of information can also cause people to be fearful and anxious.

As service providers, it is important we recognise when a consumer may be fearful about working with us or another agency. We need to consider why they may be worried and talk to them about this, so we can work to support them appropriately. To find out more about how to best do this, I spoke to a range of consumers and AOD workers.

Consumer feedback

Have you ever been worried or fearful about working with services including AOD programs? Did this effect the way you worked with the services? And what suggestions can you give workers to help people who are feeling this?

Dan (38 years) has an extensive history of incarceration for drug related offences. Dan stated that people assumed he knew where to get help for his drug use. He said, 'I wanted help, but I was fearful about asking for it.... I didn't know if it even existed'.

Dan said, 'It made me feel hopeless and disempowered, and led to me feeling more depressed and using more drugs'.

Dan suggested, 'even if someone is older or has been in prison, or whatever, don't assume they know what drug treatment is or what services are out there... people need information'.

Sally (40 years) said her biggest fear was 'of authority like the police, FACS, the law'. She stated that she worried about working with AOD services because of 'family issues, her kids being removed and being a failure' [if she couldn't finish treatment].

Sally said because of these fears, 'I just stopped working with them' (services).

Sally suggested, 'people need more information about treatment, how to handle the law, Centrelink—the practical things, because it's hard to work on your drug use if you're worried your kids will be removed or about getting paid'.

Worker feedback

In your experience what are some of the main fears or worries that clients have about working with AOD services or other agencies?

Gesse (Continuing Coordinated Care worker) stated, 'I think a majority of their fears are based on "word of mouth" and hearing negative stories or outcomes about someone else's time in rehab or detox. In particular for women with criminal justice involvement, there is fear around disclosing level of drug use because their children may be removed and/or they will be asked to complete a longer residential treatment program, meaning more time away from their kids.'

Laura (AOD youth residential worker) stated for young people it was often about 'having to re-tell their story multiple times'. It was 'fear of being judged poorly because of their drug use, or that 'services won't be understanding of the LGBTQI community'.

Resli (Senior project officer) reported some of the fears include 'fear of police or other legal consequences; Centrelink fraud being exposed; confidentiality and anonymity; fear of FACS involvement and children being taken; being labelled, stigmatised and discriminated against; losing self-control of life choices, finances and cigarette smoking'.

How can we reduce fear of services?

continued

Practice tips to support someone whose fears are impacting their engagement in treatment

Tip

Be transparent, provide clear information and don't make assumptions

Gesse suggested, 'complete transparency is important and ensuring your client is informed and aware of their rights in terms of engagement with the service'. Gesse stated that 'promoting self-advocacy and capacity building through providing information is critical'.

For clients with child protection involvement Gesse said, 'I always provide them with resources including a copy of a FaCS contact diary, tips for dealing with FACS, and what to do if their children have been removed. I find giving clients information and education reduces their fear and they can advocate for themselves and get the support they are entitled too'.

Laura said, 'services should have clear policy and consent information—inform clients upfront about what to expect from treatment, provide clients with feedback in real time, talk through the processes'.

Resli suggested, 'above all—clear communication; take it slow using a step-by-step approach; explain things fully and clearly; pointing out the legal and ethical parameters in a given situation'.

As **Dan** stated, 'just because someone is older and been in the system, don't assume they know what drug treatment is and what services are available'.

Tip

Be non-judgemental

Laura said, 'it's important to provide a positive non-judgemental organisational culture'.

Tip

Provide practical support with referrals and identify appropriate contacts

Resli suggested, 'attend appointments with other services with your client, or support them when making phone calls to other agencies and introduce your client to the other professionals and services'.

'Identify appropriate contacts and supports within your organisation or another service for the person you are working with; for example, Aboriginal workers, LGBTI workers, familiar staff, peer workers'.

These tips may sound straightforward but sometimes when providing services, we can get caught up on qualifications and using a particular technique (e.g. cognitive behaviour therapy, dialectical behaviour therapy, motivational interviewing). And while these things are important, we must support people to reduce their fears to obtain and maintain engagement. We should provide clear information so they understand what treatment entails, and so they know their rights when working with other agencies (e.g. child protection, police, Centrelink).

For more practice advice and tips see:

- NADA's elearning modules about family inclusive practice, and working with people involved in the criminal justice system and/or with complex needs
- AOD LGBTIQ inclusive guidelines for treatment providers resource
- Aboriginal inclusion tool resource
- Engaging with consumers webinar
- Navigating the child protection system factsheet.

For more information contact Michelle Ridley.

Translating research into practice

Using social research to develop destigmatising online resources

Dr Adrian Farrugia Research Fellow
Australian Research Centre in Sex, Health and Society, La Trobe University

In 2014, a research team led by Professor Suzanne Fraser (Director, Australian Research Centre in Sex, Health and Society, La Trobe University) began a program of research aiming to address in new ways common understandings of drug-related issues. This article describes two projects conducted by this team: (1) a study exploring experiences of addiction, dependence or drug habit which led to the development of the website Livesofsubstance.org; and, (2) a study exploring understandings of take-home naloxone which also led to the development of a new site: Overdoselifesavers.org.

Experiences of addiction, treatment and recovery: An online resource

AOD consumption practices understood as 'addictions' are heavily stigmatised in Australia and elsewhere.[1] Seeking to address this stigma, our team initiated a project entitled 'Experiences of addiction, treatment and recovery: An online resource for members of the public, policymakers and service providers'. In this qualitative project we explored how people experience and give meaning to drug consumption and addiction, make decisions about treatment and manage stigma within the context of their whole lives.

To this end we collected a wide range of experiences in interviews conducted with 60 people (35 men and 25 women, aged between 19 and 59). Importantly, all identified as having an addiction, dependence or drug habit, and would have met DSM 5 criteria for Substance Use Disorder. Drawing on the rich accounts we collected from the interviews, we produced the website Livesofsubstance.org. In doing so, our aim was to show people affected by these issues in ways usually not visible in the media and popular culture: as ordinary people living ordinary, rich lives. The material on the website presents these experiences in people's own words, using original audio, re-enacted video, and text clips.

Livesofsubstance.org is made up of two key sections: 'Personal stories' and 'Topics'. These sections carefully present participants' experiences within their life circumstances and situate them in relation to broader social issues, thereby linking experiences between participants and their social contexts.[2]

One topic section entitled 'What is recovery and how important is it?' offers an example of how we put this approach into practice. Research on recovery emphasises that it remains a contested approach to AOD treatment and policy.[3] In order to properly engage with this complexity while remaining faithful to participants' accounts, this section offers a broad range of and contrasting views on recovery. By emphasising diversity, we offer a resource for consumers and practitioners that demonstrates the importance of flexibility and specificity when developing strategies to change consumption patterns. For example, one participant, 'Phoenix' (Male, aged 48, works in the media, consumes alcohol and prescription painkillers), said that for him recovery was about 'reconnecting people':

> Rather than focusing on taking something away from people, I think recovery ought to be focused on reconnecting people. I know that in a situation where I feel loved and supported, heard, respected, whatever, I'm not as thirsty. But if I feel I have to fight for recognition, not happy about that, and I tend to drink more. Yeah, I think that pretty well sums it up.

As with the interview extracts presented on Livesofsubstance.org, Pheonix's views on recovery are contextualised in relation to his life as a whole.

Understanding the impediments to uptake and diffusion of take-home naloxone in Australia

In 2017 the team began a second research project with the goal of addressing public understandings of opioid overdose. Entitled 'Understanding the impediments to uptake and diffusion of take-home naloxone in Australia', the project's aim was to understand how consumers and relevant health professionals think about overdose and take-home naloxone, and offer avenues to increase its uptake. We were especially concerned to investigate the effects of stigma on initiatives aimed at reducing overdose deaths such as take-home naloxone programs.[4]

Again, using qualitative social research methods, we aimed to understand the meanings given to take-home naloxone by those affected by overdose and relevant health professionals, and to understand these dynamics by taking into account the broader social context shaped by drug-use related stigma.

We conducted 83 interviews (46 people who consume opioids with and without experience with take-home naloxone, and 37 health professionals who encounter opioids and overdose issues in their work). Drawing on these interviews, we developed Overdoselifesavers.org, a site designed to improve public understandings of overdose and what to do about it.

Like Livesofsubstance.org, Overdoselifesavers.org is made up the two key sections 'Personal stories' and 'Topics'. This time, the personal stories offer detailed accounts of opioid overdose and the lifesaving measures people take in responding to it. The topic sections cover a range of issues relating to overdose and naloxone use including access, cost, stigma and other issues. In 'Experiences with take-home naloxone', participants describe using naloxone in their own words. This topic highlights the diversity in participants' experiences, including the emotions they describe. For example, Andrew (M, early 40s, consumes non-prescribed opioids) described saving the life of a young women who had overdosed in a public toilet:

> One of my friends came running out the dunny screaming at me. She knew I had the Narcan there. Her friend had dropped in the dunny. We pulled her out and put her on the grass in the recovery position and gave her one Minijet at the time [...] The ambulance was rung as well. One of the girls was on the phone to them, and told them what I'd done and everything, and the ambos turned up and checked her out and made sure her heart was all right and everything.

Similarly, Gabrielle (F, late 40s, consumes non-prescribed opioids) told the story of working with a group of people to revive a man who had overdosed in her apartment block.

> When I was called [to an overdose] the other day, it was like, grab the kit and run down a couple of flights of stairs, and when I got there a girlfriend of mine was administering CPR on a guy that I'd never met. They had called triple zero and he was non-responsive [...] So I administered the Narcan, a full ampoule of Narcan into the top of his leg [...] and after 90 seconds, a second one, and could see that nothing was changing. [But...] within like 30 seconds of the second one, he gave a cough and a bit of spluttering and things were good.

Overall, like Livesofsubstance.org, Overdoselifesavers.org is intended as a destigmatising intervention that supports take-home naloxone uptake by focusing on the individual stories of those affected by overdose, and how they come to access naloxone and save lives.

Opportunities to use our websites

Part of the role of these websites is to be used in education, professional development, volunteer training and advocacy efforts. For example, Livesofsubstance.org is used in undergraduate teaching at La Trobe University and the Masters of Addiction Behaviours at Monash University.

Examples and suggestions for using Livesofsubstance.org

1. The section 'What is recovery and how important is it?' could be used in training to demonstrate that efforts to change consumption practices are deeply personal, and individual recovery experiences will diverge in important ways. The website material could stimulate discussion or provide case studies to explore different understandings of the relationship between AOD consumption and health and well-being.
2. The 'Personal stories' section could be used in training programs aimed at addressing stigma. These stories position AOD consumption within people's whole lives, and show that people who consume drugs share many of the same responsibilities, challenges and concerns as other members of the community. This material could be explored alongside the topic section entitled 'Dealing with stigma and discrimination'.

Examples and suggestions for using Overdoselifesavers.org

1. Accounts of responding to overdose found in the section 'Experiences with take-home naloxone' could be used in advocacy efforts and de-stigmatising initiatives. This content could be used to highlight the life-saving work of people who consume drugs and counter stigmatising media narratives of drug consumption.
2. The health professionals' reflections found in the sub-section 'Supporting and expanding a life-saving technology' could be used to advocate for increased availability of take-home naloxone. For example, local GPs or community pharmacies that may not actively promote it may find this content informative and may be compelled to learn more.

Livesofsubstance.org and Overdoselifesavers.org have the potential to improve public understandings of people who consume drugs and expand efforts to save lives that may otherwise be lost to overdose.

References overleaf.

The art of managing emotions

Based in Newcastle, The Recovery Point provides practical support to people leaving the prison system or AOD treatment services to re-engage with the community. They approach this transition one step at a time, helping people to find accommodation and clothing; obtaining identification and Centrelink payments; and opening a bank account. They provide a range of AOD programs including pharmacotherapy, counselling and several SMART Recovery groups.

They also hold an emotion regulation program named 'The art of managing emotions', or TAME, for short.

Former correctional centre teacher Inez Geddes developed the program with the Samaritans. 'Some clients have used their incarceration as an impetus to stop using substances, but have found when they stop using drugs, their emotions rise to the top,' she says.

TAME gives them the tools to navigate this skilfully.

According to Recovery Point coordinator Helen Fielder-Gill, most of their clients have experienced trauma in their lives. Revisiting the past with counselling can unearth traumatic experiences that have affected them, so they can be emotionally vulnerable during recovery. TAME complements counselling by providing support to people to cope with these difficult emotions.

TAME's approach is based on cognitive behaviour therapy, where clients are taught that their thoughts are driven by their emotions. They are helped to develop critical analytical skills, to self-question, examine their own lives, for a more constructive outcome. Each week focuses on a new topic with some practical skills training.

The program covers:

- developing self-enquiry skills, reconnecting clients to their emotions and core values.
- how to build and maintain more fulfilling relationships.
- managing emotions, focusing on the relationship between anger, aggression, defence, protection, fear and hurt. Clients also learn practical strategies to avoid escalation by diffusing volatile situations by applying conflict resolution strategies.
- building a range of coping skills to deal with situations of grief and loss.
- taking ownership for mistakes and maintaining integrity so that guilt and shame become our life wisdom teachers, not torturers. It also covers techniques that may help clients to move beyond resentment and blame when they have been hurt, so that they can move on without adding to the suffering.
- maintaining a healthy lifestyle and applying stress management strategies.

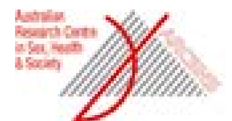
A facilitator is also available after the session, should anyone need further help.

The program content is largely driven by client need, gained from feedback. The program is of six week's duration, long enough to cover the content, while short enough to maintain their interest.

'We know that clients benefit from this program, as most of our referrals are word of mouth, and they enjoy the program, sometimes returning for more!' says Inez.

Translating research into practice

continued



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Mapping client emotions

Changes in psychological distress measures from intake to progress one

Sue Hailstone, NSW Ministry of Health and **Resli Büchel,** NADA

Since the introduction of COMS (our Client Outcomes Management System) in 2010, NADA has been compiling data as collected by you, our member services. These data help to paint a picture of non government AOD services in NSW. Recording and interpreting 'hard data', such as client demographics and physical health status, is generally straightforward, however, there are limitations to what these quantitative measures alone can tell us about the individual experiences of our clients.

The nature of each client's life experience and drug use is complex, nuanced and subjective, making their emotions and perceptions an integral part of their treatment journey and outcomes. For this reason, we also collect data using tools which are designed to provide measures of a client's more 'qualitative' experience of AOD treatment. This includes self-report tools like the Severity of Dependence Scale (SDS), the WHOQOL-8, and the Kessler Scale (K10).

The Kessler Psychological Distress Scale

Most of you will be familiar with the K10, a scale for self-reporting depression and anxiety. Clients respond to 10 standardised questions using a 'Likert' scale (i.e. 'none of the time ', 'a little of the time', 'some of the time', 'most of the time', 'all of the time'). The responses are then given a numerical value from one to five, and a total psychological distress score ranging from 10–50 is calculated. There are also four additional questions to the K10 that capture the impact of the psychological symptoms on clients' activities of everyday life.

To date, NADA COMS contains 'paired' records from 7,702 clients whose psychological distress was reported using the K10 both at intake to treatment and at their next assessment ('progress one'). These clients received treatment in residential and / or community services. The median number of days between the two K10 measurements was 31. The average total K10 score at intake was 25.94, compared to 20.53 at progress one, revealing an average reduction in psychological distress of 5.4. In other words, your clients are feeling better after entering treatment.

This reduction in psychological distress is reflected across all 10-items of the K10, with the average score for each symptom decreasing from intake to progress one. (*Table 1*)

Table 1. Average score for K10 questions at intake and progress one, non government AOD services, NSW, 12 April 2010 to 21 August 2019*

In the last four weeks, about how often did you feel…	Average score at intake (min=0, max= 4)	Average score at progress one (min=0, max= 4)
restless or fidgety?	2.89	2.46
nervous?	2.81	2.4
tired out for no good reason?	2.78	2.39
depressed?	2.75	2.21
everything was an effort?	2.66	2.15
hopeless?	2.47	1.92
worthless?	2.47	1.86
so restless you could not sit still?	2.24	1.85
so sad that nothing could cheer you up?	2.16	1.69
so nervous that nothing could calm you down?	1.96	1.58

**Note: The symptoms are presented in rank order, based on average score, and not in survey order.*

The three symptoms that showed the greatest improvement related to feeling less hopeless, less depressed, and less worthless. Also, in line with the pattern of WHOQOL-8 'quality of life scores' (as discussed in the last Advocate), the degree of psychological distress is shown to increase with age among clients, peaking in 45-54-year-olds and then decreasing in older groups (i.e. 55 years and over).

The additional four questions to the K10 capture the impact of the psychological symptoms, depression and anxiety, on a client's daily life. The results (*Table 2*) show that clients are not only feeling better after entering treatment, but they are also more able to undertake activities of everyday life.

Mapping client emotions

continued

Table 2. Average score for each question at intake and progress one, non government AOD services, NSW, 12 April 2010 to 21 August 2019

	Average at intake	Average at progress one
Totally unable to work/ study or manage day to day activities (days)	5.35	1.68
Cut down work / study or managing day to day activities (days)	4.97	2.85
See health professional consultations about their feelings (occasions)	1.31	0.85
When physical problems have been *main* cause of feelings ('likert' scale 1=none of the time, 5=all the time)	1.75	1.6

Some of the 'hard data' from our Minimum Data Set (MDS) helps to tell more of the story (*Table 3*). The greatest improvements in K10 scores over time were reported by female clients, those in residential settings, those undertaking rehabilitation activities, and clients who reported alcohol as their principal drug of concern.

Table 3. Average score for selected MDS demographics at intake and progress one, non-government AOD services, NSW, 12 April 2010 to 21 August 2019**

		Average score at intake (min =0, max= 4)	Average score at progress one (min =0, max= 4)
Male	4962	24.89	19.64
Female	2713	27.81	21.56
Aboriginal	895	25.45	20.44
Torres Strait Islander	28	23.13	17.77
Aboriginal and Torres Strait Islander	77	26.24	20.85
Neither Aboriginal nor Torres Strait Islander	6576	25.96	20.50
Residential setting	4280	27.10	20.44
Community/ outpatient setting	2958	24.49	20.77
Outreach setting	452	24.57	19.82
Rehabilitation activities	4780	27.06	20.68
Counselling	1976	23.43	19.69
Support and case management	633	24.90	20.88
Day programs	229	27.72	24.15
Alcohol	1742	27.31	21.40
Methamphetamine	1272	25.89	20.58
Cannabinoids	1049	24.00	19.99
Heroin	1015	25.56	20.23
Amphetamine	981	25.02	19.83

***Data generally shown for variables with larger numbers. Subsequently, numbers within categories do not sum to 7702 clients.*

What can the paired K10 records tell us?

This analysis is descriptive and we've examined a client's perception of themselves at two points in time. It does not consider other outcome measures in NADA COMS such as severity of substance dependence or quality of life. Nor have we compared the characteristics of clients who completed the K10 to all clients in NADAbase who did not complete the K10.

Interestingly, anecdotal reports from NADA member services suggest that, perhaps unintuitively, the K10 scores of clients tend to rise again as they approach discharge from residential AOD treatment. However, far fewer records of K10 scores at discharge are available in NADA COMS at present, limiting our possible analysis of this trend and, perhaps, highlighting a future direction for data collection and research within non government AOD services in NSW.

Holistic DBT program in an Aboriginal medical service setting

By Georgina Moore, Programs Manager, Yerin

Based on the Central Coast, the community controlled Yerin Eleanor Duncan Aboriginal Health Centre provides comprehensive primary care to the local Aboriginal and Torres Strait Islander community. The Yadhaba Wellbeing Team run a dialectical behaviour therapy (DBT) program at the centre.

Our clients

Our Aboriginal and Torres Strait Islander clients are aged over 18 years, and are experiencing mental health/and or substance use issues which impacts their ability to regulate their emotional states.

Dialectical behaviour therapy program

We identified that clients who received individual care co-ordination and/or therapy would benefit from some extra support. Complex intergenerational trauma is common in our client group, and as the evidence suggests, DBT is gold standard for addressing some of the emotionally related issues. We engaged an experienced private practitioner to facilitate the program.

To begin the program, clients must be linked to a care co-ordinator and/or therapist in our service.

Providing seamless support

First, clients are allocated to an Aboriginal health worker who provides culturally appropriate and safe support to address their mental health/AOD issues. Through this relationship, clients develop trust to be able to access services and practitioners they otherwise would not usually feel safe to do via mainstream services. This relationship is not time limited, and addresses their individual needs.

Via a stepped care model approach, if a more intensive intervention is required, the client can also be linked with a psychologist. They can also be referred to the DBT group to practice the skills learned within the other therapeutic relationships and settings.

These three elements combined enables the client to strengthen and transfer their skills across a range of environments, with support from other members of staff and community within our service. With ongoing support provided by their Aboriginal health worker between group and individual sessions, our clients receive encouragement, feel safe and remain motivated, moving seamlessly through their journey in a culturally appropriate framework.

The modules are also divided into four eight-week blocks to minimise the impact of the clients feeling overwhelmed, allowing for entry or re-entry as per what is suitable for the individual. Also, an Aboriginal health worker attends every module to support cultural practice.

We are coming to completion of the final module. The team will soon come together to evaluate the program and consider any improvements or adjustments to be made. Qualitative feedback from staff and clients so far have been positive, and attendance numbers have grown as the program developed.

How to access our program

We have a referral form on our website. Services can make a referral or clients can refer themselves.

Tips for the holiday season

The holiday season can raise difficult emotions for some people. NADA's clinical consultant, Michelle Ridley offers advice for helping people through this time.

For many people Christmas and the holiday season is a time for fun, indulgence, and getting together with family and friends. But for others this can be a challenging and lonely time that raises difficult emotions, which can impact mental health and AOD use issues. Unfortunately, when some people are experiencing these issues during the holiday season, it can be difficult to access support. Services are limited and many programs are closed. I recall when working in frontline services, how busy and stressful it could get before the Christmas break. Thinking about this time and with the holiday season fast approaching, I've come up with a few tips and information for services that could be useful:

- Be prepared. This sounds obvious, but for most of us, time flies by and it's the holiday season before we know it.
- Talk with your clients about the holidays, how they're feeling, what are their plans and assist them to be prepared ahead of time.
- If they identify potential issues for the holiday period, it is important that you help them to develop strategies to cope with them (e.g. taking a 'cool down' walk when conflict arises with family, or avoiding certain situations). Some relapse prevention and harm reduction activities and plans you could use with your clients see, Smart Recovery worksheets and tools, and Insight stay on course tools.
- Provide the contacts for relevant services available over the holiday season and sit with your client while they save the details into their phone so they have them handy. You could also print and laminate a wallet size card for your client that has the most relevant services listed. Provide these contact details on your organisation's telephone message service and mobile phones. Some useful services **open 24 hours x 7 days** a week and are free for anyone needing information, advice, support or referrals are:

Alcohol Drug Information Service (ADIS) assists with information, advice, support or referrals about AOD. Sydney call (02) 9361 8000 or outside Sydney free call 1800 422 599. Refer to ADIS site.

Stimulant Treatment Line (STL) provides information, support, referrals and counselling regarding stimulants (e.g. amphetamines, methamphetamine, cocaine, and ecstasy). Sydney call (02) 9361 8088 or outside Sydney free call 1800 10 11 88. Refer to STL site.

Family Drug Support (FDS) provides telephone support to families and significant others impacted by AOD. Call 1300 368 186. Refer to FDS site.

Counselling Online provide webchat counselling and email, as well as the peer support forums, an anonymous online space for people to connect, share hope and encouragement, and empower self-efficacy. Free call 1800 888 236. Refer to Counselling Online.

Needle Syringe Programs (NSP) some are closed during the holiday season so talk with your client about being prepared. For details NSPs across NSW, see the directory of all NSP locations in NSW managed by the Ministry of Health.

Domestic Violence (DV) **Line** is a statewide telephone crisis counselling and referral service for women and persons who identify as female who are victims/survivors of DV. Free call 1800 656 463. See the DV helpline.

Mental Health Access Line provides referral information and support 24/7 for people experience mental health issues. Call 1800 011 511.

Lifeline provides crisis telephone support service available 24/7 from a landline, payphone or mobile. Phone 13 11 14.

Kids Helpline provides free, confidential 24/7 phone and online counselling service for young people aged 5 to 25. Phone 1800 551 800.

Useful resources

Resources

Australian Dialectical Behavioural Therapy Institute
The Australian Dialectical Behavioural Therapy Institute is a specialist service of the Centre for Mental Health Education providing leadership in the delivery of dialectical behaviour therapy (DBT), mindfulness based approaches and modified DBT programs.

Emotion Regulation and Impulse Control (eRic)
ERIC is a modular program designed to promote healthy social and emotional development for adolescents and young adults by cultivating helpful emotion regulation and impulse control skills. ERIC is appropriate for vulnerable young people seeking help in AOD, mental health, youth justice and primary care settings who present with complex issues.

DBT regulator
Triple Care Farm has been providing a modified DBT group program for over seven years. Together with the Foundation for Alcohol Research and Education, Triple Care Farm has developed a manual [PDF] for clinicians, which includes the strategies and group work protocols it has found to be the most effective over that time. This manual is accompanied by a student workbook [PDF] and website, a self-help resource that provides refresher material for both clients and clinicians.

Dovetail good practice guides
Dovetail have developed a suite of good practice guides and accompanying tools and resources for AOD workers working with young people.

Blue Knot
Blue Knot Foundation advances the needs of the estimated four to five million Australian adults who are survivors of childhood trauma. For health professionals, the organisation provides training, workshops and factsheets e.g. trauma informed practice [PDF].

SANE Australia
SANE Australia's work includes mental health awareness, online peer support and information, stigma reduction, specialist helpline support, research and advocacy.

NADA worker wellbeing
Designed for the non government AOD sector, these resources encourage workers to invest as much time and care looking after their health as they do others.

Shame
In this TED talk, Brené Brown explores what can happen when people confront their shame head-on. Her humour, humanity and vulnerability shines through every word.

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NUAA's Peers and Consumers Forum

'The whole forum was awesome, I have never been in a place with such a range of different personalities but yet felt totally at ease and comfortable.' Forum participant

By Michelle Ridley, NADA
In September 2019, I attended NUAA's Peers and Consumers Forum. It was inspiring and informative, building upon the foundation laid last year. The forum supports consumers and peers, and provides opportunities to connect and network. It aims to raise the voice of people who use drugs and AOD service users; support advocacy; reduce stigma and discrimination; and improve health service delivery.

Kerry Chant (NSW Chief Health Officer) opened the forum, next Charles Henderson (NUAA Deputy CEO) and Dan Burns (former DanceWize NSW coordinator) delivered a presentation about peers as teachers. Over two days there were discussions on the crucial role of peers and consumers in all issues facing people who use drugs. There was a wide range of engaging and thought-provoking panel discussions and presentations including: rethinking recovery, peers and research, old people do use drugs, the unique role of peer workers, and practical peer skills in addressing stigma.

While it's difficult to pick a highlight, for me it has to be the First Nations panel, about ways to build the Aboriginal peer workforce. Also, it was the opportunity to connect and network, share stories and hear the experiences, and wealth of knowledge of consumers and peers, and the important role they play in AOD service delivery.

I asked delegates: what were the best part of the forum?
'The whole event was miraculous and uplifting, after attending hundreds of conferences over the past 30 years it was the best by a mile.'

'I got something out of each session—I would say the "Old people do take drugs" session was really interesting to me—I was really grateful for the information and stories shared in that session.'

'The incredible generosity of the people who shared their experiences and knowledge. The community are a really positive and caring group of people.'

I encourage AOD service providers to go along to the next forum in 2020. For more details see the website or contact Melanie Joyce at NUAA for information about how your service can work with consumers and peers.

Introducing the new NADA Board of Directors

NADA held its 41st annual general meeting in November, with approximately 50 people in attendance. As you know, all the current board members were retired and a new board was elected. Besides the usual AGM activity, members were given an opportunity to comment on the key advocacy priorities of our network and an update on NADA's workforce development program.

I am pleased to inform you that the nine new NADA board directors are:

- **President** Julie Babineau, Odyssey House
- **Vice president** Libby George, Drug and Alcohol Health Services
- **Treasurer** Peter Valpiani, Haymarket Foundation
- **Board executive** David Kelly, Wellington Aboriginal Corporation
- Norm Henderson, Weigell Centre Aboriginal Corporation Health Service
- Carolyn McKay, Sydney Drug Education and Counselling Centre
- Latha Nithyanandam, Kathleen York House
- Ed Zarnow, Lives Lived Well
- Sandy Kervin, Jarrah House.

NADAbase update

Tata de Jesus NADA

Reporting

The annual 2018/19 National Minimum Data Set (NMDS) for AODTS was submitted to AIHW in November 2019 on behalf of members who are funded by the PHN/ Department of Commonwealth. If you have questions, please get in contact via nadabasesupport@nada.org.au.

What's been happening?

NADAbase worker survey

We are currently reviewing NADAbase to ensure that it is meeting the needs of our sector. We are hoping you might be willing to complete a brief survey that examines your experiences with using the NADAbase client outcome measures, risk screeners, and the NADAbase. Information collected will be analysed by the University of Wollongong. Take the survey.

Work with PHNs

NADA is working to create a standard template for quarterly data reporting to PHNs. This template aims to streamline data collection resulting in a more efficient process for members.

NADAbase data snapshot now available

The NADAbase data snapshot for 2017/18 and 2018/19 are now available for members to view. The data snapshot provides useful and timely data from across the non government AOD sector and can be used as an effective benchmarking tool for your organisation.

A new version of the NADAbase data dictionary has been released to incorporate ATOP data elements.

AODTS NMDS elearning course

In November, NADA uploaded this new eLearning course which aims to:

- increase participant awareness of the data elements in the AODTS NMDS
- increase participant understanding of common errors in NMDS data collection
- increase service capacity to accurately record and report AODTS NMDS data
- increase participant awareness of the resources available to support data collection and reporting.

Addition of postcode field to service contacts

In October, NADA added an additional field for postcode of service contact. This field should use actual geographic post codes provided by Australia Post, and should record the post code for where the service contact has taken place. This is implemented as a requirement to the NSW Health data dictionary and collection requirements for the NSW MDS DATS [PDF].

NADAbase online tutorials

In August, NADA held a video shoot of members and consumers for the ongoing revamp of the NADAbase tutorials. We would like to extend our thanks to those who participated and volunteered their time. We are now bringing the online tutorials to life with the videos.

As always, Suzie Hudson and Tata de Jesus are always happy to help with any of your NADAbase questions. Get in contact via nadabasesupport@nada.org.au.

2019
annual report

Take a look

cc by nc nd 2.0 Paul Carmona

National quality framework for drug and alcohol treatment services

In November 2019, the Ministerial Drug and Alcohol Forum endorsed the *National quality framework for drug and alcohol treatment services* in a move to improving quality in AOD treatment services. The framework is part of the work of the National Ice Action Strategy, where governments agreed to implement a quality framework to support consistent treatment in line with best practice. This framework sets a nationally consistent quality benchmark for providers of AOD treatment services. It includes strong clinical governance requirements and a list of accreditation standards that AOD treatment service providers must meet.

Whilst the majority of NADA members have already achieved accreditation under the standards outlined in the framework, it is important for members to note that the framework includes a transition period of three years. During this time treatment service providers must work towards meeting the requirements. The transition period will finish on 28 November 2022.

Do you need support with accreditation or clinical governance? See the NADA Policy Toolkit, or contact a NADA staff member.

Take home naloxone rollout across NSW

Naloxone is a short-acting opioid antagonist drug that reverses the effects of an opioid overdose. With basic training, the drug can be safely and effectively administered by non-health workers in community settings.

To increase community access to naloxone, NSW Health is expanding the Opioid Overdose Response & Take Home Naloxone program to all Local Health Districts by April 2020. Through this program, health workers can supply naloxone (as Prenoxad® prefilled syringe or Nyxoid® intranasal spray) to community members who might experience or witness an opioid overdose, and teach them how to administer the medicine.

NGOs will play a key role in increasing community access to naloxone and reducing opioid related deaths. NSW Health is now working to legally enable NGOs to obtain and supply naloxone medicines. In early 2020, NSW Health will invite NGOs to submit an expression of interest to supply naloxone. From May 2020, participating NGOs will be offered free training and credentialing for workers. NGOs will be able to order naloxone at no cost via a recently launched Australian Government Take home naloxone pilot.

For community information about take home naloxone visit yourroom.health.nsw.gov.au/naloxone and for information for healthcare professionals visit health.nsw.gov.au/aod/programs/Pages/naloxone.aspx.

Contact your Local Health District for details on when and where they will supply take home naloxone, and check if your local pharmacy is signing up for the Australian Government's pilot. For further enquiries email moh-naloxone@health.nsw.gov.au.

Profile

NADA staff member

Dejay Toborek
Events and Grants Administration Officer

How long have you been associated with NADA?

I started in my role in mid-July, so I'm a new member of the team here at NADA.

What experiences do you bring to NADA?

My role is a new part-time position at NADA, and I'm thrilled to be able to bring my years of experience working in theatre and events to the role. I have also worked in research, administration and peer support for Positive Life NSW, a peer organisation for people living with HIV. I bring a diverse range of skills and perspectives to the role.

What NADA activities are you currently working on?

I've got quite a number of plates spinning at any one time, which keeps me on my toes! I'm working on various grants programs and associated reporting, and provide event logistics and planning for our training sessions and other events. Last but by no means least, I'm working with the team to hold the NADA Conference 2020, a significant event for the organisation and one we are excited to deliver.

What is the most interesting part of your role?

By far the most interesting part of the role has been meeting members and hearing about the important work they do as organisations and individuals. When back in the NADA office, the most interesting part of my role is working out ways to maximise our engagement with members through our events and grants programs, and to streamline some of our procedures within this new role.

What else are you currently involved in?

I've been involved with the City of Sydney's Citizen Jury, a group of 50 randomly selected people who live, work or visit the city that deliberate and provide advice to Council as to what concepts should be implemented in its 2050 plan. I'm also a budding (pun intended!) indoor plant enthusiast!

A day in the life of...

Sector worker profile

Debra Graham Program manager
Calvary Drug and Alcohol Centre

How long have you been working with your organisation?

I joined the Calvary Drug and Alcohol Centre 11 years ago as a volunteer whilst studying psychology.

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

On completing a Bachelor of Arts Psychology, I accepted a position as the mental health program coordinator to improve the services Calvary offer to both staff and clients.

What does an average work day involve for you?

I work in a joint clinical and administrative role. For the most part I coordinate the ACE (Alcohol and Drug Cognitive Enhancement) program, facilitate SMART recovery and offer art therapy to our clients.

What is the best thing about your job?

The highlight of my working week is taking clients on an early morning eight-kilometer mindfulness walk in a nature reserve. I have the opportunity to share a conversation with clients and see and hear the difference taking time with nature makes to the start of their day.

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

More funding directed towards mental health for resources and training opportunities in the AOD sector. We have one part-time mental health clinician working across three programs to support co-morbid clients.

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

An area of interest to me is mindfulness and how the practice can be incorporated into all aspects of life. Walking and cycling are a major part of my self-care, especially when shared with friends.

Vale Russell King

WAYS Youth & Family, formally known as Waverley Action for Youth Services, was established in Bondi Beach in 1979. The organisation began as a grass roots not for profit non government organisation, initially offering an AOD free space for local young people to socialise, engage in organised recreation activities, and receive practical assistance in terms of staying engaged in employment.

Since its inception, WAYS has flourished under the innovative leadership of CEO, Russell King. In his 30 years as CEO, Russell expanded WAYS services to meaningfully meet the changing needs of local young people and their families. He grew the wellness team to include additional case managers, a G.P. and an acupuncturist. He oversaw the creation of a registered RTO—WAYS Youth Training—that offers a range of nationally accredited Certificate II to diploma level courses, the completion rates of which are double the national average. Russell was also integral to the creation of WAYS secondary—an accredited alternative high school for years 9–12. More recently, he expanded the Youth Space service to include afterschool care.

Throughout all this innovation, Russell focus was to always ensure that young people who were at risk of, or who were affected by AOD, be it via their own use or that of family members, had a place that would meet as many of their needs as possible, without judgement and with unconditional positive regard.

The countless success stories of so many clients with AOD issues, who remained in education, stayed in the home, got a job and felt more in control of their lives, is testament to the hard work of Russell. In 2017 the Hon. Gabrielle Upton awarded Russell the well-deserved Premier's Community Services Award to acknowledge his years of passionate, dedicated and outstanding work for the youth and families of our local community.

WAYS Youth & Family are incredibly blessed to have been be guided by a CEO with such vision, tenacity and compassion.

SPEAK OUT

DUAL DIAGNOSIS PROGRAM

The Glen

Learn about NADA and our members

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 Clinical Care Network

As of their last meeting held in August 2019, the Women's AOD Services Network has decided to undertake a redesign, with the aim of more effectively supporting women's AOD services throughout NSW. Moving forward, the reformed and renamed Women's Clinical Care Network will continue to build the skills, knowledge and connectedness of AOD professionals who work with women. NADA will support this, as before, by coordinating biannual training sessions and forums related to women's AOD service provision. However, networking and communications within the network will be more casual and open, with no further plans for formal meetings.

NADA thanks the members of the former Women's Network for their dedication and contribution to the AOD sector over the past six years and is excited to support the work of its new iteration—Women's Clinical Care Network—into the future.

Youth AOD Services Network

The NADA Youth AOD Services Network held a meeting in October, hosted by Weave in Waterloo. Special guests at this meeting were representatives from NSW Health, along with key team members from NSW Local Health Districts, who engaged in an open and constructive discussion with the network on improving referral pathways and inter-sector communications, as well as how to 'plug the gaps' and stop young people getting 'lost' in the handover between government and non government services.

The network was also presented with the results of their recent network needs analysis, which highlighted the need for further advocacy for increased funding for youth-specific services and pill testing, skills based training in suicide prevention and feedback informed treatment, and the promotion of strengths based outcome measures (as opposed to deficit based tools) in evaluating current services. The needs analysis feedback will be used to plan training and events for the network over the next 12–24 months.

NADA network updates
continued

NADA Practice Leadership Group

The NPLG met in September to discuss projects underway, and take part in discussions with the Ministry of Health on the newly released depot buprenorphine for opioid pharmacotherapy.

Meeting highlights

1. NADA's workforce capability framework is supported by the NPLG. The NPLG believe this to be an integral framework that will help shape a more robust and informed AOD workforce.
2. The NPLG support the release of depot buprenorphine; it provides consumers the flexibility and choice around their substance use and the management of it.
3. The NPLG are advocating for clearer guidelines and KPIs for data collection to better reflect a service's activity.

The NPLG also welcomed three new members: Tara Morrisson of CRC, Mathias Dussey of DAMEC, and Yasmin Iese of DAMEC. We look forward to a fruitful collaboration.

CMHDARN

The CMHDARN **research ethics consultation committee** (RECC) has been established to provide 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 who receive services from mental health and/or AOD organisations is encouraged to apply for ethical consultation.

Community research mentoring program

Do you want to conduct research in your service but don't know how? Would you like to develop new research skills? Apply now for short-term mentoring. [PDF]. CMHDARN will link you with an academic who has expertise in the area related to your questions / ideas to form a mentoring relationship.

CMHDARN
Community Mental Health, Drug & Alcohol
RESEARCH NETWORK

Member profile

Glebe House

Service overview

Glebe House is a therapeutic community that helps men transition to a life free from addiction. Our mission is to provide an inclusive, personal service where men are treated with compassion and respect.

Treatment assists clients to

- address their substance use issues
- develop healthy relationships
- build the capacity for independent living
- reintegrate as productive members of the broader community.

Glebe House provides treatment for men with complex needs, including substance and other dependencies, dual diagnosis and complex trauma, including physical and sexual abuse.

The program is holistic in nature: yoga, pilates, art therapy, sport, recreation and social activities are included in the structured timetable, as well as the requirement for clients to attend two 12-Step fellowship meetings per day. In addition, psychological counselling helps clients explore their underlying emotional issues and develop self-awareness. Group work addresses negative thinking and behaviour and enables men to better cope with emotions and the challenges of daily life.

Glebe House clients commit to a structured program of recovery, reinforced by an immersive experience in the 12-Step fellowships, working with a sponsor, developing vital support networks. It is a design for living drug free.

For many men, Glebe House is their first experience in a long time living substance free and building positive connections. In response to the level of trust and freedom granted, the men establish a personal program of recovery for themselves, taking on responsibility and enjoying hope for a better future.

The Glebe House Family provides ongoing, open-ended support for men in recovery. The Outreach Community continues to grow, with men sharing their lived experience, becoming role models for their peers. Glebe House enables men to build healthier relationships, to give and receive love. It is a place for connection and community.

It is a safe place for change.

Our clients

Men aged 25+, who have AOD, mental health and trauma issues, experiencing homelessness and who have been affected by the criminal justice system. We admit men directly from jail at the end of a custodial sentence to assist them to reintegrate back into the community. We also have community beds for men with over 30 days abstinence, who are typically referred from shorter-term AOD services.

Service highlights

We are not an institution, we are a family. We provide open-ended support and treatment, you are always part of the Glebe House Family.

Our staff

Glebe House is a small team of well-trained, multi-disciplined staff members, who live in with the clients. All clinicians are themselves in recovery. The majority of members of the board of management are also in recovery, highlighting the importance of lived experience to the service.

Contacts

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A smartphone app research trial to help Australians manage methamphetamine use

A new smartphone app research trial aiming to help people who use methamphetamine to understand and manage their use, is currently underway. The S-Check App, developed by St Vincent's Hospital Alcohol and Drug Service, seeks to help users to identify their individual risks associated with methamphetamine use.

Through a series of self-assessments, S-Check App provides users with individualised tips and feedback on any methamphetamine related risks and harm. The app also contains relevant resources and helps people track their use over time. The S-Check App was created in recognising the fact that not everyone who uses methamphetamine would like to seek formal therapy or treatment, but might benefit from having access to other sources of information and support.

If you are 18+ years, live in Australia and have used methamphetamine in the past month, this is a great opportunity to participate in the S-Check App trial. You will test drive the app, complete a few surveys, and find out how the app can help you.

The app will be available for download in late December 2019. To participate, simply download S-Check app at the Apple store or Google Play store and read the participant information sheets which will be provided in the app. For more information about the app trial, please visit www.scheckapp.org.au

Daybreak: economic program evaluation

Alcohol support app Daybreak, by Hello Sunday Morning, returns 149% to the Australian economy for every dollar invested by the Federal Government, a report has found.

The economic impact of changing our relationship with alcohol: the Daybreak program [PDF], published by Evaluate, shows the online app is delivering tangible economic benefits by improving work productivity and reducing household expenditure on alcohol.

Daybreak is an online program which assists Australians to change their relationship with alcohol through a supportive community, habit-change experiments and one-on-one chats with health coaches.

NADA Practice Leadership Group

Meet a member

Lauren Mullaney Senior Psychologist — Triple Care Farm, Mission Australia

How long have you been working with your organisation? How long have you been a part of the NPLG?
I began working with Triple Care Farm in 2015, and became part of the NPLG in 2016.

What has the NPLG been working on lately?
The NPLG has been working on a variety of items, ranging from standardising 'clinical standards of care' to understanding and implementing feedback informed treatment.

What are your areas of interest/experience—in terms of practice, clinical approaches and research?
My background is psychology, and for some time now team management and clinical supervision. Most of my role comprises working with young people, and the clinical and wider teams to ensure we are delivering evidence based treatment and meeting the needs of our clients.

What do you find works for you in terms of self-care?
It depends on the week, but self-care that rejuvenates and reminds me of my values is super important. Whilst doing 'nothing' can be appealing, its rarely restoring in the way that good self-care should be.

What support can you offer to NADA members in terms of advice?
Ethical practice is really important to me, and I am passionate about ensuring that the people we work with are provided with safe and therapeutically sound support. I am always open to exploring themes around clinical guidance and practice. At Triple Care Farm, we also run a modified dialectical behavioural therapy program and use feedback informed treatment, so if anybody had questions around how this works in practice, I would be more than happy to discuss this too!

Stay in touch with the AOD sector

Frontline

Keep up-to-date with best practice articles, resources and training. Frontline is sent monthly.

Advocate

Explore AOD news and issues with our quarterly eMagazine. Read previous issues.

When you subscribe, you'll also receive occasional emails from us about grants, events and more.

Subscribe on the homepage www.nada.org.au.

cc by sa 2.0 media evolution

What we're working on

Program update

Workforce capability framework

An initial draft of the Workforce Capability Framework: Core capabilities for the NSW non government AOD sector has been completed.

The framework is a foundational document that describes the core knowledge, skills and attributes that all NSW non government AOD workers require regardless of their role, occupation, level of seniority, target population or practice setting.

The draft is the result of an extensive consultation process that included a workforce mapping survey, environmental scan, and workshop facilitated by NCETA (National Centre for Education and Training on Addiction).

An online survey providing all stakeholders with the opportunity to comment on the draft was undertaken in October–November 2019 and membership support in principle was sought through NADA's AGM.

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

NGO service development grants

NADA is excited to announce that in February 2020 we will open a second round of our successful NGO Service Development Grants program to members.

In partnership with the NSW Ministry of Health, a total of $475,000, will be allocated as one-off project grants designed to increase service capacity in regard to access, equity and safety for people seeking and engaging in AOD treatment. Up to $60,000 for individual organisations and $100,000 for collaborations between multiple organisations will be available for projects commencing in April 2020 and completed by October 2020.

There are two streams in which to apply:

- Stream 1: Projects designed to improve the access, orientation to and safety while in, AOD treatment
- Stream 2: Projects that focus on improving access and equity regarding a specific target population (such as Aboriginal, cultural and linguistically diverse populations, etc).

Do you have a project idea, or partnership just waiting for a funding opportunity like this? Now is the time to start detailing a proposal for when the expressions of interest open in February 2020.

Grant eligibility: The applying organisation must be a current financial member of NADA, a registered non government organisation, and contracted by NSW Health to provide AOD treatment services in NSW. An interim and a final report will be required from each successful grantee.

For more information, please email Dejay Toborek or phone 02 8113 1324.

Continuing coordinated care

The CCC programs have been providing intensive outreach wraparound support across NSW to people experiencing AOD issues and other co-occurring needs. NADA's CCC clinical consultant has provided advocacy and other support to CCC program staff and other NADA members and recently has:

- facilitated meetings with CCC staff and their Primary Health Networks AOD advisory groups and Family Community Services (FACS) offices and co-presented with the teams about the program. co-authored an article about the CCC Central and Eastern Sydney team and Lou's Place for their PHN online newsletter. Click here for more details CESPHN AOD enewsletter [PDF]
- provided workshops on pharmacology, methamphetamine and pharmacotherapy.

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

Training grants

Our training grants round for the January–June 2020 period has recently closed and we are pleased that we were able to offer all our applicants funding.

Answering our call-out for more applications focused on group training, close to a third of applications this round were for groups, allowing many staff over a number of organisations to benefit from NADA's grants program.

Keep an eye out for the next round opening in May 2020.

NADA's training grants program is funded by the NSW Ministry of Health. All current financial member organisations of NADA can access this program for their staff, building capacity within non government organisations in the NSW AOD sector.

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

Advocacy highlights

Photo by Kris Ashpole

Policy and submissions

- NADA provided submission expressing concerns with Sections 8(5) and (6) of the Religious Discrimination Bill 2019 Exposure Draft.
- The AOD Peaks Network signed on to a media release with a range of other peaks nationally to oppose the Senate Community Affairs Legislation Committee inquiry into the Social Services Legislation Amendment (Drug Testing Trial) Bill 2019.
- The AOD Peaks Network provided a submission to Draft Food Regulatory Measure—Proposal P1050—mandatory pregnancy warning labels on alcoholic beverages.

Advocacy and representation

- NADA was invited to be part of a roundtable for the Special Commission of Inquiry into the Drug 'Ice' related to funding and planning.
- The NSW Health Drug and Alcohol Program Council meeting focused on workforce development. NADA was part of the working group to formulate the agenda, with priorities being discussed at the December meeting.
- NADA was invited to give evidence based on our submission to the Senate Community Affairs Legislation Committee inquiry into the Social Services Legislation Amendment (Drug Testing Trial) Bill 2019 in October.
- NADA has attended two meetings with the NSW Ministry of Health looking at the establishment of an AOD Research Strategy and associate governance arrangements.
- NADA attended a workshop at Parliament House with AOD leaders on Reform of the Alcohol and other Drugs Treatment System initiative.
- NADA and QNADA, on behalf of the AOD Peaks Network, met with the AIHW regarding NGO AOD data collection.
- NADA has been asked to be a part of the Take Home Naloxone roll-out to the non government AOD treatment sector.
- NADA is representing the non government sector at the Clinical Outcomes and Patient Experience (COPE) steering committee and the Drug and Alcohol Clinical Research Network (DACRIN).
- Key meetings: NSW Ministry of Health, NSW PHN AOD Network, Department of Health and Department of Social Services, NSW Council of Social Services Forum of Non Government Organisations, Quality in Treatment, Hepatitis B&C strategies and implementation committee.
- NADA is part of a collaborative partnership project with NSW Ministry of Health, ACI and NUAA focused on stigma and discrimination.
- NADA has sought out partnership projects with South Eastern and Sydney LHD HARP units to establish partnerships with members to ensure greater access to Hep C testing and treatment.

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Feedback **Training grants**