Advocate

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What works?

- YSAS • Alcohol and Drug Cognitive Enhancement
- Lives Lived Well • The Matilda Centre

NADA network of alcohol and other drugs agencies

CEO report

Larry Pierce NADA

This edition of the Advocate focuses on the topic 'what works', an interesting yet potentially challenging topic for our sector. We all agree with statements like 'treatment works' but do we share a common understanding of *why* treatment works? Or more importantly, what are the elements of AOD treatment that make it 'work' for our clients. There are four main types of drug treatment (outpatient counselling/day programs, withdrawal management, residential rehabilitation and pharmacotherapeutic treatments) but do we agree that within those treatment types, there are key therapeutic elements and practices that 'work' and provide the client with the tools and support to make appropriate life changes in their treatment journey?

Of course, treatment isn't the only service provided by NADA members. Members provide a range of harm reduction, health promotion and community engagement activities. We know that harm reduction work and we're very fortunate in Australia to have needle and syringe programs, the injecting centre and a range of peer led harm reduction approaches that have prevented harms to people who use drugs. Whilst we know that health promotion is essential to preventing AOD related harms, more funds are needed to increase these services, and also investment in research to build the evidence base.

Over the past twenty or more years, the non government AOD treatment landscape has changed significantly. Most significant has been treatment agencies shifting their focus from the programs and interventions they offer—the treatment menu if you like—to positioning the client at the centre and determining 'what works' for them. It follows then that the treatment focus should also widen from the internal environment of the treatment program to the social environment in which the client lives. This is what we mean when we say we are developing a person centred approach, and the inclusion of families and the client's social networks into the treatment process is now more common.

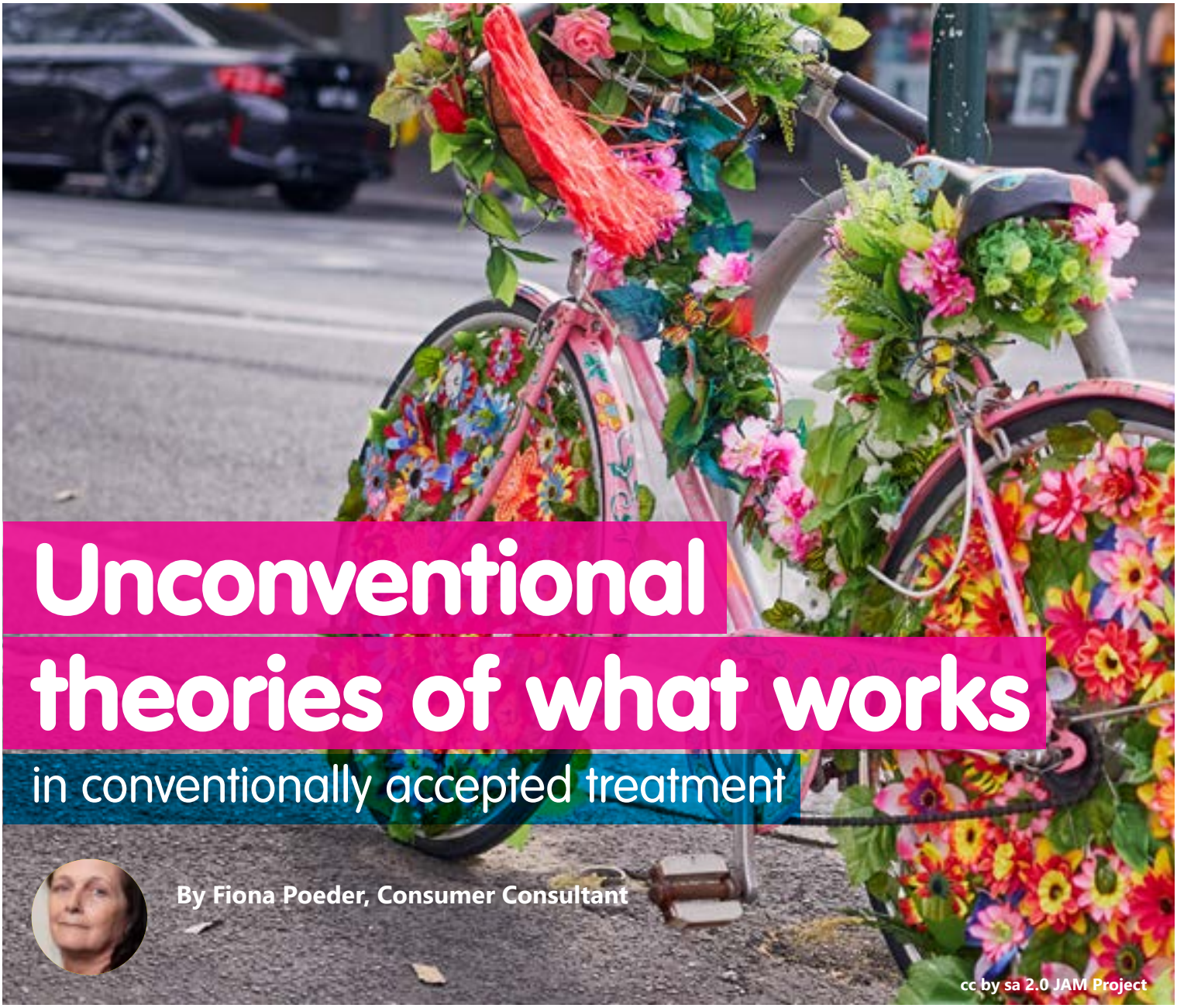
Another key shift is addressing stigma and discrimination of drug use and the people that use them. We know from both the mental health and blood borne virus sectors that addressing stigma and discrimination was core to their approach to client service and a big part of their advocacy programs. I think we are still in the early days of recognising how stigma and discrimination impacts on our clients, and how language, media and popular culture representations, as well as the legal and criminal justice systems, perpetuates this. Addressing these issues are key to reducing stigma and discrimination that our clients experience, and often internalise.

> How can we help our clients to 'recover' through a treatment program without recognising the cultural and societal stigma they face and will continue to face, when they exit the treatment system?

Key to the person centred approach is the active involvement of consumers and peers. Recognition of the role that they can and must play within the treatment system, and also how we as treatment service providers elevate the roles at all levels of service provision. NADA has been helping our membership in developing consumer led approaches to treatment service provision and we look forward to doing much more work in this space over the coming years.

And finally, when thinking about 'what works', we need to refine our advocacy role at all levels across our sector. For NADA this means advocacy for better resourcing of our members and better treatment system planning. Support for access to more resources for research and evaluation, for broader health and social services system reform, and where appropriate, reform of the policing and criminal justice system in relation to the negative effects these systems have on people who use drugs and impede their access to effective treatments and social supports.

I hope this edition of the Advocate will help us navigate these tricky issues and move forward to improve and better refine the services we provide, and the way in which we work with the wider world.



Unconventional theories of what works

in conventionally accepted treatment

By Fiona Poeder, Consumer Consultant

You can lead a horse to water, but you can't make it drink. So if the AOD sector led a hundred horses to water and they noticed the majority weren't drinking, at what stage would they stop and wonder: 'What's going wrong here?'

Abstinence has not been an option for me; opioid treatment has worked. It's kept me stable and luckily (cross fingers) kept me out of prison all these years. But I realise it will only work so long as I live in Sydney, and only then because I've managed to find the flexibility to live life on my terms.

It's worked this long; however, like I said, I doubt it would work anywhere else. If I didn't have the combination of the prescriber, pharmacist and the money to pay for this treatment—it simply wouldn't work. Having those factors fall into place, knowing the clinical guidelines, knowing my rights and being in a position where I can advocate for my rights makes it work for me.

But I'm still scared: what if my doctor retires (as I've experienced before), I become incapacitated (which I've witnessed with friends), I need to move out of Sydney (likely to occur because of costs), the guidelines change (this has happened too), or the pharmacist raises prices and I can't afford it any more (another experience of mine)?

Scary stuff—so what works for me is a group of factors falling into place at the right time and place, but they are arbitrary and hinged on external factors. But, what about what works for others?

I spoke with several people about what was positive for them in relation to abstinence, therapeutic communities and/or opioid replacement treatment and delved into the question of: *What works for you?* Everyone interviewed had attempted at least two of these conventionally accepted AOD treatments more than once.

Unconventional theories of what works

continued

To begin, these 'treatments' (for want of a better word) were largely viewed as forms of control. They were perceived as being pressed upon them by external factors—not necessarily something that people wanted for themselves. For some it was other peoples' expectations of what they should do; or a choice to adopt treatment to avoid harsher situations: fear of children being removed, being forced into treatment rather than accepting incarceration, parental pressure, or a combination of similar options. So we need to be careful that 'what works' is working for the individual and not just meeting other peoples' expectations.

Not one option was preferred more than any other. Rather, the themes raised most often were those that underlined human factors rather than treatments themselves which would make them as individuals 'better'.

However, everyone found something which worked for them in some way. As Jason explains, 'Using drugs can be a really lonely experience—you're cut-off and you can't trust anyone … but while being in rehab can be a nerve racking experience, when you see that "glow" people get when they aren't using, or you're hanging around with non-users and make connections and have good belly laughs, you're sense of self-worth increases.'

Connections are important, and so too is structure and having a routine: a life you don't want to give up. Jason describes this experience as, 'I wake up and say; I feel good about getting up today because I'm not overwhelmingly depressed and I have a purpose. When I have to "get on" as a priority, I can't do anything else.'

These sentiments are reflected by others who suggest that having a purpose, goals, a plan—regardless of the treatment they are attempting, helps. Meaningful direction is suggested as a means to an end. Yet also, activities like study can provide additional benefits such as leading to employment. Alan suggests it's about 'shifting your headspace'.

Therapeutic communities can make you more self-aware, you interact with people without being 'shit-faced', and providing the facilitators are good—they know when to push rather than punish—it can eventually give you the confidence to take on the world, find a path to follow. When these factors come together, therapeutic communities work for Alan.

For others, therapeutic communities worked when the lessons learned could be taken back into the 'real world'. For instance, learning practical strategies to aid in negotiating the real world, to help in making informed choices, gaining knowledge of available and appropriate services, and maintaining connections with those in similar circumstances or with recognisable life experiences.

Not one option was preferred more than any other. Rather, the themes raised most often were those that underlined human factors rather than treatments themselves which would make them as individuals 'better'.

So, having touched at the edges of 'what works' for people in the spheres of opioid treatment, abstinence and therapeutic communities what is the take home message for service providers? Viewing people as individuals with no 'one-size fits all' treatment. Acknowledging that not everyone even wants to be in a form of treatment and that they may be there for reasons other than 'getting better' on someone else's terms. Alan throws up his hands and says, 'recovery is confusing, you do become lost and in a shit place. It can take lots of attempts at different things to be the person you want to be in the place you want to be. It may not even have anything to do with drugs and treatment.'

Engaging consumers
Develop your skills and understanding to engage and support consumers.

Watch the video

Consumer participation audit tool
Where is your organisation situated in relation to consumer participation?

Download this resource

Complementing AOD treatment

By Michelle Ridley, NADA

People accessing AOD treatment will often present with co-occurring issues like homelessness, isolation, mental health problems, family and domestic violence, criminal justice and child protection involvement.[1] So it's unsurprising that the National Drug Strategy reports that their multiple needs must be considered, including their physical and mental health, social, economic, legal and/or housing circumstances.[2]

When I asked consumers how they would like to be supported to help them achieve their goals in AOD treatment, they echoed the strategy:

'Keeping connections is hard, people need help to link with other services.' Sarah

'Help with housing and Centrelink—the practical things are important.' Barry

'Help working with FACS, for me and my kids.' Debbie

Unfortunately, the complexity of these co-occurring problems means that helping people with their AOD use and other psychosocial needs is not always straightforward. Social determinants like discrimination, unemployment and poverty can contribute to AOD use issues.[3] And the chronic shortage of affordable and available housing is one of the main factors driving homelessness.[4] Challenges like these cannot be addressed by individuals and AOD services alone. Nor can they be resolved overnight.

People experiencing AOD use issues who have other psychosocial needs, most often require continuing and integrated support for a longer period. It can often be the co-occurring issues that get in the way of people accessing or staying engaged in AOD treatment. However, it can be difficult for AOD services to provide support around all the needs of a client due to limited resources and gaps in service provision. While workers have made admirable attempts to leverage off goodwill partnerships with other services and sectors, and to provide holistic care with stretched resources, systemic barriers still exist.

Recognising the need for people with AOD issues to have more continuing and integrated support, the Continuing Coordinated Care (CCC) program was implemented with funding from the Ministry of Health. The program provides intensive wraparound support for people with AOD issues and other co-occurring needs. CCC helps with care coordination, intensive outreach support and access to other services (e.g. health, housing, and education), information and advocacy.

The program does not provide AOD treatment but compliments the work of AOD services, helping clients to access or maintain engagement with treatment. For example, if your client is on a waiting list for residential rehab they could be linked to CCC during this time, or when they leave, they could be referred to the program for ongoing support. If you provide AOD counselling in the community, you could refer your client to CCC for outreach support to help them navigate other health and human services.

Complementing AOD treatment

continued

James' story

James was experiencing issues with methamphetamine use and moving from crisis to crisis accommodation before being referred to CCC. Alongside a long history of substance use, he experienced long term unemployment and homelessness. Socially isolated, he also experienced mental health issues, intense self-stigma and shame.

Working with James for nine months, CCC helped him to engage with an AOD counsellor and a community based AOD treatment program. They referred him to housing support where he secured permanent social housing and helped him to participate in volunteer work.

He is now taking a computer course, reducing his debt through a 'work and development order' and will soon start casual work. James has reconnected with family, made new friends and was referred to a good GP. He is regularly active, attends the gym and enjoys cooking healthy meals—now that he has a kitchen. He has achieved his goal of abstinence for several months and, while he still feels urges to use drugs at times, he reports that he now has the skills to work through these feelings.

Sarah's story

A mother of two toddlers, Sarah had a diagnosed mental illness, and was experiencing homelessness. While she was addressing her AOD use issues with the Local Health District's AOD service, CCC helped her to secure stable rental accommodation with the assistance of Community Housing, access a good GP who developed a mental health care plan, enrol her children in day care twice weekly, and to successfully appeal a Centrelink debt.

With the help of a lawyer, Sarah is now working to regain shared custody of her eldest son. Her confidence has grown over the past seven months and she is now advocating for herself and her children and has the supports in place to move on with her life independently.

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The CCC program is a state-wide service for referral information

- For the Mid North Coast and Northern NSW see The Buttery
- For Northern Sydney, Western NSW and Far West NSW see Mission Australia
- For all other areas refer to St Vincent De Paul

To learn more, email Michelle Ridley who helps CCC with systemic advocacy, liaison, training and advice.

How do you engage your clients

David Manager, Maayu Mali,
Moree Aboriginal Residential Rehabilitation Service

Maayu Mali is an Aboriginal community controlled service. All the residents are Aboriginal people, as are all the staff at present. The service is well integrated into the local community. For many Aboriginal people coming into a treatment program, particularly a residential centre, located in a regional area, this is a vital first step in engagement.

Substance use and substance use treatment for **Aboriginal and Torres Strait Islander people** needs to take place within context. Holistic support means not just the whole individual, but their understanding of themselves within family, community, culture, country and spiritually.

We don't just find out about their drug use or mental health but who their people are, where they are from and what supports might be needed in that area. Engagement tends to happen informally and opportunistically and often while other activities are taking place like sports, art or recreation. As much as we possibly can, we involve community members, involving elders in engagement with program participants and volunteering in the community.

Genevieve Associate Director
(Client and Clinical Services), ACON

First impressions really do count. For **people of diverse sexualities and gender** it can be an incredibly daunting experience stepping through the doors of a health service. Often it is left to the person to decide whether it is safe to disclose their gender or sexuality. And, we know that too often people choose not to disclose this information due to fears of discrimination or stigma. Yet it is crucial for health providers to be able to deliver person centred care.

At ACON, we ask all clients their sexual orientation and gender identity as a standard demographic question during intake, and provide diverse prompts to indicate inclusion. We make no assumptions about people's identities or relationships. Rather we reflect the language that our clients use to describe their identity and relationships. And finally, people of diverse sexualities and gender are resilient. Tap into this resilience to enable your clients to picture the steps that it might take to create their preferred future.

Clare Team Leader,
Mission Australia Kings Cross Youth Services

All our youth services work in an outreach capacity, so we engage **young people** in their own community, in locations where they feel comfortable. This also reduces their barriers to engage such as navigating public transport, not having the funds for travel, or anxiety around attending a centre. We actively spend time working on the professional relationship and building strong rapport and trust with young people.

We provide intensive support which may be home visits, living skills development, transport or accompanying young people to attend important appointments. We also act as consistent, positive role models for young people we work with, promoting self-determination, treating them with respect and celebrating the small and big wins. Having a flexible approach and the ability to work long-term helps us to engage and work with each young person at the stage they are at and sit with them in this process.

Margherita Manager,
Sydney Women's Counselling Centre

The women who present to our service come with complex issues including mental health, domestic and family violence, substance use and underlying trauma. Around fifty to sixty percent of women who access our centre are from **culturally and linguistically diverse communities**.

We have a bilingual counselling program (Mandarin, Cantonese and Shanghai dialect) so clients can express themselves in their mother language and feel culturally connected and understood. We also have an array of printed resources in the waiting area in many different languages, which along with the use of interpreters as required, helps clients access the services they need.

Most importantly the centre operates in a trauma informed care framework that is culturally sensitive and individually tailored and provides safety, builds trust and assists clients to engage with and respond to support and treatment.

How do you engage your clients

continued

Jane Program Coordinator, Family Recovery

Family members often feel powerless, unheard and unseen. From first contact, we convey hope, validation and confidence in their ability to make change for themselves and the family system. We also provide the space for clients to share their experience, so they recognise that they aren't alone.

We identify family dynamics that may be inadvertently keeping the family locked in rigid patterns and increase anxiety. We enhance their awareness around how some automatic behaviours used to 'fix the problem' are perhaps keeping them stuck. And we support them to try some different approaches. Through a therapeutic, peer group process, we support clients to move from an outward 'change-other' focus to 'self-focus'. They learn how to listen without blame, set boundaries that protect self but allow natural consequences, and prioritise long term goals rather than short term reactions.

Sarah Manager, WHOS New Beginning/WHOS West/WHOS Newcastle Day Program

We are diligent about ensuring New Beginnings is a safe place—from the physical environment to the language used by staff and residents. Many of the **women** accessing treatment have children, so we have allocated times when they are able to call their children and we facilitate children's visits twice a week. Contact with their children is encouraged immediately!

We run a plethora of groups that support women through their treatment journey such as acceptance and commitment therapy, family and domestic violence and gender specific women's groups.

WHOS New Beginnings has employed a strong and dedicated team of 10 women who are passionate about working with women that are struggling with AOD dependence.

Tony CEO, Family Drug Support

When **families** seek support, they often fall into either of two categories:

- Type A: where the person has a decision to make or a dilemma to resolve. In this situation we help them to make a decision that they can live with, without telling them what to do. We provide non-judgmental and non-directive support and information.

- Type B: where people are confused, tired and the situation is chaotic, and they generally feel stuck. In this situation families often just need to vent and express their emotions. We acknowledge, validate and support the family.

We recognise that families generally go through a stages of change process: denial, emotional stage, control, chaos, and coping, and they need to be supported at the stage they are at. The model Family Drug Support uses incorporates a reality-based approach and includes education on harm reduction, communication and tips on how to cope. We do this by encouraging self-care, improving communication, setting workable boundaries, providing education and preventing negative outcomes such as bullying, violence etc. We empower families, by harnessing their collective wisdom and experience in regards to their family and situation.

Living with others and a higher quality of life

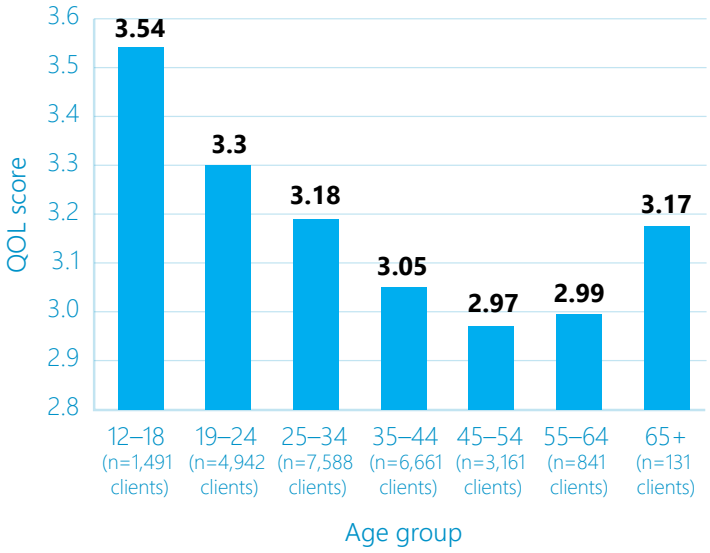
Sue Hailstone and **Resli Büchel,** NADA

Since the introduction of COMS (our Client Outcomes Management System) in 2010, NADA has been recording quality of life (QOL) data as collected by you, our member services. During that time, 24,445 of your clients have answered questions about how they rate their health, relationships, finances and living conditions.* This means that we now have almost a decade of data from 41 non government services and 124 different treatment programs, giving us an interesting picture of client's perceptions of their QOL as they enter AOD treatment.

As those of you performing regular client intake will know, quality of life data is collected and organised using the EUROHIS-QOL 8-item Index tool—a series of eight questions to which clients respond on a 'likert' scale (i.e. 'very dissatisfied', 'dissatisfied', 'neither satisfied or dissatisfied', 'satisfied', or 'very satisfied'). The responses are then given a numerical value from one to five, and a total quality of life score is calculated.

The highest satisfaction scores were reported by clients in response to the 'ability to do the tasks of everyday living' and 'satisfaction with living place' questions. The lowest reported satisfaction scores related to the questions about 'having enough money to meet need' and clients 'satisfaction with self'.

Overall, younger clients aged 12–24 years reported highest levels of satisfaction with quality of life while clients aged 45–54 years reported the lowest levels of satisfaction with quality of life. Scores for satisfaction with quality of life then begin to rise again as clients age.



Average score client perception QOL (Q1) at intake by age, non government AOD services, NSW, 9 Apr 2010-5 Aug 2019.

Consistent with existing research into the social determinants of health[1], our data reflects the relationship between health outcomes and lifestyle factors. Clients living alone at intake reported the lowest average scores for six of the eight EUROHIS-QOL questions. This included 'overall perception of quality of life', 'satisfaction with health', 'energy everyday life', 'ability to do daily living activities', 'satisfaction with self', and 'satisfaction with personal relationships'.

Other notable differences in the QOL scores of NADA member services include:

Higher QOL scores for:

- male clients
- Indigenous clients
- clients receiving community based treatment
- clients who identify their principle drug as nicotine, cocaine, or cannabinoids
- clients who are employed or who are dependent on others for income
- live with others.

Lower QOL scores for:

- female clients
- non-Indigenous clients
- clients in residential treatment
- clients who identify their principle drug as benzodiazpeines or methadone
- client's receiving pensions or temporary benefits
- live alone.

* Based on the EUROHIS-QOL 8-item Index tool

Living with others and a higher quality of life

continued

It is important to remember that this data is self-reported and reflects client QOL in the two weeks prior to intake. This means we're looking at a static landscape i.e. an individual client's perception of them self at one point in time, and not a change over time. The analysis is descriptive. It does not consider other outcome measures in NADAbase such as severity of substance dependence or psychological distress. We have not compared the characteristics of clients who completed the E-QOL to all clients in NADAbase who did not complete the E-QOL.

EUROHIS-QOL 8-item Index questionnaire

1. How would you rate your quality of life?
2. How satisfied are you with your health?
3. Do you have enough energy for everyday life?
4. How satisfied are you with your ability to perform your daily living activities?
5. How satisfied are you with yourself?
6. How satisfied are you with your personal relationships?
7. Have you enough money to meet your needs?
8. How satisfied are you with the conditions of your living place?

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Support for parents

with kids in the child protection system

Michelle Ridley NADA

Many clients engaged in AOD treatment services have experienced the trauma of being removed from their parent's care and/or have had their children removed from their care. When children are in long term out-of -home care (OOHC), contact can become infrequent, which causes a great deal of distress for the parents and families.[1] Parents often feel angry and distrustful of the system and struggle to deal with the loss.[2]

Unfortunately, it's not uncommon for parents whose children are in OOHC to be denied access to family and parenting services, which in turn increases the risk of any future children being removed. These parents are also directed to attend mainstream parenting courses with other parents whose children are still living with them, and that often require the parents to complete homework with their children before the next session. It's unsurprising that research has shown that mainstream programs are not suitable for parents whose children are no longer in their care.[3]

My kids and me

Developed by CatholicCare, My Kids and Me is a seven-week course for parents with children in long term OHHC, or who have Family and Community Services (FACS) involvement and restoration as part of the case plan. Parents participating in the program reported that it was helpful to be part of a group with others who share the same experience of having their children removed.[4] They said the program was motivating, educational and that they felt supported for the first time.[5] The program enabled them to express their feelings of loss and anger in a safe and contained way.[6]

Always mum

Always Mum, created by Lou's Place, builds upon the My Kids and Me parenting course with three extra sessions tailored specifically for mothers around self-care and domestic violence. These sessions focus on connecting with children, giving the mums an opportunity to record or write a story for their children and have professional photographs taken to share with their kids.

'One of the key components of the program is the advocacy. Our service engages with FACS/non government child protection services and helps mothers to understand and navigate the child protection system,' says Lou's Place manager, Nicole Yade.

'Many haven't been able to speak from the heart with other women who have similar experiences, about the stigma and shame of what has happened, and importantly, how they have started to heal as well.'

Practice tips

- For parents who have kids in OOHC, explore a referral to My Kids and Me. CatholicCare and Interrelate run My Kids and Me across NSW. Or for Always Mum, contact Lou's Place.
- Talk with the parents to understand their child protection concerns. If you're unsure why child protection is involved, try organising a meeting with your service, FACS and the parents. Or request to attend a group supervision [PDF] session that FACS facilitate to discuss the family's case. Working with child protection can be challenging, but as difficult as it may be, it is best to understand the system and work together to support our clients.
- Support is available for children and young people (e.g. counselling, play-therapy services, peer support and mentoring programs) to make sense of their experience, process any trauma and learn healthy coping strategies. Contact Family Referral Service for advice.
- See Emerging Minds for online training and practical resources to help you in your work with children and families impacted by mental health issues and other healthcare needs.
- Look at the NADA factsheets and the NSW Women's Legal Service's booklets for practical advice for parents whose children have been removed [PDF] and for working with FACS [PDF].

For advice about working with child protection please email Michelle Ridley. References overleaf.

Working together

Ever heard of the saying 'the whole is greater than the sum of its parts'? This is the value of strong partnerships, one of the best ways to maximise on each other's strengths. Read on for two examples of partnerships working well in the AOD sector.

Two Aboriginal community controlled services

Western NSW PHN sought expressions of interest from organisations to partner and develop hubs to support Aboriginal people in rural and remote NSW. The aim of service delivery was to maximise the ability for general practitioners to manage AOD clients in their practice. Two of NADA's Aboriginal community controlled members—Weigelli Centre, Aboriginal Corporation and Orana Haven—won the tender.

Weigelli and Orana developed hubs in Parkes/Forbes, Bourke and Walgett. With decades of experience providing services to Aboriginal communities in the region, they knew that fly-in fly-out workers would not work. Instead, they employed local Aboriginal people in each community to draw on the local knowledge to address local issues.

What made the partnership work? Both services are strongly united. Both are Aboriginal community led, and use culture as the guiding principle of their model of care. They know what works for the Aboriginal people in the local region and share the desire to empower them, which is a great outcome for the whole community.

With thanks to Norm Henderson, Weigelli.

NADA, Family Drug Support and LHDs

By all accounts, NADA's Family Inclusive Practice workforce development project was a huge success. The workshops had an enormous reach, the evaluation feedback was overwhelming positive and there has been an impact on service delivery on follow up. The reason it worked so well was the partnership we formed with Family Drug Support (FDS) and the Local Health District (LHD) in each region.

Each partner had different, but complementary strengths. FDS, experts in supporting families and significant others, provided insights about the experiences of people supporting someone using AOD through their consumer volunteers. The LHDs have experience in providing AOD treatment in a clinical setting and shared their knowledge on how to navigate privacy and confidentiality. NADA increased the reach and engagement of the workshops by inviting members and a raft of partners from welfare, mental health and other social services.

What made the partnership work? The clear focus of the project, the commitment from those involved and the collective desire to improve support for families and significant others concerned about the substance use of someone they care for.

Programs for parents with kids in the child protection system

continued

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Translating research into practice

While different therapies come and go, the therapeutic alliance stays strong,

Dr Karen Hallam Director The Centre for Youth AOD Research and Policy, YSAS

Just as we see in the fashion world, trends come and go in the psychotherapeutic community. New approaches are developed, old methods are supported with new evidence and emerging paradigms are placed on pedestals for scrutiny or worship. Underlying all of these changes, the single greatest predictor of therapeutic outcomes remains constant—the therapeutic relationship.

Therapeutic alliance is the most robust predictor of treatment outcome and mediator of therapy change.[1,2] In my own undergraduate training we were reminded that despite therapeutic orientation the single greatest predictor of positive outcomes in therapy is how much the person seeking help feels heard, understood and supported by the therapist. This does not imply that therapeutic orientation is unimportant. Having a strong sense of therapeutic orientation helps therapists remain consistent, grounded and develop a strong voice.

Irvin Yalom described the important relationship in therapy as that of 'fellow travellers'.[3] When viewed this way the role of therapist is that of a guide, to walk alongside the person, not ahead and not behind on their life path. Our role is to gently point out obstacles that may fall in their way and note the times when similar obstacles seem to keep re-appearing. This stance is at the very foundation of a strengths based approach to wellbeing and resilience based frameworks. Importantly it also removes the 'us and them' of therapy which dehumanizes both people and the relationship between them. Dehumanization is a distressing yet prevalent experience for those engaged with both mental health and AOD services, an experience that leads to significantly poorer outcomes.[4]

An ever-present awareness of therapeutic alliance is often most important at the moments of intense distress when the person seeking help asks ‘have you lost someone to cancer?’ or ‘have you been divorced?’ or ‘have you suffered depression?’ Strangely these are the questions my students most fear. If we look beyond the superficial of the question and focus on the meaning the person is often asking ‘can you understand the depth/pain/intensity of my experience?’, ‘am I alone?’ and ‘will I be ok?’. All who are asked these questions should answer with honesty… but not your story. It does not take much for any of us to remember these universal feelings. Typically I will answer that I, like all who have lived a meaningful life have experienced pain/loss/fear, etc. Our job is then to acknowledge the feeling this causes inside and let them know that I hear their experience and ask them about their distress.

One of the rather beautiful quotes that most befits this discussion is from Carl Rogers who in the 1950s was one of the founders of the client centred therapy and humanistic movements. Rogers remarked:

> Hearing has consequences. When I truly hear a person and the meanings that are important to him at that moment, hearing not simply his words, but him, and when I let him know that I have heard his own private personal meanings, many things happen. There is first of all a grateful look. He feels released. He wants to tell me more about his world. He surges forth in a new sense of freedom. He becomes more open to the process of change. I have often noticed that the more deeply I hear the meanings of the person, the more there is that happens. Almost always, when a person realize he has been deeply heard, his eyes moisten. I think in some real sense he is weeping for joy. It is as though he were saying, 'Thank God, somebody heard me. Someone knows what it's like to be me.'[5]

The notion of being heard, truly heard by someone who is there as a support is the very foundation of the therapeutic encounter. It is interesting to note here that the therapist retelling their own specific experiences is in no way necessary to support this growth as it unnecessarily moves the focus to the therapist and their experience.

The notion of being heard, truly heard by someone who is there as a support is the very foundation of the therapeutic encounter.

Rogers describes three central tenets of client centred therapy which directly relate to the formation and maintenance of a strong therapeutic alliance. These elements include empathy, unconditional positive regard and congruence. Whilst empathy and positive self-regard are somewhat clear to most, there is some lack of clarity over what congruence means in therapy. Lietaer indicates therapeutic congruence may include a reflection of one’s

Translating research and policy into practice

continued

own internal experience and then the willingness to communicate to the other this sense.[6] When considering this authenticity, Yalom again highlights the conditions necessary for disclosure to be appropriate.[7] On the broadest level, disclosure about the therapists observations and reflections of the individual's behaviour are helpful (remember the pointing out obstacles on the path). The advantages of the 'here and now' discussion include that it is immediate feedback creating a dynamic place where people can test new styles and make different choices and that accurate (not second hand) data is available. In turn, this talk deepens therapeutic alliance.

On the opposite end, personal self-disclosure (whether details about one's personal life or one's own struggles with mental health or substance issues) needs very careful consideration and would generally be advised against. Evidence indicate this type of disclosure does not add to therapeutic outcomes and may contribute to changes in how the individual sees the therapist, compromises how the individual sees the roles of therapy and reduce perception of therapist credibility and competence.[8]

Overall, the evidence is clear that fostering a strong therapeutic alliance is one of the key determinants of good outcomes for people seeking support. The approach taken should be consistent within the therapist but the effectiveness of the approach itself may reflect the personal preference of modality. In contrast, a strong working relationship is essential and should include empathy, regard and authenticity in sharing with the individual important observations of the obstacles and challenges they are facing. When walking alongside people willing to share their story and experience, it is a constant privilege to be welcome into their lives.

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Do you have something to share

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

Email an expression of interest to Sharon Lee.

WE ASKED YOU

How do you cultivate connections

Positive connections and support networks are important for all people. AOD services consider supporting clients to build connections and support networks vital to their treatment.

Richard Care Coordinator, CCC, St Vincent De Paul

Why is it important to support clients to build connections as part of their treatment? Building support networks can address the social isolation and minimize any stigma people might be experiencing because of their substance use.

Share an element of your program that helps with this. We run a SMART Recovery Group as part of the support available through the Continuing Coordinated Care program. The group provides an excellent forum for people to build a sense of belonging, by making peer connections in a safe and supportive space. Participants share information and experience regarding what has helped them in their recovery so far. They offer information regarding services they have used, whether that is rehabilitation, counselling, or case management type services, as well as their own personal experience of what recovery means to them. It is vital that opportunities exist to exchange information on connections and support networks by the people directly using them.

Troy Centre Manager, ONE80TC

Why is it important to support clients to build connections as part of their treatment? Clients have become used to connections and support whilst they're engaged in treatment so it is crucial that they continue these relationships so they don't feel overwhelmed or abandoned when the reality of life knocks on their door. Staying connected assists them in their treatment by having services help them navigate their challenges, develop their care plan, assist them wherever necessary and most importantly to help them move away from treatment services where possible.

Share an element of your program that helps with this. We hold a BBQ every three months for our clients to build external connections. We have an aftercare program that meets and talks with clients for at least six months after they leave the service and we also have an outreach program that provides free one-hour counselling sessions to clients who would like to continue working on their treatment post program.

Jonathan Manager, Glebe House

Why is it important to support clients to build connections as part of their treatment?
Many of our clients feel different, like they do not fit in. They feel they are 'against the world' with only their substance as an ally. They find it extremely difficult to connect, to ask for help. The 12-Step program suggests the 'addict' cannot fix themselves on their own, they need support and our program reinforces this in the concept of the Glebe House family. Men learn to reach out for support and also reach out to their peers in support. In some ways the program is about moving from a state of dependence on a substance to a state of interdependence as a proactive member of the Glebe House family and recovery community.

Share an element of your program that helps with this.
Every Tuesday, current residents host a spaghetti night where any former resident (if currently abstinent) can attend to eat dinner, socialise and network. Dinner is followed by a topic meeting, where all participants get to share. Any milestones are celebrated together and the men hang around for coffee afterwards. Up to 35 men attend this weekly event, which has been running for over 13 years. A safe, supportive space has been created over the years for men to open up, be vulnerable and talk about feelings (or just talk shit and laugh!). The evening epitomises the concept of connection and community which is a vital framework for recovery.

CRAFT

Michelle Campbell Group Manager Clinical Services NSW

The Community Reinforcement and Family Training (CRAFT), developed by Robert J Meyers, is designed for the family members and partners impacted by the use of AOD by someone they care about.

CRAFT aims to:

- help families to support the person using AOD to get the help they need
- help families to provide social support, promote positive behaviour change and have a positive impact on the substance use of the person they care about
- promote the health and wellbeing of families by reducing the negative impact their relative's substance use is having on their wellbeing.

CRAFT prioritises the emotional and social wellbeing of family and friends because these people are often as much at risk as the person who uses substances. It acknowledges that families can influence how their relative uses AOD. CRAFT also includes training to increase the knowledge and skills of families who are caring for a relative who is AOD dependent. This training ensures that families are better equipped to deal with issues as they may arise. Finally, CRAFT is designed to help improve outcomes for families who may also use AOD by helping them to reduce the negative effects of their own substance use.

A decision was made to implement CRAFT via the internationally recognised training and accreditation process within a rural AOD outreach setting, with support from a local Aboriginal Community Controlled Health Service. Supporting AOD counsellors to become accredited CRAFT therapists was central to this approach. This involved training sessions with accredited trainers and a process of fortnightly supervision with the trainer and ongoing assessment and rating of workers via audio recordings. The team leader had the ongoing role of supervision and training to ensure consistency of method.

Findings from research conducted about the program's implementation suggests that alcohol treatment approaches that simultaneously target individuals and families offer considerable potential to reduce these harms if they can be successfully tailored for routine delivery to indigenous Australians.[1]

Key recommendations by health care providers included:

- **modifying technical language** E.g. instead of 'Functional analysis', call the procedure a 'Road map'
- **reducing the number of sessions** Initially 12, but sessions were reduced to six
- **incorporating the option for groups sessions rather than individual** The content was modified to suit a group program

An Australian training manual was developed with the above adaptations.

Key recommendations by local Aboriginal community members were that:

- counsellors should be local people who were known and trusted by the community
- there was a preference for comprehensive rather than brief interventions
- treatment should focus on talking about alcohol related problems and skill acquisition
- follow up support should be provided.

The 'Community reinforcement approach' was used with individuals as well as with family members.

This approach showed a statistically significant reduction in the use of alcohol, tobacco, cannabis, amphetamine and over the counter medications, level of psychological distress, and an increase in levels of empowerment for Aboriginal and non-Aboriginal clients.[2]

The feasibility and acceptability were highly rated and there is justification for a large-scale randomised trial.

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Cognitive impairment

Antoinette Sedwell and Jo Lunn
Alcohol and Drug Cognitive Enhancement

It is common for people accessing AOD treatment to experience cognitive impairment. In fact, it affects 30–80% of people in treatment. The term 'cognitive impairment' refers to decreased functioning in one's ability to process thoughts. This includes learning new things, memorising or remembering information, concentrating, making plans and following through on decisions, and controlling or regulating behaviour.

What causes cognitive impairment?

There can be different causes of cognitive impairment, and there may be a combination of factors.

The points below outline the main causes of cognitive impairment for people who use substances. Not all people who have had these experiences will necessarily have cognitive impairment.

Alcohol and other drug use

Use of AOD can change the structure and the functioning of the brain. Cutting back or stopping taking these substances may return the brain to normal functioning.

Traumatic brain injury This is when there is a physical injury to the brain after a blow to the head, such as a car or motorbike accident, assault or fall.

Hypoxic brain injury This occurs when the brain does not get enough oxygen, such as overdose or stroke.

Childhood disorders Childhood disorders, such as dyslexia and attention deficit hyperactivity disorder can cause a person to struggle with reading, writing, attention, memory and higher level thinking.

What are the signs?

If your clients have ever experienced any of the problems listed above, they could have cognitive impairment.

Day-to-day signs of cognitive impairment include: being easily distracted, not understanding, forgetfulness, speaking too much and acting impulsively.

Strategies to help your client

Attention

- Avoid noisy, distracting environments when trying to concentrate on something important
- Complete one task, activity or conversation at a time
- Summarise what you have been told to make sure you have correctly understood what has been discussed

Memory

- Use devices including electronic devices to help tack information (e.g. smart phone with reminders for appointments)
- Set up daily/weekly routines that are written down or represented visually
- Have a place for essential belongings—put items back in the same place each time

Thinking

- Set up times to plan your day/week
- Write a list of what needs to be done and then number the tasks in order
- Use the PIE (plan-implement-evaluate) approach
  1. Plan your approach to a task
  2. Implement your plan
  3. Evaluate whether you achieved your desired outcome; if not, start PIE again

Alcohol and Drug Cognitive Enhancement

The Alcohol and Drug Cognitive Enhancement (ACE) program is a joint venture between the Agency for Clinical Innovation (ACI), We Help Ourselves and Advanced Neuropsychological Treatment Services. The aim of the ACE program is that all services in NSW working with clients who are seeking treatment for their substance use have access to the tools required to allow them to screen for and respond appropriately to cognitive impairment.

The ACI will shortly be releasing a package that will include:

- risk screening tool
- brief assessment tool
- brief intervention
- 12 hour cognitive remediation program
- training package to support implementation.

For more information, contact ACI Drug and Alcohol Manager, Antoinette Sedwell.

Co-occurring mental health and AOD issues

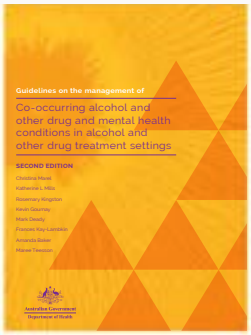
Christina Marel, Katherine L Mills and Erin Madden
The Matilda Centre for Research in Mental Health and Substance Use, University of Sydney

We know that more than one in three people with an AOD use disorder have at least one co-occurring mental disorder, and this rate is even higher for those in AOD treatment programs (up to three in four people). As such, AOD workers are often faced with the need to manage clients with complex, and sometimes challenging, psychiatric symptoms. People with co-occurring conditions often have a variety of other medical, family, and social problems (e.g. housing, employment, welfare, legal problems), and these issues accompany a person throughout their treatment.

Although there has been a recent increase in the amount of research to improve our understanding of how to best manage and treat people with co-occurring conditions, the translation of this evidence into practice has been limited and there have been few evidence based resources available to the AOD sector to improve the management of co-occurring conditions. AOD workers have reported feeling overwhelmed when treating people with co-occurring mental health disorders, due to lack of knowledge and confidence, and inadequate clinical resources. As such, we have been working with the sector to identify the best and most useful ways of developing and translating this evidence-based research to AOD workers.

Key strategies that appear to have some advantages over other approaches:

- **Providing coordinated care** (active engagement of other appropriate services and involving them in client care): Evidence has linked coordinated care with improved treatment outcomes, including prolonged client retention, increased treatment satisfaction, improved quality of life and increased use of community based services.
- **Treating the whole person, not their illness** Management and treatment approaches that can incorporate the whole person, and consider psychological, physical, and sociodemographic perspectives will be better able to provide complete, individualised care, and achieve improved outcomes.
- **Integrated care** (AOD use and mental health condition are treated simultaneously by same provider/service): Although there is no conclusive evidence, integrated treatment has several advantages over other approaches and there is increasing evidence to support this approach.
- **Worker self-care** Making sure AOD workers take the time for self-care can reduce psychological responses to client trauma, reduce the risk of burnout and stress, and increase the capacity to respond to workplace situations.



National co-morbidity guidelines

The *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings* were developed specifically for AOD workers, in collaboration with workers, clinicians, consumers, carers and families, and researchers. Based on the best available research evidence, they have been accompanied by an online training program to support uptake into practice. They aim to increase knowledge and awareness of co-occurring conditions, improve confidence and skills of AOD workers, increase the uptake of evidence-based care, and ultimately, improve the outcomes for people with co-occurring mental health conditions.

Download this resource

Online training

We have had a lot of support from the AOD sector in producing these resources and the feedback has also been positive. We've been conducting an evaluation of the online training program, and although we are still going through the results, the early findings are very positive. More than 90% of program users reported an increase in knowledge, skills and confidence, more than 80% reported referring to program content to assist with clinical decision-making, and more than 60% reported use of the guidelines led to improved client outcomes.

Take the training

Useful resources

Treatment works

AOD treatment works and we have all of our NADA members to thank for the promotion and delivery of evidence based practices.

Women in AOD treatment

Working with women engaged in alcohol and other drug treatment

This resource supports the provision of best practice interventions for women accessing AOD treatment and to effect organisational change around becoming gender responsive, family inclusive and trauma informed.

Supporting families and significant others

Tools for change: A new way of working with families and carers

This resource aims to improve the support offered to the families and carers of clients with co-existing mental health and AOD problems that are accessing non government drug and alcohol services.

Supporting people from LGBTIQ communities

ACON are leaders in the provision of health care for the LGBTIQ community, and NADA has been fortunate to support them on a number of projects including those listed below:

- AOD guidelines for working with LGBTIQ communities
- Pivot Point
- eLearning: Asking the question about gender diversity and sexual orientation

Young people in treatment

Stockings, E., Hall, W. D., Lynskey, M., Morley, K. I., Reavley, N., Strang, J., ... and Degenhardt, L. (2016). **Prevention, early intervention, harm reduction, and treatment of substance use in young people**. *The Lancet Psychiatry*, 3(3), 280-296.

Meuman, N., Allan, J., and Snowdon, N. (2019). **A review of AOD interventions for young people.**

- Emotion regulation and impulse control (eRic)
- Dovetail good practice guides

Children who are impacted by substance use

Dawe, S., Harnett, P. and Frye, S. (2008). **Improving outcomes for children living in families with parental substance misuse: What do we know and what should we do** Download PDF

- NSW Communities and Justice: Working with children whose parents use substances

Aboriginal and Torres Strait Islander clients

- Australian Indigenous Health InfoNet
- **New review says strong connection to country and community can help reduce methamphetamine use by Aboriginal and Torres Strait Islander people** Read more
- Social, emotional and cultural wellbeing Read more

Improve the therapeutic alliance

Brattland, H., Koksvik, J. M., Burkeland, O., Klöckner, C. A., Lara-Cabrera, M. L., Miller, S. D., Wampold, B., Ryum, T., and Iversen, V. C. (2019). **Does the working alliance mediate the effect of routine outcome monitoring (ROM) and alliance feedback on psychotherapy outcomes? A secondary analysis from a randomized clinical trial.** *Journal of Counseling Psychology.* Advance online publication. http://dx.doi.org/10.1037/cou0000320

Brattland et al. (2018). **The effects of routine outcome monitoring (ROM) on therapy outcomes in the course of an implementation process: A randomized clinical trial.** *Journal of Counseling Psychology*, 2018, Vol. 65, No. 5, 641–652 http://dx.doi.org/10.1037/cou0000286

Clients with complex needs including mental health

- Complex needs capable
- Comorbidity guidelines

Worker wellbeing

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

AOD national workforce survey

National Centre for Education and Training on Addiction

Your sector, your say—NCETA invites you to have your say, share your views and experiences.

It's been over 10 years since there has been a national survey of the AOD workforce, in which AOD workers voiced their views, experiences and perspective on working in the AOD sector in Australia. Evidence based policy, practices, programs and funding require good quality workforce data and information.

The 2019 'AOD national workforce survey' is an opportunity for AOD workers to share your views. The survey is being conducted by the National Centre for Education and Training on Addiction (NCETA), Flinders University. The results of the survey will help inform and influence workforce development priorities and initiatives in your sector and organisations.

All workers in the AOD sector are invited to participate, including those in client service, management, project, administration and other roles. Tell us what you do, how you experience your work, how this affects your job satisfaction and wellbeing, and what your professional developments needs are.

This national survey will provide consistent information and insights for the AOD sector Australia-wide. It compliments various workforce surveys that are conducted independently in each state/territory.

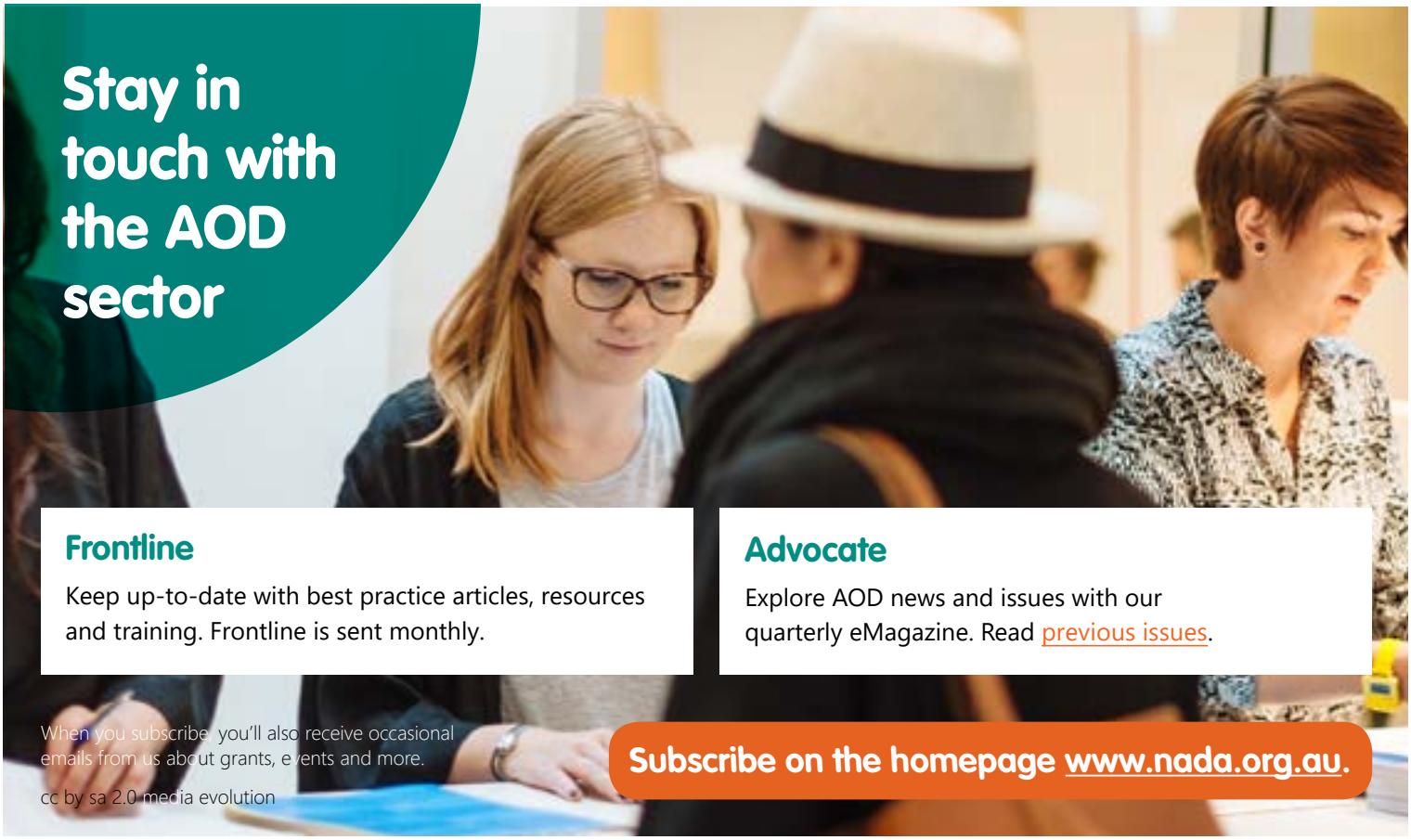
NCETA invites you to participate in the anonymous online survey, which will take about 15–20 minutes to complete. The survey is open until **31 October 2019**.

All participants who complete the survey will go into a draw to win an iPad mini. Please feel free to forward this information and encourage your colleagues and work mates to participate.

Take the survey

The 'AOD national workforce survey' is funded by the Australian Government Department of Health.

For more information about the survey contact the Project Manager Dr Natalie Skinner or go to the NCETA website.



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New long-acting depot formulation available in Australia

NSW Ministry of Health

The Therapeutic Goods Administration (TGA) in Australia has approved two long-acting injected depot buprenorphine medications: Buvidal™ and Sublocade™. The Buvidal™ product is now listed on the PBS. Increasing numbers of clients may present to your service who have received treatment with depot buprenorphine.

This formulation of buprenorphine is administered weekly or monthly

- Buvidal™ is a modified release formulation of buprenorphine which is administered via subcutaneous (SC) injection in *weekly* or *monthly* intervals
- Sublocade™ is an extended-release formulation of buprenorphine which is administered via subcutaneous injection in monthly intervals.

Depot BPN is released slowly, with a duration of effect of up to 20 weeks

Plasma concentrations of buprenorphine slowly reduce after the injection and may remain at therapeutic levels for up to 20 weeks, depending on dose and duration of treatment.

How do consumers access the new formulation?

For at least the first six months the product can only be prescribed by specialist prescribers attached to public Opioid Treatment clinics or hospitals, or in large volume private clinics with dispensing facilities. The TGA will review these restrictions in December.

Further information on depot buprenorphine is available

- The Ministry has published the NSW interim clinical guidelines for use of depot buprenorphine. Information will also be made available for non-AOD clinicians in settings such as emergency departments, pain clinics, maternity units and surgical units to alert them that their patients may have been treated with depot buprenorphine.
- Drug and Alcohol Specialist Advisory Service (DASAS) is a 24/7 free helpline that health professionals may use to contact Specialist medical consultants who can provide advice on diagnosis and management of patients with drug and alcohol issues. DASAS clinicians can also provide advice on any issues arising from Depot Buprenorphine that clinicians may encounter. Sydney metropolitan: (02) 9361 8006; Regional and rural NSW: 1800 023 687
- A consumer information leaflet is being developed in consultation with NUAA. This will support consumers to make informed decisions about treatment with depot buprenorphine.

NSW GOVERNMENT Health

For more information, see the NSW Health Depot Buprenorphine website.

LGBTIQ inclusive

HWEI SILVER SERVICE PROVIDER 2019

NADA was awarded a Silver Service Provider for the inaugural 2019 Health + Wellbeing Equality Index. The Health + Wellbeing Equality Index has been designed to assess and benchmark LGBTIQ inclusive service provision annually among Health + Wellbeing service providers. The award is a reflection of the work NADA has done to ensure that it is an LGBTIQ inclusive service, but also to support its members being more inclusive. This is important as LGBTIQ people have high-levels of drug use then the general population, as well as have more barriers accessing AOD treatment.

What's new

NADA recently partnered with ACON and CESPHN to develop the *AOD LGBTIQ inclusive guidelines for treatment providers*. Learn more.

Have you taken our eLearning course?

Asking the question: Recommended gender and sexuality indicators helps AOD workers and organisations to be LGBTIQ inclusive, by providing guidance on gender and sexuality indicators that can be implemented to meet the specific needs of all clients. Learn online.

pride in health + wellbeing

Peer and clinical partnerships Improving access to hep C cure

Hepatitis NSW

Pictured (l-r): Sinead (nurse) and John (peer)

New effective medications mean curing hep C is now easier than ever. However, access to treatment isn't that easy for everyone and there are unique challenges faced by people from priority populations. Live Hep C Free is Hepatitis NSW's peer-based program making hep C healthcare as simple as possible.

Increasing the uptake of cure and related healthcare requires making hep C testing and treatment accessible and immediate. Live Hep C Free partners hepatology nurses with experienced, trained, and paid peer workers based at methadone clinics, homelessness services, residential rehabs, and other similar settings. The program creates access to hep C healthcare where it might not otherwise exist by taking healthcare to people and with the peer worker providing a supportive bridge to on-site healthcare.

Currently, the standard hep C healthcare model is at least 14 steps, from initiation to cure, including GP appointments, blood tests and Fibroscans. Live Hep C Free pares this process down to six steps by meeting people where they're at with the healthcare they need.

We have 24 peers across NSW with capacity for peer support in every Local Health District. Out of 124 peer visits to services this last year, over 2,200 people were engaged about hep C testing and treatment. One third of those engagements led to the person visiting the nurse, with 169 people starting hepatitis C treatment and 303 referred on for further healthcare. The long-term aim of the program is service-based micro-elimination of hepatitis C.

More info: 1800 803 990

The Live Hep C Free program is a collaborative partnership between the peer and the clinical, using both of their expertise to meet hep C healthcare needs of clients.

Smart Track app

SMART Recovery Australia in conjunction with the University of Wollongong has launched Smart Track, an app that helps people manage and overcome AOD dependence. The app allows users to log their urges, set goals, track their progress and access helpful resources.

Like SMART Recovery meetings, the app gives users the power to design their own recovery journey through establishing personalised goals and sources of motivation. App users can also track and monitor their cravings while receiving real-time feedback and progress reports.

SMART Track forms part of a research project to examine use of an online routine outcome monitoring tool which involves real-time feedback being provided to participants whilst attending SMART Recovery groups.

SMART Recovery participants interested in taking part in the trial can visit: smartrecoveryaustralia.com.au/smart-track-app.

Digital time capsule

I cherish every moment of my recovery. Yet when I was once reflecting on a milestone, I realised I had no record of what I was like. What was I thinking? How was I feeling? So, I decided to create a video message to my future self. I recorded my hopes, dreams and aspirations.

Working as a case manager at Glebe House, I've recorded over 100 videos for clients. Clients recorded messages of care to their future selves, and set goals with a time frame to help them achieve them.

I created the web platform Encapsulator to build upon this idea. Clients can create an account and:

- create a digital time capsule: record a video, select a 'lock date' and upload
- update their time capsule around significant milestones e.g. six months post admission.

Glebe House has integrated Encapsulator into their case management program. To learn how Encapsulator can be tailored into your model of support, please email admin@encapsulator.io.

NADAbase update

Tata de Jesus NADA

Changes to AODTS NMDS data collection

The Australian Institute of Health and Welfare (AIHW) have now released the AODTS NMDS data collection manual for FY2019–2021. These changes will *impact services funded by PHNs or Commonwealth ONLY.* The following changes are implemented as of 1 July 2019:

Main treatment type

- 'Support and case management only' will now change to 'support and case management'
- 'Information and education only' will now change to 'information and education'

Rationale: The removal of the word 'only' from 'support and case management' and 'information and education' will allow agencies to report and more accurately capture the additional treatment types used in conjunction with these two treatment types.

Other treatment type

- 'Support and case management' and 'information and education' now included in 'other treatment type' options

Rationale: The inclusion of the two treatment types in 'other treatment type' will allow agencies to better reflect and record the current use of these treatment types in services.

Treatment delivery setting for AOD

- Revised description of 'outreach' (Code 4): This code refers to an outreach environment, excluding a client's home or usual place of residence, where treatment is provided. An outreach environment may be any public or private location that is not covered by Codes 1–3. Mobile/outreach AOD treatment service providers would usually provide treatment within this setting (e.g. a mutually agreed public space).

Rationale: The inclusion of an example of an outreach setting has been added to the current description to help clarify and further improve coding and reporting for treatment setting.

Read more information on AIHW 2019–20 data collection and submission information.

New child question

In July 2019, NADA introduced a question in NADAbase around children in the care of clients. The introduction of this question is to:

1. enhance client case planning and holistic care
2. increase our evidence base of clients experiencing these situations.

Data is stored securely as with all other NADAbase data, and only used by NADA for the purposes of advocating for increased support for member organisations around the provision of holistic client treatment.

New dashboards and updated reports

Also in July, NADA launched the new NADAbase dashboards. The dashboards display an overview of a service's activity and data quality, and has increased flexibility for cross sectional data analysis. Changes to the reports section were also made for easier data extraction and analysis.

To support members, NADA arranged two webinars in July and August that explored dashboard functionality. View the online tutorial.

What's in store?

- Updating the online NADAbase tutorials
- Factsheets for data collection
- New NADAbase workplan

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.

Clinical care standards for AOD treatment

NSW Ministry of Health

The Clinical Care Standards (CCS) for AOD Treatment are due to be launched by December 2019. They have been co-developed with senior clinicians and staff from NSW Local Health Districts, NGO service providers, NADA, Ministry of Health stakeholders, and AOD consumer workers.

The Clinical Outcome and Quality Indicator (COQI) project team developed the AOD Treatment CCS as part of their broader aim to develop a mechanism to describe the quality and outcomes of treatment. Two key questions were asked:

1. 'Is treatment delivered well?
2. 'Do consumers achieve good clinical outcomes?'

The AOD Clinical Care Standards aims to:

- articulate the core processes of care (*diagram below*), and describe key elements related to the delivery of care at each point of delivery
- outline what the standards mean for consumers, clinicians and health service providers
- provide a benchmark for measuring the current level of delivery of AOD treatment in relation to the standards and to inform the development of clinical analytics solutions to measure this
- guide and support future quality improvement activities
- design a workforce development strategy and clinical competency framework for AOD treatment delivery.

The standards are linked to the core treatment processes as developed and refined by the COQI Project. The CCS describe the foundational elements and processes of care that underpin practices in all AOD treatment services.

Services can use these standards to ensure appropriate information is gathered to support clinical decision making. The CCS can be targeted to all AOD service types and locations however they do not identify specific interventions used in treatment.

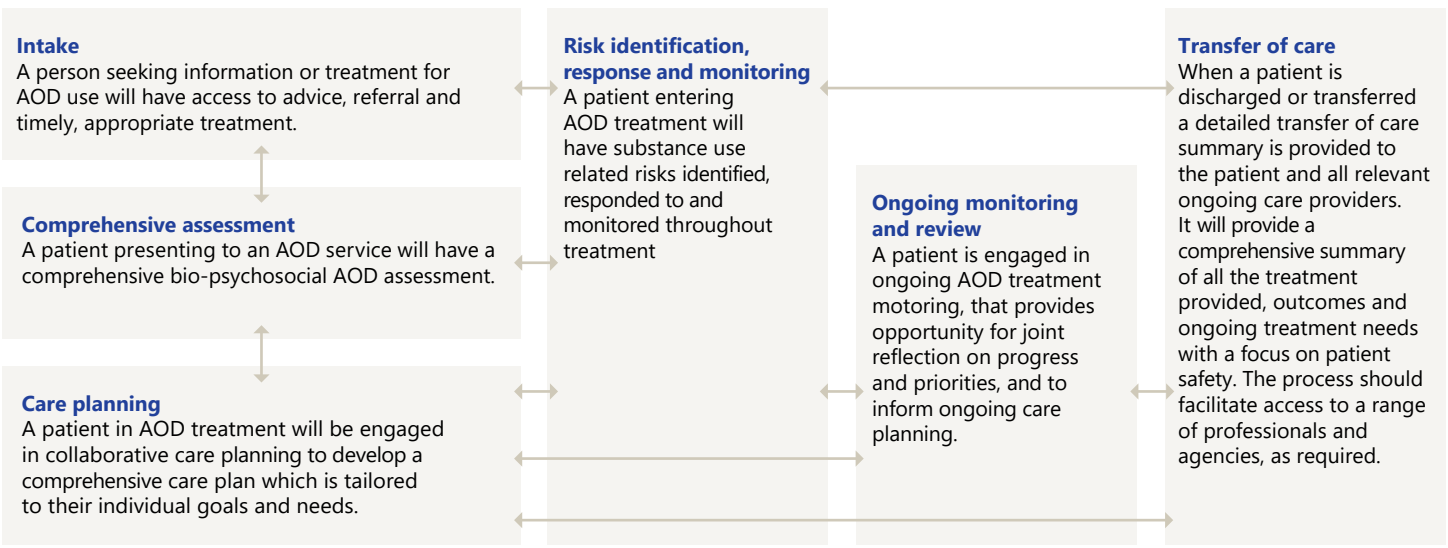
The standards in action

Accompanying each CCS is a *suggested standard measure* to help health providers understand how well they have implemented the care described in the CCS. *The measures are not a set of targets or mandatory indicators for performance management*, rather a tool for quality improvement which can be integrated into your existing quality work plan.

Clinical accountability linked to	• Accreditation • Clinical governance • Local protocols • Systems of CQI
Interventions guided by	• Professional training • Clinical guidelines • Best practice • Models of care • Decision support systems
Clinical care standards foundation	• Intake • Comprehensive assessment • Care planning • Identifying and monitoring risk • Ongoing monitoring and review • Transfer of care

The suggested standard measures will support the implementation of the CCS and can assist in quality improvement initiatives at a service level.

Services will have full access to the standards via the NSW Health website once they are launched. To learn more, please email Tonina Harvey.



Profile

NADA staff member

Resli Büchel
Senior Project Officer

How long have you been associated with NADA?

After briefly acting as a consumer representative on a couple of NADA projects, I started working as senior project officer for the organisation in July.

What experiences do you bring to NADA?

I have been in the AOD sector for about ten years, in a variety of clinical and advocacy related roles. Most recently, I worked for the Medically Supervised Injecting Centre in Kings Cross. However, I originally trained as an emergency department nurse and studied medicine. I also have extensive experience working in health promotion and as a medical writer and journalist, but it is my lived experience that led me to AOD work and makes me passionate and motivated to support and develop the sector and improve treatment outcomes for individuals.

What NADA activities are you currently working on?

In my new role, I will be providing support to the NADA AOD Service Networks (Women's, Youth and ADARRN), as well as coordinating the development of NADA's Reconciliation Action Plan. I'm on the organising committee for the upcoming NADA Conference, scheduled for 4–5 June 2020 and I'm also currently finalising an updated version of the NADA Policy Toolkit which will be available on the website soon.

What is the most interesting part of your role?

I am loving visiting our amazing AOD services and getting to know NADA members. It is really great to work with so many skilled and like-minded AOD professionals and I feel privileged to be in the position to support and advocate for clients, services and the sector. I also very enthusiastic about research and developing a strong evidence base for clinical AOD practice.

What else are you currently involved in?

As the mother of a two-year-old, I spend a lot of my spare time watching Peppa Pig and The Wiggles. When I'm not toddler-wrangling, I am continuing my MPH studies and I'm planning a trip to visit my sister in Los Angeles next year.

A day in the life of...

Sector worker profile

Jo Beavan Care Coordinator, SVDP
Continuing Coordinated Care Program

How long have you been working with your organisation?

I joined St Vincent de Paul's Mary MacKillop outreach team as a caseworker in 2017.

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

I began as a property manager in a private practice. I progressed to FACS Housing NSW working in various roles, including homelessness support. Working with vulnerable people helped me to move into the mental health sector, and from there I worked with youth in crisis care and disabilities which lead me to my current role.

What does an average work day involve for you?

I link my clients into services that help them to become empowered and work towards their life goals. Any given day can be about getting basic needs, like food and essential services, helping with housing, court support, health and wellbeing, and any other presenting issue impacting their quality of life.

What is the best thing about your job?

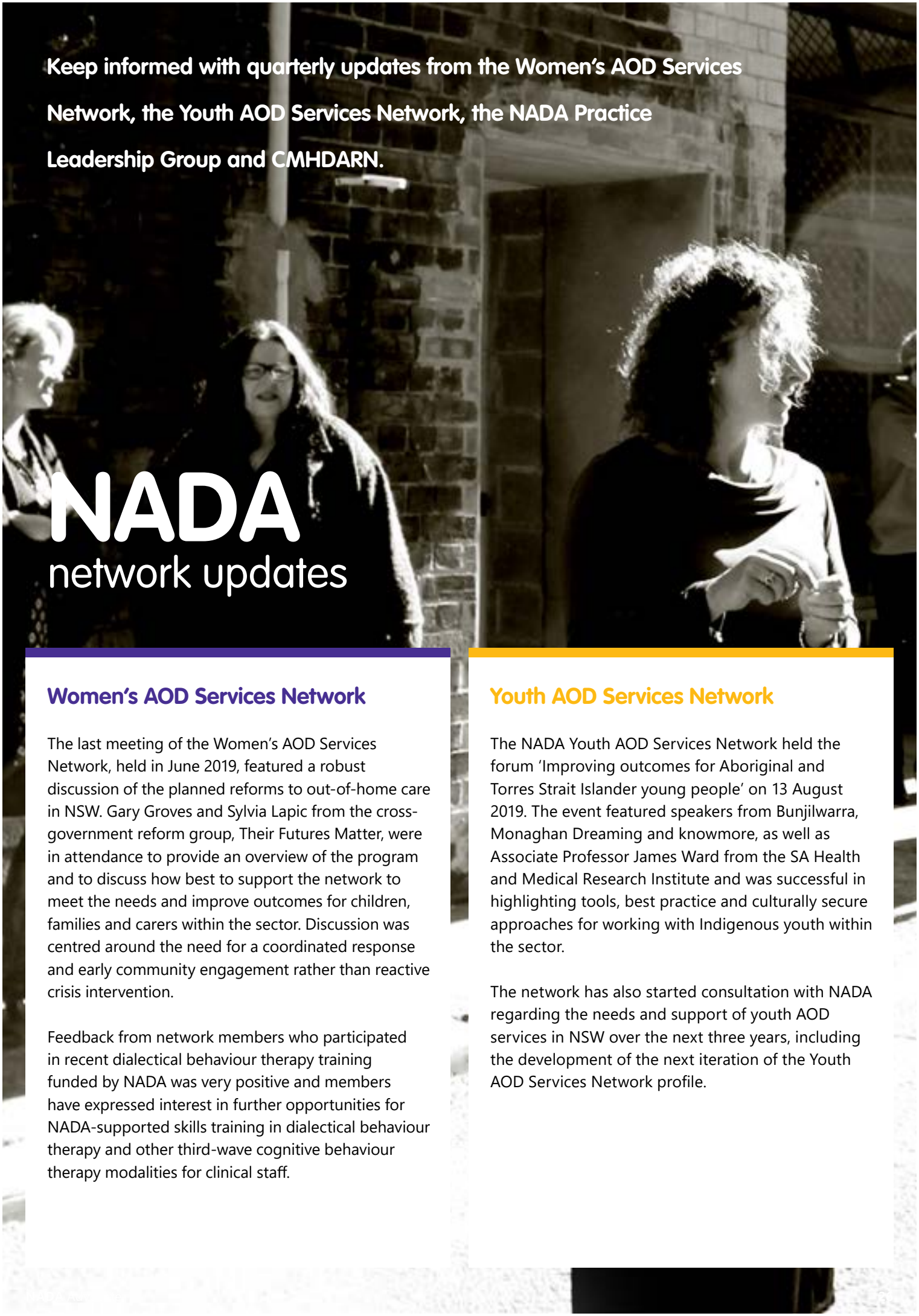
Walking alongside clients on their journey of minimising or abstaining from AOD misuse. Providing support during the highs and the lows until they can find strength and progress on their own.

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

I would like to see brokerage support for fees incurred by clients staying in resi rehab. So often clients state they 'want to get clean but can't afford to pay both rehab and their rent'. The reality of committing to rehab often places them at risk of homelessness and therefore the cycle of poor mental health and substance dependence is a reoccurring problem. Change will only occur if the issue is addressed with an 'end to end' seamless approach by all stakeholders.

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

I play netball and softball. I have a close relationship with my family and pets and I often debrief with my colleagues. I love to watch movies at the cinema.



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

NADA network updates

Women's AOD Services Network

The last meeting of the Women's AOD Services Network, held in June 2019, featured a robust discussion of the planned reforms to out-of-home care in NSW. Gary Groves and Sylvia Lapic from the cross-government reform group, Their Futures Matter, were in attendance to provide an overview of the program and to discuss how best to support the network to meet the needs and improve outcomes for children, families and carers within the sector. Discussion was centred around the need for a coordinated response and early community engagement rather than reactive crisis intervention.

Feedback from network members who participated in recent dialectical behaviour therapy training funded by NADA was very positive and members have expressed interest in further opportunities for NADA-supported skills training in dialectical behaviour therapy and other third-wave cognitive behaviour therapy modalities for clinical staff.

Youth AOD Services Network

The NADA Youth AOD Services Network held the forum 'Improving outcomes for Aboriginal and Torres Strait Islander young people' on 13 August 2019. The event featured speakers from Bunjilwarra, Monaghan Dreaming and knowmore, as well as Associate Professor James Ward from the SA Health and Medical Research Institute and was successful in highlighting tools, best practice and culturally secure approaches for working with Indigenous youth within the sector.

The network has also started consultation with NADA regarding the needs and support of youth AOD services in NSW over the next three years, including the development of the next iteration of the Youth AOD Services Network profile.

NADA network updates
continued

NADA Practice Leadership Group

The NADA Practice Leadership Group met in June 2019 to finalise the action plan for 2018–2020.

Highlighted at the meeting and in the plan, the NPLG:

- emphasise the importance of the consumer voice and the necessity of embedding consumer participation in all areas of clinical practice and therapeutic work
- support the recent Cognitive Remediation study conducted by the ACI that shines a light on the importance of targeted intervention strategies for cognitive impaired clients
- seek to continue representing and advocating for the sector at Quality in Treatment meetings.

The NPLG is helping to shape the NADA Conference in 2020, and is looking to focus on inclusive practice with future thought to innovation.

We would like to thank Jesse Taylor and Jessica Burgess who stepped down from their positions in the NPLG and wish them all the best in their future plans.

CMHDARN

CMHDARN are excited to announce we have awarded the inaugural CMHDARN Innovation and Evaluation Grant 2019–2020 to the Sydney Drug Education and Counselling Centre (SDECC). This grant provides SDECC with the opportunity to undertake research on the topic of 'What are experience and outcome measures telling us about the services we deliver?' We look forward to supporting and facilitating this exciting project!

Do you want to conduct research in your service but don't know how? Would you like support? Would you like to develop new research skills? Mentoring for a period of up to six months is available. The CMHDARN Community Research Mentoring program will link you with an academic who has expertise in the area related to your questions/ideas to form a mentoring relationship. Apply now [PDF].

CMHDARN
Community Mental Health, Drug & Alcohol
RESEARCH NETWORK

Member profile

Phoebe House

Service overview

Founded in 1984 by a group of young, independent and motivated women, Phoebe House provides a safe and supportive environment for women and children who may be experiencing difficulties with AOD. Our evidence based, AOD rehabilitation program focuses on women who may be on opioid treatment and who have children under the age five in their care, or partial care. We promote their self-determination while embracing a holistic vision that involves their cultural identity, understanding parenting capacity, improving positive community and family engagement and addressing mental health needs and other life skills.

Our clients

Our nine women and their children range in culture, diversity and experience. To improve access to treatment, we are happy to admit women who are over 18 and from any part of Australia. We have also recently began working with women who are pregnant and on opioid treatment to support them and their children, during and post pregnancy.

Service highlights

The program provides individual in-house counselling and case management. Our staffed children's centre provides care for six children, four days a week. We link residents to external organisations to provide support with housing, Centrelink, FACS, court, health care and community development.

Program foundation

The program is *outcomes based*, whereby residents progress through five stages to achieve their own goals that align with recovery and wellbeing. The residents grow by engaging in community based activities, and reconnect with vital family networks.

Group therapy

We provide an evidence based group therapy program. Here, residents develop relapse prevention skills, train in emotion regulation and behaviour management. They improve their self-esteem, parenting skills and better understand the impact of drug use on their lives.

Safety management

Derived from the concept of harm minimisation, our safety management framework encourages a culture of resident responsibility and honesty. This allows for effective engagement in individual management plans and regular progress reviews that influence their long term recovery.

Community engagement

We foster residents' responsible and healthy participation in self-identified, drug free, community based activities. Our Community Engagement Program promotes recovery learning and development of better attachments between the resident and their family.

Our staff

Our team of 10 highly passionate women share their diverse knowledge, wisdom and experience. They are tertiary trained in social work, psychology, early childhood education, mental health, family violence and AOD work.

A seven-person board of governance steer our strategic direction and ensure our financial viability.

Contacts

We are located in the Bayside Council area near Sydney Airport. We respectfully request our location be kept private.

Phoebe House

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E rebecca@phoebehouse.org.au
W www.phoebehouse.org.au

A new beginning

Aboriginal Drug and Alcohol Residential Rehabilitation Network

The ADARRN Group was established in 2019 by a group of like-minded Aboriginal community controlled organisations who run residential rehabilitation centres. The members of the group were formally part of NARHDAN supported under the umbrella of the Aboriginal Health and Medical Research Council (AH&MRC) but didn't really fit as the focus for AH&MRC is primary health care.

In discussions with the AH&MRC, NARHDAN decided to incorporate, became ADARRN and will be looking to position itself as the 'peak body for Aboriginal drug and alcohol services'.

The key objectives for ADARRN include:

- enhancing the long-term viability and operational performance of its members so that Aboriginal people who are affected by AOD issues can be efficiently and effectively rehabilitated and healed in residential facilities operated by ADARRN's members
- supporting and advising Aboriginal families and communities in dealing with issues they face themselves because of those faced by members of their families and communities affected by AOD issues, including where housed in Aboriginal community controlled residential rehabilitation and healing centres
- to advocate for its members and Aboriginal community controlled residential rehabilitation and healing centres in general.

There are many additional areas of Aboriginal health and wellbeing that ADARRN intend focusing on and the group is keen to be a resource of advocacy and knowledge to promote the contribution of Aboriginal community controlled organisations in the specialist AOD sector.

NADA is in full support of ADARRN's endeavours and will work to support and promote their work into the future.

AOD and child focussed practice

The Emerging Minds: National Workforce Centre for Child Mental Health (NWC) develops free innovative online training, implementation and practice support tools and information, webinars, podcasts, toolkits and other resources for professionals working in the health, community and social sectors. Their team of child mental health consultants can also work with organisations to connect, implement and enhance these resources.

The team at the NWC are currently developing a series of resources for the AOD sector to support child focussed practice, including a suite of e-learning courses which will be released at the end of September: AOD and child focussed practice.

The courses will consist of a foundation course and two modules all of which can be worked through at the learner's own pace. It will also contain links to practical guides for having conversations with parents (including pregnant women) to support children's social and emotional wellbeing whilst also working on parental substance use issues.

The courses and additional resources were developed in consultation with people with lived experience; with AOD practitioners and other professionals including maternal health specialists and through literature reviews.

Who is the course for?

- Specialist AOD practitioners within government and non-government organisations
- Generalist practitioners who work in adult-focused services and who engage with parent-clients who experience issues with substance use

To be notified of the course release please sign up to their eNews for monthly updates, and also feel free to circulate this amongst your networks or follow the NWC on Facebook, LinkedIn and Twitter.

Diversity of representation

Voting at NADA's annual general meeting

This year's annual general meeting, on 18 November, is a voting year. Many of you will remember the recent special general meeting where the proposition to change the Constitution to remove the current two term limitation on board members holding office was voted on in the negative. That is, the stipulation on board members not holding office for more than two consecutive terms was not amended and stays in place.

This means all current board members, except for three, will not be able to renominate for election. Therefore, most of the board members who are elected at the AGM will be new to the role. This is positive in terms of renewal of the board but brings with it some challenges.

I want to take this opportunity to discuss with you the importance reflecting the diversity of our membership, and more broadly, the issue of representation from the Aboriginal community controlled organisations, women's specialist services, CALD representation, LGBTIQ representation and consumer representation to name some of the range of diversity across our sector.

As the NADA CEO, I'm an employee of the organisation and in no position to influence the voting at the AGM, nor would I try to lecture the membership about who they should vote for. That process is codified in the NADA Constitution. But I would like to ask you to consider the issue of diversity in representation when you consider nominating for election, and especially when it comes time to vote for the candidates. I would also ask that members who are the organisational delegates for the AGM to discuss these issues within their services and with their boards or committees of management.

Having good representation of service types, geographic locations, population groups, gender balance and particularly Aboriginal, CALD and LGBTIQ representation can only be a good thing for the make up of the next NADA Board of Directors. This will help ensure a comprehensive representation of the non government AOD sector across NSW. I look forward to seeing you all at the November AGM and I and all NADA staff look forward to working with the new board. The next three years will be a dynamic period for our sector and together we can help move the AOD service delivery environment forward and keep innovation and excellence in service delivery at the forefront of everything we do.

We will send members nomination forms for election to the NADA Board of Directors in October.

Partners, friends and family

Most LGBTQ people who use AOD do so in a way that does not cause problems however some LGBTQ people experience significant harms related to AOD use. When it comes to seeking support for issues associated with AOD use, partners, friends and family members play a key role in helping LGBTQ individuals.

In recognising this, ACON has redeveloped their *Partners, friends and family* resource. This booklet is available in print, PDF and on the Pivot Point website. It aims to upskill LGBTQ friendship and peer networks to provide appropriate care for their loved one's experiencing AOD related issues. The resource provides practical information about how to be an effective support person and important advice on how to exercise self-care.

If you are service provider and you would like a printed copy of the resource mailed to your service, please contact aod@acon.org.au.

NADA Practice Leadership Group

Meet a member

Michele Campbell Group Manager Clinical Services NSW — Lives Lived Well

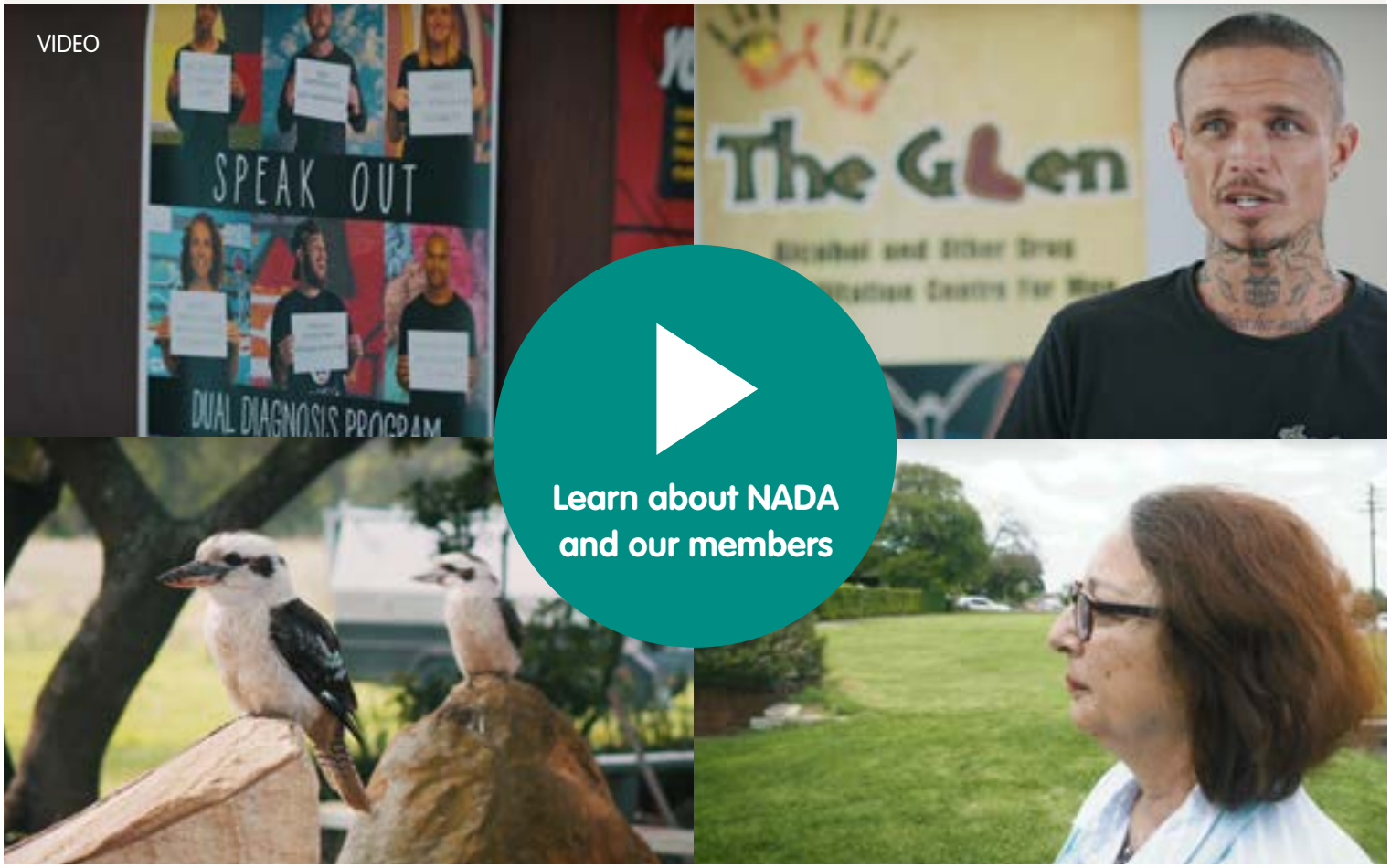
How long have you been working with your organisation? How long have you been a part of the NPLG?
I have worked with Lives Lived Well (formerly Lyndon) for 12 years and have been part of the NPLG since its inception.

What has the NPLG been working on lately?
The NPLG has been working on the 'Clinical withdrawal guidelines', standardising position descriptions across the sector, advocacy through the NADA Advocacy Sub-Committee and the 'Psychosocial guidelines'.

What are your areas of interest/experience—in terms of practice, clinical approaches and research?
These days it is around working with managers to improve practice outcomes and embedding evidence based practice in all our programs. Research around cognitive impairment is one area we are focussed on now. I have an interest in workforce development and leadership development.

What do you find works for you in terms of self-care?
Time out during the day, pilates, table tennis, spending time with family, horses, dogs, cats and riding motorbikes. I also schedule regular breaks, even a day out can recharge.

What support can you offer to NADA members in terms of advice?
I can advise on information from a rural and remote service delivery perspective, withdrawal management, leadership development and project management.



Learn at a time place and pace to suit you

NADA eLearning

Complex needs capable

Increase your awareness and confidence when working with clients with mild cognitive impairment and contact with the criminal justice system. This course was developed as an extension of the resource and website by the same name. Take this course to learn about:

- what we mean by complex needs
- cognitive impairment
- experiences of clients with criminal justice system involvement
- strategies to implement to better support clients.

Magistrates early referral into treatment

Take this module to brush up on MERIT! This program provides early referral into treatment at any time up to the first court appearance for eligible clients. It differs from other drug court initiatives as all legal, supervision and treatment issues are dealt with by a single team of case workers.

Asking the question: Recommended gender and sexuality Indicators

For an organisation or service delivery to be inclusive of lesbian, gay, bisexual, transgender and intersex people and communities, it means taking into account a person's lived experience of gender identity, sexual orientation, body diversity and intersex status. This course provides guidance on gender and sexuality indicators that can be implemented to meet the specific needs of all clients.

Learn online

What we're working on

Program update

Worker wellbeing

Interest in NADA's worker wellbeing resources has been strong with the webpage attracting over 1,000 page hits in the first month. The resources, including online worker and manager assessment tools, encourage workers to invest as much time and care looking after their health as they do others. What do you think of NADA's worker wellbeing resources? Are they meeting your needs? Share your feedback by completing this short survey.

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

Continuing coordinated care

It has been business as usual for the Continuing Coordinated Care (CCC) programs providing intensive wraparound support across the state to people experiencing AOD issues and other co-occurring needs. NADA's CCC clinical consultant has been providing advocacy and other support such as training to the CCC program staff and other NADA members.

Recently the clinical consultant has:

- organised for the CCC program staff and the clinical consultant to present about the program at various Family and Community Services (FACS) offices across the state. These in-service presentations have been facilitated to network and enhance working relationships between FACS and the CCC programs to improve collaborative practice and subsequently client outcomes.
- provided workshops on domestic and family violence, gender responsive practice and methamphetamine.

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

Policy toolkit

An expanded suite of policy templates and other supporting documents will be soon available on the NADA website. Each policy template can be customised to suit the particular needs of your organisation and support the governance and accreditation practice of your service. The updated toolkit includes templates and guidance for developing policies for clinical governance and critical incident management.

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

Innovate reconciliation action plan

NADA is reconvening a Reconciliation Action Plan (RAP) working group to work on the next stage of our RAP. The Innovate RAP follows on from our earlier reflection process and will outline specific actions to support NADA's ongoing vision for reconciliation, as well as reflecting the voice of our Aboriginal and Torres Strait Islander members.

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

NADAbase dashboards webinar

NADA recently held webinars to train members on how to use, analyse and maximise the new NADAbase dashboards.

Did you miss out? Watch the video recording.

Advocacy highlights

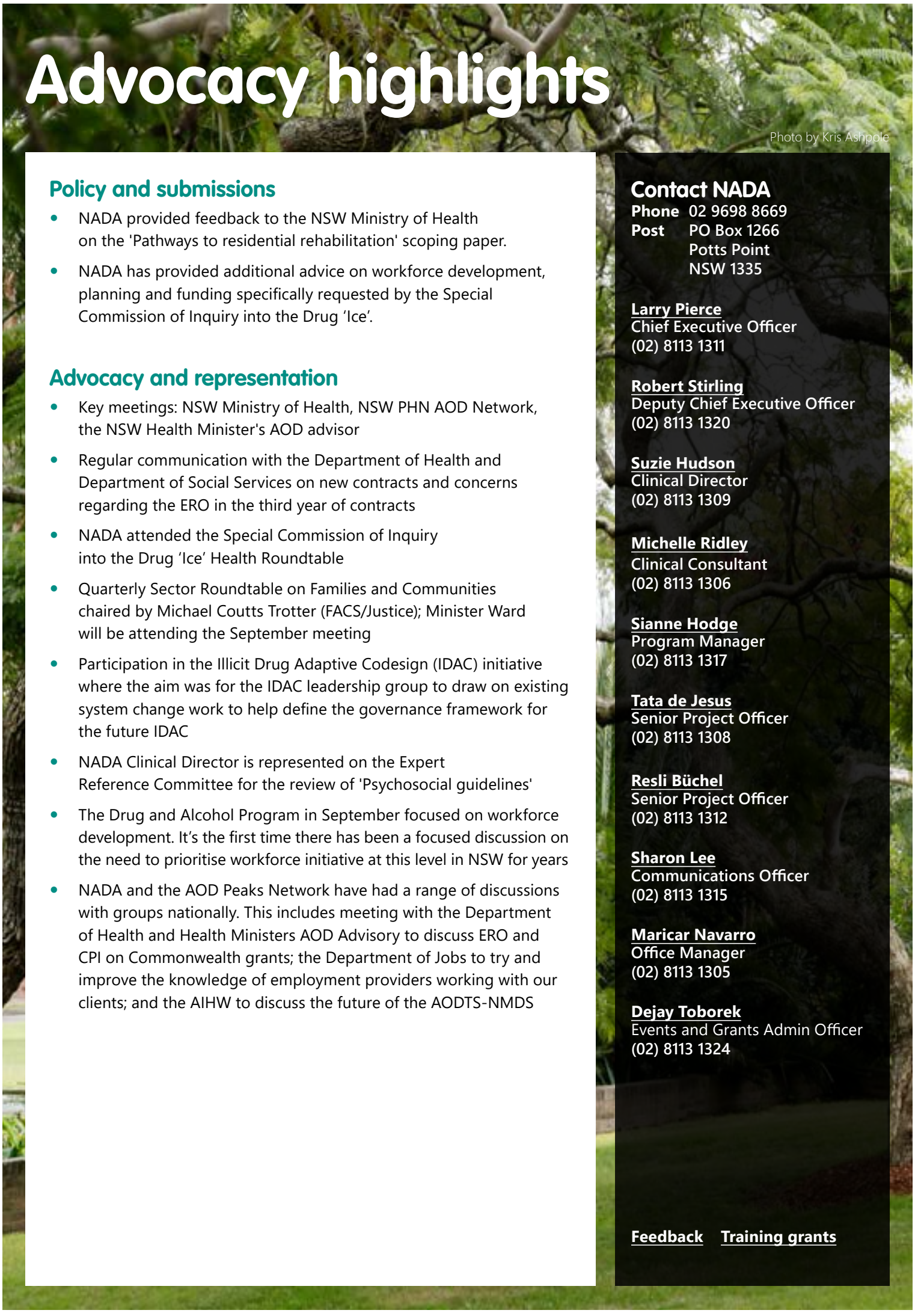


Photo by Kris Ashpole

Policy and submissions

- NADA provided feedback to the NSW Ministry of Health on the 'Pathways to residential rehabilitation' scoping paper.
- NADA has provided additional advice on workforce development, planning and funding specifically requested by the Special Commission of Inquiry into the Drug 'Ice'.

Advocacy and representation

- Key meetings: NSW Ministry of Health, NSW PHN AOD Network, the NSW Health Minister's AOD advisor
- Regular communication with the Department of Health and Department of Social Services on new contracts and concerns regarding the ERO in the third year of contracts
- NADA attended the Special Commission of Inquiry into the Drug 'Ice' Health Roundtable
- Quarterly Sector Roundtable on Families and Communities chaired by Michael Coutts Trotter (FACS/Justice); Minister Ward will be attending the September meeting
- Participation in the Illicit Drug Adaptive Codesign (IDAC) initiative where the aim was for the IDAC leadership group to draw on existing system change work to help define the governance framework for the future IDAC
- NADA Clinical Director is represented on the Expert Reference Committee for the review of 'Psychosocial guidelines'
- The Drug and Alcohol Program in September focused on workforce development. It's the first time there has been a focused discussion on the need to prioritise workforce initiative at this level in NSW for years
- NADA and the AOD Peaks Network have had a range of discussions with groups nationally. This includes meeting with the Department of Health and Health Ministers AOD Advisory to discuss ERO and CPI on Commonwealth grants; the Department of Jobs to try and improve the knowledge of employment providers working with our clients; and the AIHW to discuss the future of the AODTS-NMDS

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Feedback **Training grants**