

Advocate

The eMagazine of the Network of Alcohol and other Drugs Agencies

Issue 1: March 2020

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CEO report

Larry Pierce

NADA

This edition of the Advocate focuses on the issue of trauma, and there are some very insightful articles contained within, but I would like to take this opportunity to recognise the systemic trauma the AOD sector is experiencing, plus the drivers of this phenomena.

But what do I mean by this? I am referring to the long-term effects of the rising burden of responsibility for providing high quality treatment and client care in an environment where the funding levels from all sources of government funding programs are going backwards in real terms. Feedback from service managers and CEOs is consistent here—how can we be expected to provide x number of beds and x number of counselling and support interventions when the real value of our funding income keeps slipping behind the real costs of providing these services?

Apart from the declining dollars, non government AOD services do not have the benefit of large administrative and human resources bureaucratic support that hospital based, or Local Health District (LHD) based specialist drug services may have. We don't have the economies of scale for information technology and communications support or goods and services purchasing support that LHDs can bring to bear for government drug health services. Most non government service providers have very limited ability to fundraise to meet the funding shortfall. The net effect of poor funding of non government AOD services is stress on managers and workers who are consistently being asked to deliver more on a declining funding base. This demand is coming from the complexities of our clients, prospective clients and from government contract managers—and it is also coming from the community more broadly—when they can't get their loved ones into treatment.

And what is the effect on staff and managers? We believe it is adding to the overall burden of stress in terms of dealing with ever increasing levels of complexity the clients present to services with, and trying to do so in services that are increasingly finding it difficult to provide internal support to staff. With totally inadequate resources or no budgets for staff development and the purchasing of brokerage service supports and in the worst cases, no surety of ongoing funding for many elements of their service budgets.

Together we must demand the government step up and provide the level of resourcing we need to serve our clients and look after our staff.

NADA has been advocating for real cost of service budgets for all non government AOD contracts for the past two decades and we have most recently addressed this issue squarely in our submission to and appearances before the Special Commission of Inquiry into the Drug 'Ice'. We know that the Commission's report specifically addresses this issue in its final report to the government.

The take home message is that we can't keep doing more with less, if fact, we can't keep doing what we are currently doing on the money we are getting in current service contracts. We can't continue to tolerate the stress and service level trauma that this situation is putting on our workforce and on the clients of our services! Together we must demand the government step up and provide the level of resourcing we need to serve our clients and look after our staff.



NADA Conference 2020
**Enhancing
connections**

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We've postponed the NADA Conference

The health and wellbeing of our members and their clients, our colleagues, and the greater community is of utmost importance to the staff of the Network of Alcohol and other Drugs Agencies (NADA).

The coronavirus (COVID-19) pandemic affects us all, and NADA is working to respond to this. To help mitigate its transmission, we have decided to postpone the **NADA Conference 2020: Enhancing connections**. This is a vital step towards 'flattening the curve' to protect us all, and to ensure our health system will be able to cope.

[Read more](#)

Working in the AOD sector with people experiencing trauma



By Dr Cathy Kezelman AM President of Blue Knot Foundation—National Centre of Excellence for Complex Trauma

More than five million Australian adults have experienced interpersonal trauma (i.e. trauma between people). When interpersonal trauma is repeated, extreme and ongoing, it is called complex trauma. Complex trauma can occur from events in childhood, as an adult or both. Statistics suggest that between two-thirds and three-quarters of people seeking services for AOD issues have a lived experience of trauma, often complex trauma from childhood.

Many people struggle with complex trauma impacts, mental health issues and AOD use. Yet traditionally each element has been approached in a compartmentalised way. Trauma informed care is an approach which recognises that most people seeking services are living with the effects of overwhelming life experiences. This includes people seeking AOD services.

Trauma informed services depend on 'a thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual and an appreciation for the high prevalence of traumatic experiences in persons who receive mental health and addiction services'.¹ A trauma informed approach recognises that services designed to support survivors can also be triggering and potentially

re-traumatising. This is why trauma informed training is needed across all sectors, including the AOD sector to support understanding and the skill development around complex trauma related issues.

Tools

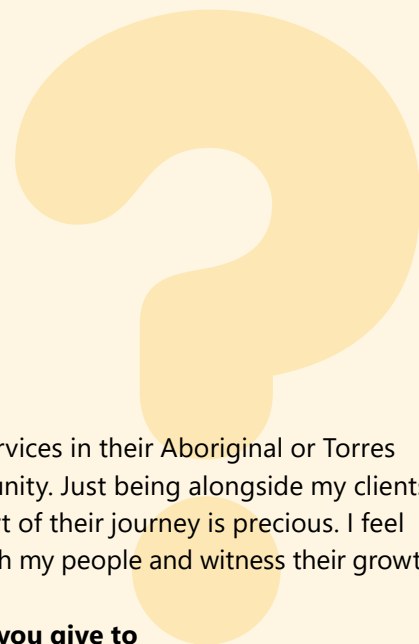
Use these tool to audit your services against trauma informed practice principles.

- [Trauma informed care and practice organisational toolkit](#) Mental Health Coordinating Council (MHCC)
- [Trauma informed organizational toolkit](#) [PDF] Services, Substance Abuse and Mental Health Services Administration (SSAMHSA)
- [Practice guidelines for treatment of complex trauma and trauma informed care and service delivery](#) Blue Knot Foundation

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How do you work with clients impacted by trauma



Supporting Aboriginal and Torres Strait Islander people

Tara Morrison, Aboriginal Worker—Community Restorative Centre

How does the CRC work with Aboriginal and Torres Strait Islander people impacted by trauma?

From my perspective as an Aboriginal worker, we develop ways to work with Indigenous clients in a culturally safe way. This means applying a unique Indigenous specific trauma informed practice. A large part of working in a culturally appropriate way involves working within the boundaries of the trauma itself. It also means working with the family—AOD use and recovery impacts the whole family and community.

How do you think these responses differ from approaches in mainstream AOD services?

For us, working with Aboriginal and Torres Strait Islander community involves taking the time and developing connections. Indigenous specific trauma informed work from an Indigenous practitioner's experience means often working outside the clinical sphere—not often seen in mainstream frameworks when working therapeutically. The foundation of our work is organic in nature and authentically based around culture. It enables us to practice our culture in our work that isn't tangibly seen in a clinical sense. Our work consists of supporting our clients to lead their own recovery and providing gentle guidance when the client invites us to do so. This allows them to take responsibility, empowering them to reach their own goals in their own time, at their own pace. In our work we also link clients

into culturally safe services in their Aboriginal or Torres Strait Islander community. Just being alongside my clients and being a small part of their journey is precious. I feel honoured to work with my people and witness their growth.

What advice would you give to mainstream services that work with Aboriginal and Torres Strait Islander people to improve their practice to be more trauma informed?

It is important to acknowledge that Aboriginal and Torres Strait Islander people are the experts when working with clients who are of the same cultural background. In terms of cultural safety and working with people experiencing complex trauma and/or AOD issues, seek and take advice from Aboriginal and Torres Strait Islander workers. They work within cultural knowledge systems that benefit the client and the community. Each Aboriginal or Torres Strait Islander client comes from a different cultural area so don't assume all clients are the same. Talk to Aboriginal and Torres Strait Islander staff, regardless of what their position is in the workplace. The knowledge they have with working safely and respectfully with Aboriginal and Torres Strait Islander clients is invaluable. This will help to build relationships and connections. Working collaboratively in this way will strengthen and benefit your client on their recovery journey.

Supporting families and children

Jane Singleton, Adult Program Coordinator and Sally Riley, Child and Adolescent Programs Coordinator—Family Recovery, CatholicCare (formerly Holyoake)

How does Family Recovery work with clients impacted by trauma?

Work at Family Recovery has to be trauma informed, and in doing so, recognises that positive experiences of relationships are essential. Staff adhere to the core principles of trauma informed practice of safety, trust, choice and empowerment in working with families and children. We recognise that experiences of trauma are possible in all clients, and as such all clients are assessed.

With adults that's about being attuned to traumatic events and exploring what comes up from the client that may have resulted in experiencing trauma. With children, it's about exploring developmental milestones related to family, school and peers. It's really important from the perspective of the child to respond in the moment, and be guided by, and adaptable, depending on what is noticed in the children.

How do your work with clients impacted by trauma?

continued

We conduct pre-briefings with group facilitators about clients that have experiences of trauma and facilitators are mindful of potential triggers. We work with clients about what has been helpful in the past to support people in the group if trauma is triggered. A big part of our groups, both adult and children, is psycho-education on trauma. We use grounding and body awareness work through mindfulness in response to 'hyper' and 'hypo' arousal. Specific interventions that support children are the use of somatic exercises: yoga pretzels, guided imagery, belly breaths, sensory games, art expression. Use of universal language and creating a safe space is also important. This helps children to not to feel the intensity or be polarized about their problem belonging only to them.

How do you think responses differ from approaches in mainstream AOD services?

Research such as the well-known ACE study have supported the need to break intergenerational transmission of trauma and substance use issues. Trauma heals best in the context of relationships, and that goes across the life span of working with families. We aim to heal the family as a whole—as far as we are aware, Family Recovery are a specialist program like no other in NSW. Generally speaking, in AOD services the client is their primary focus, the family is secondary.

Supporting gender and sexuality diverse people

Ann Marie Crotty, Counsellor, Substance Support and Care Coordination Team—ACON Health

How does ACON work with clients impacted by trauma?

ACON Client Services Team (including psychologists, counsellors and social workers) provide services to clients through a range of trauma informed and client centred modalities. Clients are assessed for trauma experiences with a view to managing and reducing impacts on their day to day life. Working within a trauma framework, clients are empowered through psycho-education and may work with their practitioner on the stage—stabilisation, processing and/or reconnection—that is appropriate to them. Currently we also have two practitioners who can provide eye movement desensitization and reprocessing therapy to support clients with specific trauma processing.

How do you think responses differ from approaches in mainstream AOD services?

ACON AOD services acknowledges the significantly higher rates of experiences of trauma in people of diverse

What advice would you give to mainstream services that work with children and families to improve their practice?

Services need to be aware that the family are also likely to have experienced trauma and should also be responded to with the same core principles of trauma informed care. We encourage services to use warm referrals, rather than just providing families with a telephone number to call for support. Importantly, keep an antenna up for children in their client's life, whether being involved in children's lives as an active parent, or having children removed by child protection and not being in contact. The children have typically seen or heard negative behaviours related to substance use, recovering from substance use or the stigma of having a parent in active use. Children almost always believe it is somehow their fault i.e. 'I'm too naughty', 'I'm too dumb', 'I'm too hard to deal with' etc. They need support to process their experience (which typically parents tend to believe they have sheltered them from). Typically, we find the children are far down the list of priority for receiving help because the problem in the family takes precedent due to many crises. Refer clients with children to our program or to the NADA page ['working with families'](#).

sexualities and genders and also separately, the higher rates of AOD use within the community. We work within a harm reduction model and recognise that for people of diverse sexualities and genders there is a large proportion who use AOD in a non-problematic way. However we also know that many in our community struggle with their AOD use and do face unique barriers to seeking support and accessing services. We acknowledge and address barriers to accessing mainstream services by providing a person centred approach that enquires about the specific and unique factors that has lead their substance use to become problematic. We acknowledge and attempt to work with the socioeconomic determinants that can create and exacerbate symptoms. Our approach will assess if experiences of trauma are being managed or masked by AOD use. We will then (if appropriate for the client) work in a way that addresses both the substance use and trauma impacts in a tailored client centred approach.

How do you work with clients impacted by trauma?

continued

What advice would you give to mainstream services that work with gender and sexuality diverse clients to improve their practice to be more trauma informed?

Acknowledge the unique barriers faced by clients with diverse sexualities and genders including the higher rates of trauma experiences often related to their sexuality/gender identity. It is important to remember that is more likely the accumulation of minority stress experiences and societal/familial reactions to their identity rather than the

identity itself that adds to an experience of trauma and/or substance misuse. With this in mind, practitioners can work with a client's in-built resilience and well-worn coping skills. Some clients see their sexuality and/or gender identity as a factor in their relationship with substances and in their service needs, some do not. Ask the client about their specific experience and work from a place of empowering the client to identify their needs and to take the lead in their own recovery.

Supporting culturally and linguistically diverse people Sandra Evers, Psychologist with Sinatt Tang, Bilingual Counsellor—Drug and Alcohol Multicultural Education Centre

How does DAMEC work with clients impacted by trauma?

We work in a culturally responsive way. We can't assume that our clients understand the concept of counselling or treatment in the same way that a mainstream service does. In fact, some languages don't have a word for 'counselling' and that means we have to seek out their view of counselling and work in a way that supports that. For example, some clients view counsellors and psychologists as medical professionals and require us to be more prescriptive in our treatment. Some culturally and linguistically diverse (CALD) clients, particularly those who have experienced complex trauma, require a less prescriptive form of treatment. They need us to slow down, be patient and reassuring while the trusting therapeutic relationship they need, develops over time.

Often, we need to dispel myths around mental illness and trauma with our clients. Addressing their concerns around stigma within their community is important as it supports them to stay in treatment. Also, we work to understand their trauma symptoms within the context of culture. We know that nightmares are a feature of post-traumatic stress disorder but in some cultures, nightmares can be seen as an omen of bad things to come rather than a symptom of trauma. Being respectful and accepting of a CALD client's view of their trauma is vital in treatment.

How do you think responses differ from approaches in mainstream AOD services?

DAMEC has bilingual and multilingual counsellors who are themselves from CALD communities—we can provide a service in community languages and within culture. For me, being from the dominant culture and having worked in mainstream services prior to DAMEC, I have now learned that my Western view of counselling and treatment doesn't always fit with my CALD clients. For some clients, where family relationships form the backbone to their society,

I need to reveal a little of myself and family, in order for the client to get a sense of who I am, to build rapport and this can determine whether or not they stay in treatment. Our Western concept of therapeutic boundaries and self-disclosure can be really put to the test! Sometimes, what is the cultural norm in one culture can be viewed as inappropriate or disrespectful in another. For instance, it may be culturally appropriate and respectful for some CALD clients to remove their shoes when they are seated. Also, our Western culture values eye contact but for some CALD clients, maintaining eye contact can feel like staring and be considered rude. Finally, physical contact in the form of shaking hands with our clients may be viewed as appropriate within our culture but not for some of our clients, particularly if there are people of different genders involved.

What advice would you give to mainstream services that work with CALD clients to improve their practice?

So often as counsellors and psychologists, we hold the power in our therapeutic relationships. Flexibility and a willingness to learn is a key ingredient to improving practice. Be inquisitive and open to being guided by CALD clients and colleagues. Asking questions about culture and custom is inclusive and can help clients feel a little more empowered as it shows that we don't apply a 'one size fits all' model to treatment. Understanding that ideas and beliefs we hold, such as what we believe constitutes respectful behaviour, can in fact be viewed as disrespectful in another culture. Be prepared to be have your views around boundaries challenged at times. Sometimes we have to give a little of ourselves in order to break the ice with CALD clients to develop strong, therapeutic relationships. Understand that different cultures will have different views of mental illness and trauma. Sometimes the simple act of accessing a treatment service can cause distress and friction for the CALD client within their family and community.

How does trauma fit in?



Rodney Vlasis

Consultant in responding to and preventing gender based violence

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Research demonstrates a moderate association between exposure to traumatic events and the perpetration of domestic and family violence (DFV). A higher proportion of DFV perpetrators have experienced significant child maltreatment or exposure to traumatic events as an adult than general population samples.^{1,2,3} However, the majority of men and the substantial majority of women who experience traumatic events as a child or adult do not go on to perpetrate DFV in their adult relationships. So, what does this mean for how we should take exposure to traumatic incidents and environments into account when working with men who use DFV?

Trauma informed practice has an important role to play in many contexts. However, there is a danger that trauma theory can fall prey to neurobiological determinism—in other words, the view that acute or repeated exposure to horrible and overwhelming stimuli produces neuropsychological and nervous system changes that lead to psychological effects and responses out of the person's control. In this way of viewing trauma, psychological and medical treatments are then applied to change the neuropsychological and nervous system basis of the trauma. This approach not only denies a person's agency in responding to traumatic events and experiencing, but also excludes the power of social responses and contexts in influencing how people make sense of what they experience, and in influencing how they choose to act.⁴

The choices that men who use DFV make to respond to intense physical and psychological traumatic experiences can be influenced by a range of factors, including gender

based privilege. Responses to traumatic experiences that involve targeting, controlling and terrorising family members to help relieve these experiences is a choice, and is reflective of DFV as a social, rather than a psychological, problem. Predominant masculinities across many cultures condition men to respond to these intense experiences by using behaviours that are destructive to others and/or to themselves. Intense trauma related experiencing does not 'trigger' someone to use violence.

Traumatic experiences from childhood or as adults, and experiences of oppression and marginalisation more generally, can feed a perpetrator's victim stance that he adopts to rationalise his use of violence. Men who use DFV often perceive themselves, paradoxically, to be the victim of their ex/partner's 'unreasonableness'⁵, and justify their use of violence as such. This victim stance, however, does not arise entirely, or even mostly, from the genuine experiences of victimisation due to family-of-origin exposure to abuse, or traumatic stress arising during adulthood, that some perpetrators have been exposed to. Rather, the basis of the victim stance comes from the everyday reinforcers, at a number of levels in our society, of male entitlement—illustrated by the fact that many perpetrators develop a heavily defended victim stance without having experienced traumatic circumstances.

This can create a major tension for practitioners working with highly marginalised men who have faced genuinely difficult experiences and circumstances in their lives—the case with many men struggling with the use of substances. Balancing empathy for these experiences without explaining or excusing their use of DFV on them is critical.

How does trauma fit in?

continued

A biologically deterministic approach to trauma informed practice can also be detrimental to how we respond to victim-survivors. Through this approach a trauma related dissociation, for example, can easily become labelled as a mental health symptom characteristic of a mental health disorder (such as post-traumatic stress disorder or dissociative disorder), rather than a strategy that a victim-survivor uses to work towards their felt safety in the light of a traumatising experience. A narrow focus on the biological pathways of trauma, and on mental health diagnoses, can divert attention from how trauma sufferers are sometimes or often responding sanely and accurately to horrific experience(s), and that they have some agency and control over their responses. This narrow focus can also draw attention away from challenging the social injustices and systems of oppression that created the trauma in the first place.⁶

Despite these cautions in the application of trauma informed practice to DFV, a trauma informed lens does have a role in working with men who use DFV. Such a lens is relevant to this work in several ways.

- Taking into account a user of violence's experiences of trauma, and his responses to traumatic triggering, can make it more likely that a DFV men's behaviour change program (MBCP) will be able to work with him in a way that's safe and productive.
- Assessing where experience of sustained, complex trauma has contributed to an acquired brain injury or developmental trauma disorder⁷, can help practitioners to assess the man's capacity to understand or comply with DFV protection and other court orders, and/or his capacity to participate in the group-work component of a MBCP.
- For a (small) minority of perpetrators, the traumatic stress/post-traumatic stress they experience is particularly severe. Most of these men can still choose not to use violence when experiencing intense emotions; however, making non-violent choices is harder if their emotional and psychological life is chaotic and/or if they are heavily using substances to cope. Adopting a trauma informed lens does not mean that traumatic stress needs to be healed for these men to make safer choices. However, some therapeutic work focusing specifically on the traumatic stress might be useful as part of a case management response, in a way that does not displace the need for MBCP work.

Some adolescents who use DFV against family members, unlike adult perpetrators, might require a therapeutic healing approach to the post-traumatic stress they experience as a central component of an overall intervention. Depending on the circumstances, these children might need to learn skills to self-soothe in the face of intense emotions and traumatic stress, and to obtain connections and support from safe others (for example, their mother), as one part of the intervention approach.

Finally, a healing approach to the individual and collective traumas experienced by First Nations peoples due to colonisation, dispossession and dislocation is an important part of the work done by Aboriginal communities to address the use of family violence. This healing work, unfortunately, is being made highly difficult by the ongoing occupation of Aboriginal nations and disruption to their cultural and spiritual sovereignty.

Rodney Vlasis will be presenting a workshop on FDV at the [NADA Conference 2020: Enhancing connections.](#)

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Trauma informed care and best practice is...

Suzie Hudson NADA

...a whole of organisation investment

The trauma informed practice literature is consistent in its messaging regarding the need for the whole of an organisation—from top to bottom—to understand and invest in this approach for it to be effective at the client level. Trauma informed care means that services have an awareness and sensitivity to the way in which clients' presentation and service needs can be understood in the context of their trauma history.¹ Applied as a framework for human service delivery that is based on knowledge and

understanding of how trauma affects people's lives and their service needs, trauma informed care has the potential to empower people as the experts of their own lives.²

...a strengths based framework that is responsive to the effects of trauma

Trauma informed approaches to care is as a strengths based framework that is responsive to the effects of trauma.³ The key principles that should be embedded for all activities are:

Key principles ^{4,5}	In practice
Safety Staff and the people they serve feel physically and psychologically safe	<ul style="list-style-type: none"> • Entry and common areas are welcoming and well lit • Privacy is maintained by having private areas for personal discussion • What makes a person feel safe is explored with anyone accessing the service
Trustworthiness Organisational operations and decisions are transparent and aimed at building trust	<ul style="list-style-type: none"> • People accessing a service are given a clear outline of any service processes or what happens in an individual or group sessions ahead of time • There is consistency of approach among staff • People engaged in a service are kept informed about any changes to service provision, timetables or activities
Choice People engaged by service are involved in all aspects of their care, and are given choice throughout	<ul style="list-style-type: none"> • People accessing a service are given clarity about their rights and responsibilities, and these are available to them throughout their involvement with a service • In individual or group sessions, people are engaged in discussion about what kinds of approaches they respond to best with choice about how they receive information • Engaging people involved in a service to provide feedback on how interventions are delivered
Collaboration Sharing the power with people, particularly in relation to treatment decisions	<ul style="list-style-type: none"> • People have clearly defined roles in planning and evaluating services • Where challenges are identified, people receiving AOD treatment are involved in finding the solutions • Care planning needs to engage and involve the person accessing treatment and be reviewed with them regularly to ensure it remains current
Empowerment An emphasis on a strengths based approach that has an emphasis on skills building	<ul style="list-style-type: none"> • Support people to identify and engage their strengths • Explore apparent 'unhelpful' behaviours as ways of coping or surviving and tap into the strengths that could be adapted to more useful strategies • Create an atmosphere that validates each contact you have with a person accessing treatment

Best practice in trauma informed practice is fundamentally underpinned by a shift from asking 'What's wrong with you?' to 'What happened to you?'.⁵ This shift helps a

clinician or AOD workers to consider a person's behaviour, however challenging it may appear, to be a response to what has happened to them rather than something that is inherently wrong with a person.

Trauma informed care and best practice is...

continued

...an understanding and appreciation for the physical impact of trauma on the body and mind

Substance use can be perceived as an effective coping strategy for complex trauma experiences, particularly when we consider how various substances affect the body and the drivers for why people may use them:

- 'Smoking cannabis helps me stay calm'
- 'Injecting heroin takes away my pain'
- 'Smoking ice makes me feel confident and alive'
- 'Taking Valium helps me with my sleep'

Experiences of trauma can manifest themselves in the body as constant hypervigilance (being fearful and on alert) or at the other end of the spectrum hypo-arousal (disconnected, lethargic and flat)—with this in mind the use of substances can make a lot of sense. Best practice approaches would seek to focus on the management of these physical and mental states that are a common result of trauma experiences. Furthermore, normalising these experiences:

'I can understand why you feel that using xx drug helps to manage the anxiety and fear'. Couple this acknowledgment of the very physical nature of past trauma experiences with information about what is occurring with the body can empower a person to explore alternate approaches to responding—such as emotion regulation.

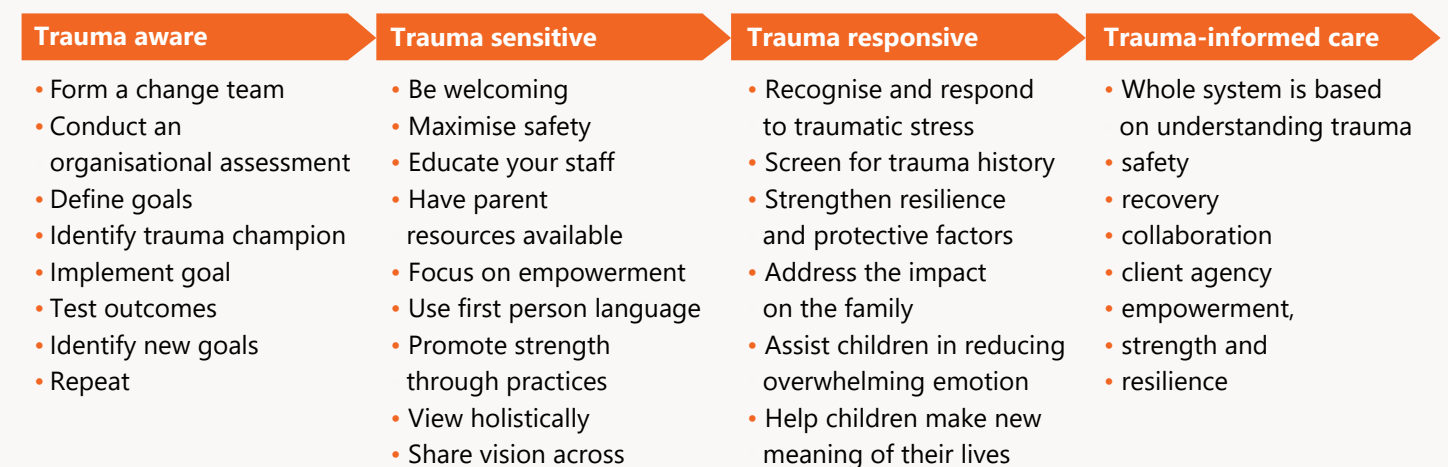
...appreciating and identifying organisational responses to the experience of vicarious trauma

Adopting trauma informed care practice into an organisation is inclusive of acknowledging that staff supporting people who have experienced trauma will be impacted. The attributes that staff bring to their work in the AOD sector include empathy, care and engagement—which means that the witnessing of painful human experiences will have an impact. However, with good support practices such as [clinical supervision](#), [peer supervision](#) and investment in [wellbeing](#), staff can manage their own responses and maintain effective practice.

Trauma informed model of care

The available literature suggests that there is a continuum from being *trauma aware* (seeking information out about trauma and its implications for organisations) to being *trauma informed* (a cultural shift at the systemic level). The diagram⁶ below sets out the progression in four stages:

- **trauma aware:** seek information out about trauma⁷
- **trauma sensitive:** operationalise concepts of trauma within the organisation's work practice
- **trauma responsive:** respond differently, making changes in behaviour
- **trauma informed:** entire culture has shifted to reflect a trauma approach in all work practices and settings.



At its most basic level, organisations that are trauma aware incorporate trauma awareness into their work. Staff have an understanding of trauma and how symptoms and behavioural presentations in individuals may be responses to traumatic experiences so that behaviours that appear self-destructive or self-defeating can be acknowledged as being adaptive behaviours to trauma that have become maladaptive over time.^{8,9,10}



AOD AWARDS

for the
NSW NON GOVERNMENT SECTOR

We've postponed the AOD Awards

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[Read more](#)

Trauma informed care and best practice is...

continued

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Understanding the experience of trauma

In order to know effective ways to respond to the experience of trauma, it is important to understand what happens to a person—in their mind and body. Bessel van der Kolk is considered one of the pioneers in the trauma field since his work with Vietnam veterans in the 1970s. His book [‘The body keeps the score: Brain, mind, and body in the healing of trauma’](#) explores in detail how the brain is impacted by overwhelming traumatic events, drawing on neuroscience from his own research as well as that of his peers. It investigates the effects of adverse childhood attachment patterns, child abuse, and chronic and long-term abuse.



In an [interview](#) with Isabel Pastor Guzman in 2019, Bessel provided a vivid description of the impact of trauma:

'When something life-threatening happens to you, you secrete stress hormones that are supposed to mobilize you for fighting back. If you are held down and prevented from restoring your safety and control, these stress hormones may begin to work against you and disrupt the workings of your mind, instead of activating your muscles to move.

Basically, our stress hormones are meant to help us move, or fight back, and get out of the situation. If they keep being secreted, they keep you in a state of hyperarousal or put you in a state of helpless collapse. When this happens over time, the filtering system of the brain is changed so you become hypersensitive to certain sounds. You have difficulty filtering irrelevant information. Gradually, you start feeling threat everywhere. Instead of being focused on what is going on right now, your mind stays on the alert for threat, while you basically feel helpless to do anything about it.

The amygdala (the 'smoke detector' of the brain) tends to continually fire, telling you 'You're in danger,' and your anterior cingulate, which is supposed to filter out irrelevant information, doesn't function very well, so things that other people see as simply unpleasant or irritating, are perceived as a threat to your very existence.

The medial prefrontal cortex (the watchtower of your mind, meant to help you to calmly survey what is going on and provide you with a feeling of 'I know what I'm doing') tends to get deactivated as well, so you get trapped in your reactions without having much control over them.

Sharing this description with both AOD workers and the person engaging in therapeutic support, can help both the understanding of why someone might feel and respond in the ways they do as well as the kinds of therapeutic approaches that are most effective.'



A place to feel safe

Suzie Hudson NADA

One specific area of trauma informed practice that can be a challenge in the AOD sector relates to the physical spaces where services are delivered. Not all services have had an opportunity to plan and custom-build an environment where they can welcome people for support—instead we work creatively to adapt and shape spaces as best we can. Key considerations when it comes to being trauma informed might be to explore a building's history and explore with people accessing the service what they feel when they are in various parts of the service. Shaping things such as lighting, furnishings, plants and introducing art are all aspects that can easily include service users and improve the look and feel of the physical space.

Embedding trauma informed practice in relation to the physical environment means considering some of the following questions:

Do staff members ask people coming into the service the kinds of things that make them feel safe in a new environment? Is it knowing where there are open spaces, or where they can be in a natural environment such as a garden or park? Where in the room would they prefer to be if they are engaging in a counselling session—does having a desk between them and you feel imposing, for example.

Is the physical space adding additional stress to an already overwhelmed individual? A reception or common area that is busy and noisy can be overwhelming for people, particularly when they are in a hyper-vigilant state, wondering what is going to happen next. This is also true for staff—so where possible, common areas are best kept calm and inviting, and scheduling fewer people in

waiting areas. Reducing ambient news from televisions or radios in waiting areas can also be helpful.

How is the space promoting psychological as well as physical safety? Some services have artworks designed by people engaged by the service in their common spaces, which sends a message to visitors that they are valued. Plants and natural light can be soothing if people need to wait for an appointment. The choice of artwork, posters or colour can signal to people accessing a service whether they are being welcomed—sensitivity to culture, good sign posting that helps with orientation to a service and the presence of peers to personally welcome people can illicit feelings of safety.

Are there opportunities in this space to promote wellness and regulation? [Sensory gardens](#), even on a small scale, can be an effective place for exploring skills for emotion regulation. The design and creation of green spaces that involves people accessing AOD treatment can be both empowering and assist in the development of self-soothing techniques that use all the senses. Quiet spaces are also helpful for people if they need time-out and reinforcing the development of specific skills that people can adopt for themselves when they leave a service.

Tools

Use these tools to audit your service in regard to trauma informed practice and the physical environment.

- [Agency environmental components for trauma informed care](#) [PDF] Aces Connection
- [Trauma informed care and practice organisational toolkit](#) [PDF] MHCC

Listening into speech

Will say, won't say, can't say

Darryl Chow

**I was a great husband before I was married.
I was a great parent before I had kids.
I was a great psychotherapist before I began
clinical practice.**

In my clinical practice, given my years of training and experience, I thought one of my greatest skills was listening. I only began to recently realise that all these years I was really listening in order to speak, instead of speaking in order to listen. (You see, we've been trained to dish out X treatment for Y problem, so I was inclined to get into the order of business as soon as I can).

When working with people who are dealing with addictions and complex trauma, and especially youth, their pieces of the bridge are often broken, fragmented and shattered by deep ruptures in their close relationships and attachment bonds that mold a significant part of their inner lives. Thus, our work begins as bridgework. Writer, teacher and activist Parker Palmer provides a useful analogy to think about how we can approach with a form of deep listening:

If we want to see a wild animal, we know that the last thing we should do is go crashing through the woods yelling for it to come out. But if we will walk quietly into the woods, sit patiently at the base of a tree, breathe with the earth, and fade into our surroundings, the wild

creature we seek might put in an appearance. We may see it only briefly and only out of the corner of an eye—but the sight is a gift we will always treasure as an end in itself.

Unfortunately, ...[we] go crashing through the woods together, scaring the soul away. In spaces ranging from congregations to classrooms, we preach and teach, assert and argue, claim and proclaim, admonish and advise, and generally behave in ways that drive everything original and wild into hiding. Under these conditions, the intellect, emotions, will and ego may emerge, but not the soul: we scare off all the soulful things, like respectful relationships, goodwill, and hope.¹

A therapist job requires a different kind of listening. When we are attempting to help and to heal someone who is carrying [invisible wounds](#), we need to listen to the person into speech. If we stop to think about it, isn't it bizarre—and almost magical—that when two people are engaged in deep conversation with an intent on helping... change happens?

As a scaffold, I find it useful to think in terms of the following three layers of listening:

1. Will say
2. Won't say
3. Can't say

1. Will say

Listening to what a person 'will say' to you is the most important step. Too often, because of our training we tend to underrate this critical step. An example of a 'will say', that a client would state in a typical clinical situation:

Someone who has been	'Will say'
Traumatized from adverse events	I use drugs.

Listening into speech

continued

2. Won't say

This layer is the metaphorical 'woods' that Palmer described earlier—the first touch of vulnerability. We need to not only listen intently, but also give words of invitation, honor and empathy in order to assist the unfolding of a deep conversation.

Someone who has been ...	'Will say'	'Won't say'
Traumatized from adverse events	I use drugs.	I'm seeking relief; I'm afraid.

2. Can't say

If what a person 'will say' is the explicit, and what a person 'won't say' is the implicit, what a person 'can't say' often speaks to the fundamental relationship they see themselves in is the source of their suffering. At this stage we need to have a full appreciation of the level of weakness and raw vulnerability for our client to reveal this part of themselves.

Someone who has been ...	'Will say'	'Won't say'	'Can't say'
Traumatized from adverse events	I use drugs.	I'm seeking relief; I'm afraid.	I feel too raw and vulnerable / I don't deserve good things to happen to me.

Practice tips

When working with someone who is traumatized from adverse events and dealing with addictions begin by asking, 'What's on your mind?'

Listen and then take one step further and ask, 'What else?'

Then take another gentle step inviting a conversation of the inner life and create an invitation, 'Would you be willing to share with me what you are struggling with on the inside that people cannot see on the outside?'

We need to go at the speed of life and not at the speed of light. Sometimes a person just doesn't know how to say it as yet... until they are listened into speech.

Footnotes

1. Parker Palmer. (2004). *A Hidden Wholeness: The journey toward an undivided life*. US: John Wiley & Sons Inc.
2. Listen to the interview with Jean Vanier, <https://onbeing.org/programs/jean-vanier-the-wisdom-of-tenderness/>



Daryl is a keynote for the [NADA Conference 2020](#), and he will also be presenting a workshop about ways to keep clients engaged.

Daryl Chow, MA, Ph.D. (Psych) is a practicing psychologist and trainer. He is the author of *The First Kiss: Undoing the intake model and igniting first sessions in psychotherapy*, as well as a co-author of the highly anticipated book, *Better results, using deliberate practice...*

For more, go to darylchow.com/frontiers



Open the can of worms

**I heard you talking as I was walking
by your open door
Telling each other to
stick to the presenting issue,
Don't go opening a can of worms
keep to our core
Let's do this on our terms.
Yet you don't realize that this can of worms
That you don't want to open
Stays stuck inside of me
wriggling and squirming,
gnawing and chewing
Eating away at my insides
with each toxic bite,
until I learn to fight
and show my might
through snide words and worse.
Or worse still,
'till I have no fight left,
no will to live,
no reason at all
And I wonder do you remember my name?
That I told you my dad
died by suicide when I was five?**

[Read the full poem](#)

By Tracey Farrell, mental health social worker and passionate advocate for overcoming childhood trauma and adversity. This poem was written after speaking to many survivors about their experiences of the mental health sector, and practitioners who described asking about trauma histories as 'opening a can of worms'.

Originally appeared in Blue Knot Review, an electronic journal published quarterly by [Blue Knot Foundation](#), National Centre of Excellence for Complex Trauma.

Asking the 'difficult' questions

Screening questions about experiences of trauma

Resli Büchel NADA

AOD sector professionals have experience interviewing and assessing their client's needs and guiding interpersonal communication in highly stressful and confronting circumstances. However, no matter your level of expertise, some topics remain more challenging to broach with clients than others.¹

Screening questions about highly personal and traumatic experiences—such as family and domestic violence (FDV), suicidality and self-harm—rank among some of the most uncomfortable things for frontline AOD workers to ask about. Initiating discussion on these topics is sometimes felt to be over-familiar within the broader social context and stigma related to them. A skilled professional may see asking these questions as creating unnecessary tension between the client and themselves, undermining the developing therapeutic relationship.

For this reason, screening questions about FDV, suicidality and self-harming behaviour may be skimmed over or even avoided by workers, particularly when the worker's capacity to implement necessary support or intervention in response to a client-disclosed risk is limited and/or unclear. It is also important to acknowledge that there is a bigger picture issue here concerning the number of screeners and 'tick box' questions that clients are expected to answer as they enter treatment.

Confronting clients with a barrage of personal questions at the first meeting even when they're relevant and necessary for informing service provision can feel dehumanising and insensitive. And, indeed, some service users concur. However despite this, studies have shown that clients are more likely to be uncomfortable or refuse to answer questions about their income and financial status than questions about trauma, drug use or mental health. This begs the question: who are questions about FDV and suicidality most 'difficult' for—the client or the questioner? And how can AOD workers who are finding it difficult to ask these questions develop the confidence and skills to ask?

The following points provide some clear underlying principles that you can apply in your practice to improve your confidence and skills to ask:

Know why you are asking the questions and communicate this to your client

The information gathered through client interview and screening questions at intake serve to guide individual treatment approaches. Data collection on entry to treatment also guides research, informs policy and supports service reporting requirements.

While this may seem self-evident as AOD sector professionals, it may not be so obvious to clients, such as those from CALD backgrounds, those with limited education or exposure to AOD services. Prefacing the screening questions with a simple and transparent explanation can reassure anxious clients and may serve to elicit information about client risk that may not otherwise have been disclosed. For example, reminding the client that they don't have to answer the questions if they don't want, clarifying that all clients are routinely asked the same questions at intake to the service (and not only this client).

Be mindful of your language and how you ask questions

Language is powerful—especially when discussing AOD and the people who use them. It is widely acknowledged among AOD professionals, and across the broader community and health sectors, that the words used when interacting with clients (as well as with other professionals) is far more than simply a measure of social nicety and political correctness.

The words you choose to use can empower clients and enhance your therapeutic connection with them, or they can reinforce negative stereotypes and lead clients to disengage from the treatment process. In general, using 'person-centred' language, which focuses on the individual rather than their substance use, is the preferred approach.

How you ask these 'difficult' questions matters also. It is possible for AOD professionals and services to extend the perpetration of harm/s related to FDV victims by misunderstanding and/or mismanaging the issue for individual clients.² Intake interviews often consist of multiple, very direct questions, aimed at gleaning the maximum information from a client in the minimum time.

Asking the 'difficult' questions

continued

However, indirect questioning can be more fruitful in some cases, as well as being gentler on the client.^{3,4,5}

As with all interviewing it is important to remember your own inherent bias. We all bring a collection of unique values and experiences to both our personal and professional interactions, often unconsciously. Therefore, it is essential to consider how this might be reflected in your use of language (including body language), in your responses to what the client discloses, and how it impacts on your overall practice.

A variety of tools are freely available to support the use of non-stigmatising and inclusive language in your practice, including

- NADA and NUAA's [Language matters](#) resource
- Mindframe's [Communicating about suicide](#)
- ACON's [Trans and gender diverse inclusive language guide](#)
- NADA and ACON's [Asking the question](#)

Understand what you are asking, in context and in real time, and be prepared to respond to the answer/s you receive

While every service has intake and assessment requirements, never forget that the intake interview is a vital first step in forming a therapeutic relationship. You are asking about very personal, frequently traumatic and potential triggering experiences.

Listen and be responsive to what is being said to you. You may have every intention of following up on a client's responses in due course, but your primary purpose in any direct client interaction is to be present and supportive of that person.

Don't underestimate the value of asking the 'difficult' questions

Regardless of how you ask questions about FDV, suicidal ideation or self-harm, some clients will not be willing to disclose their experiences to you. And, of those who do, not all will want your support. However, it is important to remember that simply initiating a general discussion about FDV, self-harm or suicide can still be beneficial by making the client aware of the support that is available to them and by reassuring them that you are willing to listen when they are ready to talk.

NADAbase

You can use NADAbase to record responses to these questions on gender diversity, sexuality diversity, BBV and STI screening, suicide screening and FDV screening. See the [NADAbase webpage](#).

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4. Spangaro, J. & Zwi, A. (2010). After the questions: Impact of routine screening for domestic violence in NSW health services. Sydney, NSW: School of Public Health and Community Medicine, UNSW. P 12
5. Turning Point. (2019). Substance use and family violence [webinar]. Available from <https://www.turningpoint.org.au/education/webinars/substance-use-family-violence> on 13th February 2020.

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](#).



Addressing trauma across the spectrum

By **Jude Sayers** (Dianella Cottage) and **Resli Büchel** (NADA)

Dianella Cottage is a harm minimisation service for women who have co-existing AOD and mental health issues. Located in the Blue Mountains, the service has been operating for eight years and is a part of the cohort of AOD services coordinated by Lives Lived Well.

The service works with women (18 years and over) impacted by the criminal justice, child protection and mental health systems and welcomes women at all stages of addressing their problematic substance use, including those who are on opioid substitution programs.

Dianella Cottage asks women who access their services to 'commit to actively participating and to not being intoxicated' when participating in their groups.

Program foundations

'At Dianella Cottage we talk about the interplay between trauma and substance use,' explains service manager, Jude Sayers.

'The majority of women we see have complex trauma, so what we work with is the legacy left by that trauma and it is both psychological, neurological and physiological,' she says.

By drawing upon a range of therapeutic modalities, including cognitive behaviour therapy, dialectical behaviour therapy (DBT), narrative therapy and sensorimotor psychotherapy, the team at Dianella Cottage is able to successfully address trauma across the spectrum.

'Managing complex trauma is all about understanding what activates your nervous and developing the skills to regulate it,' Jude says.

'We use DBT and mindfulness practices, as well as sensorimotor therapy,' she adds, 'which is a somatic practice, focusing on the body and working with the physiological effects of complex trauma.'

Dianella Cottage extends its trauma informed, client centred approach to standalone DBT workshops and SMART Recovery groups, as well as providing individual treatment and support.

The team at Dianella Cottage provides both group and individual support.

Wise woman's day treatment program

The Wise Woman's Day Treatment Program is a multimodal program designed for women who need intensive AOD treatment and support but are unable to attend a residential rehabilitation service or a detox program. This group program runs for one day per week for six weeks during school terms.

Dialectic behavioural therapy

In recent years, Dianella Cottage has expanded and refined their use of DBT capitalising on the suitability of this skill based model for their clients. As Jude explains, 'for women with a history of complex trauma [their] substance use requires a management strategy.'

'[Our clients] need to learn an alternative way of regulating their bodies, and DBT does this very well,' she says.

Dianella Cottage now runs standalone groups targeting each of 'the four pillars of DBT': emotion regulation, interpersonal skills, distress tolerance, and mindfulness. Each group is run separately, at different times throughout the year, allowing clients to cycle through them, building a complete DBT skill set, if desired.

Jude emphasises that, 'getting to know your body, what triggers it, and then developing skills to manage it, is key for our clients.'

Other services and support

Dianella Cottage also has links to AOD support services throughout the Blue Mountains and Lithgow areas, including the Making Choices program which provides ongoing community based support for adults who have recently completed an AOD treatment program of some kind. Dianella's clients are also referred to SMART Recovery groups, as well as having access to individual treatment and support when necessary.

Contact Dianella Cottage

To make a referral or find out more about the Dianella Cottage program, call 02 4782 9265 or visit the [website](#).

Further information about other Lives Lived Well services is available by calling 1300 596 366 or emailing enquiries@liveslivedwell.org.au.



Translating research into practice

Keeping community and creative connections in the picture of trauma and recovery

Professor Lou Harms Chair and Head of Social Work, The University of Melbourne

Trauma informed approaches have brought a critical awareness of the long-lasting and deep impacts of trauma in people's lives to many areas of practice in health, mental health, AOD support services.¹ These approaches remind us how important it is to bring an understanding of people's past trauma histories into the present. They also highlight the importance of understanding the impact of trauma on practitioners and the need for self-care practices. But there are some core aspects of trauma informed approaches that can be overlooked in everyday practice. One core aspect is that trauma informed approaches are whole-of-system approaches² while individuals' and practitioner's experiences are front and centre, so too are the broader organizational and social contexts of care and support. Service delivery may be about individual counselling and support, but it may also take up broader relational opportunities. Another core aspect is that trauma informed approaches are strengths-based approaches, with empowerment and recovery as the focus—yet often the focus is on assessing for past histories of traumatic life experiences and their impacts, without necessarily listening for the moments of strength and growth that so many survivors carry with them. In understanding trauma and its impacts comprehensively, this strengths perspective warrants more attention.

We found this was the case in listening to trauma and recovery experiences for those affected by the Victorian Black Saturday bushfires of 2009.³ We were particularly interested in hearing about people's experiences of post-traumatic growth (PTG), and what they saw as enabling this to occur.

PTG is now a well-documented and common experience for people in the aftermath of both individual and collective trauma experiences. It originated as a concept with five domains of positive transformation after trauma—people noticed after trauma that not only were they experiencing the acute distress of trauma but there were positive changes for many too—changes in a sense of personal strength, appreciation of life, spiritual change, new possibilities, and in ways of relating to others.^{4,5} So we sought out people affected both personally and professionally by bushfires to explore their experiences of PTG. Twenty people were part of the study—some had lost family members in the fire, others their homes, and some were practitioners who went

in and worked in the aftermath. We didn't define PTG, but rather asked people to tell us about their experiences and what they saw as their growth.

Firstly, we found that people had very diverse experiences of PTG. Some spoke about noticing it in the very early days of the fires, whereas others noticed it in the months and years that followed. Secondly, we found that people talked about their PTG in primarily relational terms—that is, it's something they discovered through their interactions with other people. For the vast majority of our participants, they talked about their experiences of growth through these sorts connections. Thirdly, they talked about their growth in terms of new skills they had acquired or how they had reconnected with long-forgotten ones. A lot of growth happened for people through the experience of creative connections with themselves or mainly with others—building, writing, talking, creating, often through arts-based activities. It was about doing things, and being involved actively in some form of pursuit. Critically, for some people, talking about their growth experiences enabled them in turn to talk further about their distressing experiences for the first time since the fires.

Providing opportunities for social connection, which can build new opportunities for safety and wellbeing, may be just as important as providing individual mental health support.

While these findings are about recovery from a large scale, collective experience, these findings have implications for trauma informed approaches with people whose traumas may be much more individual and interpersonal—the traumas of violence, abuse, and neglect, and long-term AOD use.

Three key implications are:

1. They're a reminder that positive community connection is a core part of recovery and should be part of any supportive response. Providing opportunities for social connection, which can build new opportunities for safety and wellbeing, may be just as important as providing individual mental health support.

Translating research into practice

continued

2. As practitioners already know, people's recoveries from trauma are complex—not only in terms of the negative impacts, but also factoring in the possibility of these positive transformations. Growth experiences are varied and are important experiences to assess and investigate deeply. They may provide a focus for talking with people about their distress while retaining a connection with their strengths.
3. Opportunities for creative engagement with other people increase both the social connections but also the ways in which people can recognize their own skills and strengths. Doing and creating new things provide the scaffolding for restoration of traumatized selves.

At their core, trauma informed approaches are radical approaches to supporting people recover from trauma experiences. If implemented fully, they can bring about transformative ways of working, that are fundamentally about systems and communities of recovery, and enabling people's strengths to flourish.

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NADA eLearning

Learn at a time, place and pace to suit you

Courses available

- Engaging with families and significant others in the AOD sector
- Asking the question: Recommended gender and sexuality indicators
- Magistrates early referral into treatment (MERIT)
- Complex needs capable
- AODTS NMDS

Learn online

Useful resources

Blue Knot

In 2012 Blue Knot Foundation launched their [Practice guidelines for treatment of complex trauma and trauma informed care and service delivery](#). Between 2012 and 2019 the clinical and research evidence around working clinically with complex trauma, including dissociation has exploded. This necessitated the development of their 2019 updated [Practice guidelines for clinical treatment of complex trauma](#).

Phoenix Australia Centre for Post Traumatic Mental Health

[Australian guidelines for the treatment of acute stress disorder and posttraumatic stress disorder](#) [PDF]
These guidelines provide recommendations on the best interventions for children, adolescents and adults who have been exposed to potentially traumatic events as well as those who have developed acute stress disorder or posttraumatic stress disorder.

Mental Health Coordinating Council

[Trauma informed care and practice organisational toolkit](#)
The Mental Health Coordinating Council has developed this toolkit to be used by any organisation wishing to improve its organisational and service delivery culture and practices. The toolkit is delivered in two parts; audit and planning, and implementation and evaluation. These two documents are free to download and can be used as workbooks or templates to guide organisational change.

Substance Abuse and Mental Health Services Administration

[Trauma informed organizational toolkit](#) [PDF]
This toolkit provides programs with a roadmap for becoming trauma informed. It offers service providers with concrete guidelines for how to modify their practices and policies to ensure that they are responding appropriately to the needs of people who have experienced traumatic stress.

Orygen—The National Centre of Clinical Excellence in Youth Mental Health

[What is trauma informed care and how is it implemented in youth healthcare settings?](#)
This clinical practice point supports individuals managing and working within outpatient and community based youth healthcare settings.

Australian Institute of Family Studies

[Trauma informed care in child/family welfare services](#) [PDF]
This paper aims to define and clarify what trauma informed service delivery means in the context of delivering child/family welfare services in Australia. Some of the challenges identified in implementing and embedding trauma informed care across services and systems are discussed.

Centre for Health Care Strategies

[Key ingredients for trauma informed care](#) [PDF]
This fact sheet describes key ingredients necessary for establishing a trauma informed approach at the organizational and clinical level.



NADAbase update

Tata de Jesus

NADA

Introducing a new team member

NADA are pleased to welcome Rosemaree Miller to the team. As research and data management officer, her primary focus will be to analyse data to help us to support and promote members. She will also join Suzie Hudson and I to support members with NADAbase related queries. Read page 28 to learn more about Rose.

Reporting

NADA submitted to the Primary Health Networks the PHN Quarter 1 July–September and Quarter 2 October–December reports for members who receive Primary Health Network funding. NADA also submitted to NSW Health the six-monthly July–December report for members who receive funding for the Methamphetamine Project, Drug Package Youth Treatment Project, and the Continuing Coordinated Care Project.

Data reporting agreement

In March 2019, NADA released a [data reporting agreement](#) [DOCX]. This agreement outlines the various

data reporting scenarios and require members to confirm which components of data reporting, if not all, they would like NADA to conduct on their behalf.

For members yet to submit the agreement, NADA will continue reporting as per usual. It's not too late to [email](#) your data reporting agreement to us.

Data quality checks

We introduced new logic checks in March 2020 so that:

- clients under 10 years of age cannot be entered in the database
- cessation date cannot be before commencement date.

These measures result from the validation checks provided by the AIHW, and will help to improve data quality submitted to funding bodies.

NADAbase dashboard tutorial

Have you seen the [NADAbase dashboard tutorial](#)? Take this short tutorial to learn how to use the dashboards.


What's new at SMART Recovery Australia

SMART Recovery Australia is developing some exciting new programs. We're engaged in feasibility studies concerning a program for youth, called Start SMART, another for those affected by the justice system, and we will be expanding on our current offerings both online and in the family and friends support space.

Harm minimisation and evidence led practice are the core values of our program. Accordingly, any expansion of SMART Recovery's offerings must be firmly rooted in these approaches. For example, we have experienced a significant influx of individuals at our meetings who are facing court charges for drug possession. Many of these people are not experiencing AOD dependence, but were caught breaking the law nonetheless. While our meetings are aimed at those experiencing AOD dependence, they have provided a service to these individuals who may otherwise never have been exposed to the potential

consequences of their actions, and the effects that substance use can have on themselves and those they love. For now, there is no specific offering in place for people who have no dependency, but need to address their high-risk behaviour, both from an early intervention point of view and a harm minimisation point of view. That's why we're developing a program specifically aimed at those who have been caught up in the legal system, based on SMART principles, and with the end goal of preventing these people from ever developing a dependence on AOD.

Our 'Be SMART family & friends' program is similarly aimed at people whose loved ones are experiencing AOD dependence. The sole aim of this program is to improve quality of life, coping skills and support systems. It is about getting those whose loved ones are AOD dependence to regain control of their own lives.



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

NADA

network updates

Women's Clinical Care Network

The Women's Network celebrated International Women's Day in March with a successful forum.

The event featured a member workshop led by KT Harvey, who shared her expertise in working with women and children in AOD services and across the health and community sectors. Dr Steven Mayers and his team from Sydney University presented their work on the Open Dialogue approach to mental health care and how this might work within the AOD setting.

The Glen and ONE80TC—both new to working with women—spoke about their exciting new programs. And longstanding providers of women's AOD services, Jarrah House, Phoebe House and New Beginnings (WHOS) shared their recent achievements and program developments.

Meredith Turnbull, rounded out the days' proceedings with her Worker Wellbeing Workshop.

The IWD Forum proved popular and looks set to become a key annual event for NADA and the network.

Youth AOD Services Network

The Youth AOD Services Network will meet again on 18 March, with a view to planning training and other activities over the next 12 months.

The Youth Network is also keenly anticipating upcoming NADA supported training in suicide and self-harm prevention. This has been organised in response to recent events and requests from several NADA youth services.

The 'Find Hope' workshop will be led by Fiona Livingstone and is based on the internationally recognised Suicide ASIST program. It is anticipated that this event will take place in May.

NADA network updates

continued

NADA Practice Leadership Group

The NADA Practice Leadership Group (NPLG) held its quarterly meeting in December. The network:

- invites NADA members to [contact them](#) for advice or to collaborate to help you deliver person centred and evidence based practices
- acknowledges there is more work to be done around data collection and reporting. Service delivery needs to come hand in hand with timely data collection; and KPIs for specialist non government AOD services need to be streamlined to reduce burden of data reporting
- has raised concerns on the impending end of contracts and early notification of continuity of funding, the implications of timing on staffing and service delivery.

The NPLG is looking forward to their meeting in March 2020, as they have invited key representatives from NSW Health, Department of Social Services and Public Health Networks to consult on the group's activities for the next year.

CMHDARN

Save the date The annual CMHDARN Symposium will be held on 15 May 2020 and we'll be celebrating 10 years of CMHDARN! Please put this date in your calendars.

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

Clever ideas If you have any things you'd like to see CMHDARN cover in upcoming newsletters, webinars or ideas for new ways to develop the research capacity of our sectors, please [contact us.](#)

Profile

NADA board member



Julie Babineau
CEO of Odyssey House NSW

How long have you been associated with NADA?

I was first introduced to NADA in 2001 when I joined the Drugs Program Bureau (NSW Health), one year after moving to Australia. The relationship continued when I was at Justice Health for over 14 years before joining Odyssey House NSW almost four years ago.

What does an average day look like for you?

Is there an 'average day' in the life of any CEO of a non profit organisation... probably not... which must be why I am so enjoying my current role at Odyssey. The day would usually start with a run or more a jog or a walk followed by an early arrival at work in Redfern or one of our residential sites in Campbelltown area or if I am lucky, one of our 10 community sites across Sydney. The best part of my job is meeting residents and clients and witnessing the great work our staff do to help and support individuals impacted by the misuse of alcohol and drugs. Finally, rarely does a day end the way I planned it—so my days are filled with reprioritisation after reprioritisation.

What experiences do you bring to the NADA Board?

I believe I bring a strong governance focus to the NADA Board as well as good government and academic networks. I have a passion for the clients and a vision for the sector and truly believe that NADA is as good as its collective membership (yes, just like Star Trek).

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

So much really! To work with a great bunch of incredibly committed individuals at the board and operational levels of NADA and to provide advocacy on behalf of our member organisations everywhere we can make a difference.

What else are you currently involved in?

Lots of interesting things... ask me when you see me next.

A day in the life of...

Sector worker profile



Lisa Robins Head of Digital Therapeutics
Hello Sunday Morning

How long have you been working with your organisation?

I've been at Hello Sunday Morning for 18 months.

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

I began my career as a research assistant, then trained as a psychologist, and over time became more involved in eHealth service delivery. I felt a lot of frustration in the eHealth space as although we were building tools with good clinical content, the uptake was very low. This motivated me to look for opportunities where I could apply my research, clinical and digital skills in both a meaningful and impactful way. When an opportunity came up to join Hello Sunday Morning and help design and develop the Daybreak app (a peer support service for people who want to change their relationship with alcohol) I jumped at it!

What does an average work day involve for you?

I work with a multidisciplinary team of designers, engineers, researchers and clinicians to co-design Daybreak with our members, and a typical day can be anything from design ideation sessions for service improvement through to releasing new program content.

What is the best thing about your job?

I really love contributing to a program that's achieving real-world impact and supporting people to achieve their alcohol related change goals.

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

We'd all love to see greater service accessibility. Increasing funding for our sector is critical to achieving necessary service expansion.

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

Spending time with family, friends and my puppy, and getting into present-moment and immersive activities like gardening and making furniture—great for centring myself!

Welcome here project

By Michael Atkinson

One way for a service to express their commitment to the LGBTIQ community is to register with the Welcome Here Project and receive a Member Pack with the Welcome Here rainbow stickers and charter.

Spearheaded by ACON, NSW's leading sexuality and gender diverse health organisation, the Welcome Here Project aims to support local business owners and services across Australia to create and promote environments that are visibly welcoming and inclusive of LGBTIQ people.

ACON has great working relationships with many AOD services, many of whom are already members of the Welcome Here Project, including NADA. Everyone is welcome to join.

It's a membership based project which costs \$10 to register and you receive a member pack which includes:

- rainbow stickers and charter to display in a prominent location
- a handy checklist to make the most out of the project promotional postcards
- Welcome Here Project badge and fridge magnets
- use of our project logo, and social media designs and designs to print your own pull-up banners.

A lot of people tell us they love seeing the Welcome Here rainbow sticker—they have a sense of belonging and it removes doubt about walking in for a visit.

We heavily promote our members of sexuality and gender diverse communities. For example, members are listed in our member directory, which we promote to our communities and strongly encourage people to visit members. We also send a quarterly e-newsletter full of useful information to support members on their inclusion journey.

For more information about the Welcome Here Project:

- Visit our [website](#)
- Join us on [Facebook](#)
- Get in touch via [email](#)

NADA is a proud member of Welcome Here

NADA became a member of Welcome Here to acknowledge the diverse workforce across the health and social services sector, including within our members. Our workforce survey indicates that 15% of workers in our members identify as sexuality and gender diverse. NADA celebrates diversity, which is reflected in our values of *respect* and *inclusion*.



Introducing Rose

During February, NADA welcomed Dr Rosemaree Miller to our team.

Rose is responsible for facilitating research involving NADA and its members. This includes leading research projects which strengthen the performance of the AOD sector as a whole and supporting NADA members with NADAbase and the routine collection, reporting and analysis of data and outcomes. She has worked as a researcher in the AOD sector since 2017 and has experience in university-level research and teaching. Rose has a PhD in psychological science, a BSc in psychology and a BA in creative arts and writing.



From 2017 to 2019 Rose was the on-site researcher for the first long-term evaluation of the Odyssey House NSW residential program. On behalf of the University of Technology, Sydney, Rose implemented and coordinated the research for the evaluation alongside Odyssey House NSW staff and conducted follow-up interviews with former residential clients.

Member profile

Drug & Alcohol Health Services Inc

Service overview

The Drug & Alcohol Health Services Inc. (DAHS) is a non government organisation with offices located in Muswellbrook and Coffs Harbour, New South Wales.

DAHS is a unique organisation helping people experiencing AOD issues, as well as servicing the local courts through the Magistrates Early Referral Into Treatment (MERIT) Program in both the Hunter Valley region (illicit drug use only) and the Mid North Coast region (for alcohol or illicit drug use).

DAHS aims to provide accurate and current information to the Hunter Valley and Mid North Coast communities about the effects of AOD use on individuals, their families and the wider community. A harm reduction philosophy is adopted that empowers service users to take control of their AOD use and supports changes that improve health and wellbeing.

A 'no wrong door' approach ensures those with co-occurring mental health and AOD use issues are able to access appropriate treatment.

Our staff

The dedicated and professional staff at DAHS are selected for their ability to work in a multi-disciplinary environment whilst operating under the DAHS fully accredited policy and procedure guidelines.

The team at DAHS have experience working with multicultural, Aboriginal and CALD communities with emphasis on cultural awareness, empathy and understanding of a wide and diverse community including being a member of the LGBTQI Welcome Here Project.

Locations

The Muswellbrook office provides comprehensive assessment and treatment by a visiting addiction medicine specialist, as well as one-on-one counselling for all AOD related issues.

The Coffs Harbour office delivers the MERIT Program only, however part of the treatment process may include referral and counselling services for persons affected by AOD and co-occurring issues.

Programs and services

DAHS services offered include:

- needle and syringe program
- drug and alcohol counselling
- addiction medicine specialist consultation and liaison services, including shared care with GPs
- opioid treatment program
- overdose prevention and response training, including take-home naloxone
- outpatient alcohol detoxification and withdrawal management
- hepatitis C assessment and treatment
- MERIT program (both offices).

Contact us

For more information on the Drug & Alcohol Health Services organisation, please visit their website: www.drugandalcoholhealthservices.com.au

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Email admin@daahs.org.au

Coffs Harbour

33 Gordon Street
Coffs Harbour NSW 2450

Phone 02 6650 0126

Fax 02 6650 0098

Email chmerit@daahs.org.au



Dried blood spot test helps overcome barriers to hepatitis C and HIV testing



The dried blood spot (DBS) test is an innovative pilot program offered in partnership between the NSW Ministry of Health, St Vincent's Hospital and Sexual Health InfoLink that offers an easy, self-sampling option for anyone wishing to have a HIV or hep C test. As a simple finger-prick blood collection the DBS is particularly useful for clients who may not get tested regularly or who experience barriers to conventional testing.

DBS kits are ordered through the [DBS website](#) and mailed directly to the client, who completes the test with a few drops of blood, and returns the completed test card using the supplied reply-paid envelope. Results are then sent to the client via text, email or phone call. Alternatively, health and community services which are registered as DBS sites can help clients to undertake DBS testing or distribute DBS kits throughout NSW.

Using DBS, people who have a history of injecting drug use, those who have been in or are currently in prison, Aboriginal people and people from countries where hepatitis C is endemic are eligible for a hep C test and they are also able to opt-in for a HIV test. Men who have sex with men, transgender people and those coming from countries with HIV is high in prevalence are eligible for the HIV test.

Key benefits of the DBS testing method include: allowing clients to test for HIV and hep C discreetly and privately; providing an alternative for clients where venepuncture is not suitable or desirable; and creating opportunities to deliver testing in non-clinical settings. Recent changes to the DBS website mean clients can choose to test separately for either HIV or hep C, with the ability to opt-in for HIV testing for those eligible for hep C only. The website will soon be translated into nine community languages to make it more accessible to CALD communities: Spanish, Portuguese, Arabic, Thai, Khmer, Vietnamese, French, Chinese and Bahasa Indonesian.

Across NSW several AOD services have successfully implemented DBS testing. These sites use the DBS test in a number of both clinical and non-clinical settings. It is useful in both clinical and non-clinical settings and clinical staff are not required to perform the test. DBS is particularly useful for helping people who may otherwise not be engaged with clinical care to get tested and be linked into care.

If you would like posters or business cards to let your clients know about DBS testing or if you are interested in registering your service as a DBS delivery site, please email the DBS Project Coordinator, [Nigel Carrington](#), or phone 0409 382 966.

Gender and sexuality diverse AOD worker network

In December 2019, NADA held the inaugural Gender and Sexuality Diverse AOD Worker Network. Gender and sexuality diverse people are a priority in the National Drug Strategy, and other strategies related to AOD use. Additionally, the recent workforce study by NADA found that 15% of non government AOD workers in NSW identified as gender and sexuality diverse. Whilst, NADA, and its partner in this work, ACON, have undertaken a range of activities to ensure its members are providing inclusive services, there is still much more work to be done in this area.

At the first meeting workers agreed that the network has a dual purpose to: provide a supportive network for gender and sexuality diverse workers in the AOD sector; and

improve AOD services for gender and sexuality diverse people. The membership currently comprises a small group of NSW AOD workers, which is inclusive of those providing frontline services, management, administration and research. If you're interested in joining the network, contact [Robert Stirling](#).

Would you like to ensure your services are more inclusive for gender and sexuality diverse people?

Guidelines [AOD LGBTIQ inclusive guidelines for treatment providers](#)

eLearning [Asking the question: Recommended gender and sexuality indicators](#)



NADA practice leadership group

Meet a member

Tara Morrison Transition Worker—AOD

Community Restorative Centre

How long have you been working with your organisation? How long have you been a part of the NPLG?

I have been working with Community Restorative Centre (CRC) for 18 months and with the AOD team at CRC for 12 months, and I joined the NPLG in 2019.

What has the NPLG been working on lately?

The NPLG has been focused on issues that impact on the ability of the sector to deliver front line services including data and reporting (particularly ways to reduce the burden on NGO's), short contracts and funding uncertainty.

What are your areas of interest/experience—in terms of practice, clinical approaches and research?

I am a Wiradjuri Woman and am passionate about supporting people struggling with AOD, women with children and people who have lived with complex trauma. I am particularly interested in developing ways to work with Indigenous clients that are culturally meaningful.

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

I meditate every day, I play particular music in the car between work and home, I spend time with my own family, and I try to make sure my case-load is manageable—and learn how to pull back when it gets too much.

What support can you offer to NADA members in terms of advice?

I can provide support in terms of culturally safe and trauma informed ways to work with Aboriginal and Torres Strait Islander people.

VIDEO



Stay in touch with the AOD sector

Frontline

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

Advocate

Explore AOD news and issues with our quarterly eMagazine. Read [previous issues](#).

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

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

CMHDARN's community research mentoring program

'The mentoring program can really assist you in identifying the best research questions and methodology'
– Mentee

Applications are open for the Community Research Mentoring Program run by CMHDARN.

The program is open to MHCC or NADA members who want to develop and conduct research guided by an expert mentor. Designed to support practice based research, the program helps to build the skills of the mentee and to equip them with knowledge about research processes and measuring impact and outcomes.

The scope of each mentoring project is worked out between the mentor and mentee. Themes for the projects can include:

- developing research question/s
- guidance on how to conduct a literature search
- advice regarding procedures and measures to include in an evaluation of a service
- statistical advice to assist with the analysis of data collected by a service
- advice on quantitative and/or qualitative studies within a service.

What mentees have said:

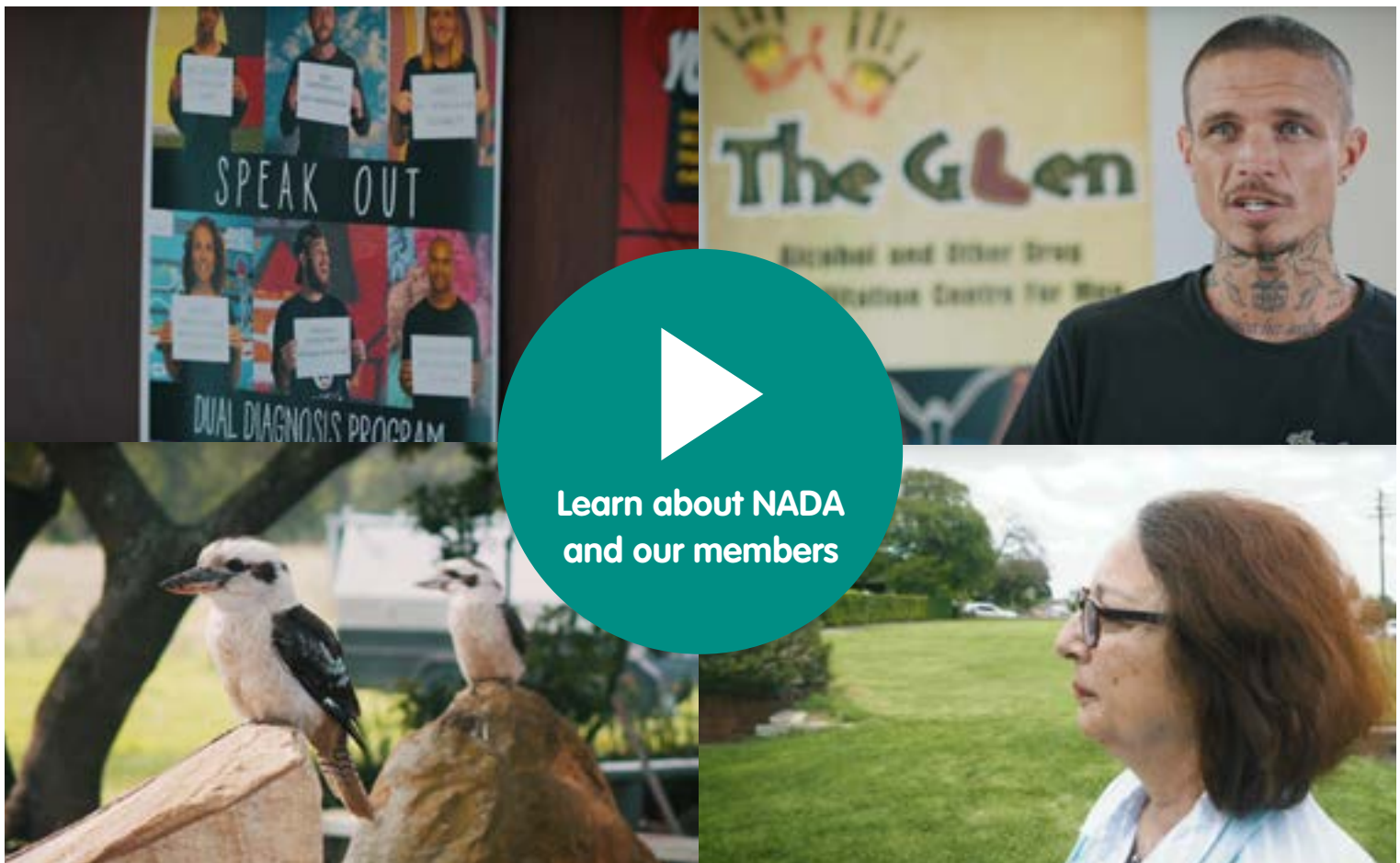
'The mentoring program has really helped establish our practice-based research and navigating the many options on clear and relevant research methodology.'

The mentor's experience:

'It has been fantastic being part of the CMHDARN mentoring program and to facilitate the application of research methods to real-world settings. I have thoroughly enjoyed developing relationships with the fabulous frontline workers I have been mentoring.'

To apply, email info@cmhdaresearchnetwork.com.au or visit the [CMHDARN website](#).

CMHDARN, the Community Mental Health Drug and Alcohol Research Network, was established in 2010 to broaden involvement of the community mental health and alcohol and other drugs sector in practice based research. CMHDARN is a partnership between the Mental Health Coordinating Council, the Network of Alcohol and other Drugs Agencies and the Mental Health Commission of NSW.



What we're working on

Program update

Workforce capability framework

The non government AOD sector plays a vital role in the prevention and reduction of AOD-related harm in NSW. Central to workforce performance are capabilities—the knowledge, skills and attributes that all workers in this sector must demonstrate to perform their roles effectively.

Due to launch in early 2020, the Workforce Capability Framework: Core Capabilities for the NSW Non Government Alcohol and Other Drugs Sector—developed for, and with input from those who work in the sector—describes the core capabilities and associated behaviours expected of all NSW non government AOD workers.

Stay tuned to NADA's communications for further details or contact sianne@nada.org.au.

Reconciliation action plan: Innovate 2020–22

The Reconciliation Action Plan (RAP) Working Group was reconvened on 10 March to start a review and update of the Innovate 2017–19 RAP. The working group includes representatives from several NADA member services, as well as an Aboriginal consumer representative.

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

Continuing coordinated care

The Continuing Coordinated Care (CCC) programs continue to provide intensive outreach wraparound support across NSW to people experiencing AOD issues and other co-occurring needs. NADA's CCC clinical program manager has provided advocacy and other support to CCC program staff and other NADA members and recently has:

- facilitated meetings and site visits with CCC staff to other NADA member services and Department of Communities and Justice
- provided workshops and team clinical case reviews.

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

Consumer engagement board sub-committee

The consumer representatives of the Consumer Engagement Board Sub-Committee met on 26th January to discuss their plans and goals for the group in 2020. The Consumer Engagement Board Sub-Committee will meet again in April to elect co-chairs for the committee and welcome the two representatives from new Board of Directors, Latha Nithyanandam and Libby George.

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

National treatment framework for alcohol, tobacco and other drug treatment

The [National Treatment Framework for Alcohol, Tobacco and other Drug Treatment](#) is designed to guide a national response, under the National Drug Strategy (2017-2016) for treatment interventions, addressing how harms from AOD are reduced based on individual needs and goals. NADA has been involved in the national planning process as part of the framework's reference group. We believe the framework will provide a useful backdrop to the service system planning at the NSW service system level and is a useful guide to understanding the principles for effective treatment and treatment system planning, purchasing and resourcing.

New report NADA member needs assessment

Over 2019 NADA undertook a comprehensive needs assessment with NSW non government AOD services. The assessment has been the result of a range of engagement strategies with members through annual member and workforce surveys, site visits with members, engagement with networks and consultation with members at NADA events. The assessment is broken down into *policy and advocacy*, *service delivery*, *workforce needs* and *research and data*.

[Click here to download the assessment \[PDF\]](#). For more information contact [Robert Stirling](#).

Advocacy highlights

Photo by Kris Ashpole

Policy and submissions

- NADA and a network of NSW peak bodies sent a letter to the NSW Premier to request a meeting to discuss a coordinated approach to the bushfire recovery
- NADA provided feedback on the Alcohol Treatment Guidelines section for sexuality and gender diverse populations
- NADA provided feedback on the revised Withdrawal Guidelines and promoted consultation with specialist networks
- The AOD Peaks Network provided a submission to the Public Inquiry into public communication campaigns targeting drug and substance use
- Brief provided to Advisor to the NSW Minister for Health on NADA member advocacy priorities
- The latest NADA [Sector Watch](#) [PDF] and update on the Special Commission of Inquiry into the Drug 'Ice'
- NADA and group of peaks nationally have provided a joint letter to Senators regarding the Social Services Legislation Amendment (Drug Testing Trial) Bill 2019

Advocacy and representation

- Held a consultation with members to prepare for the public release of the Special Commission of Inquiry into the Drug 'Ice' final report
- Key meetings: Australian Government Department of Health, NSW Ministry of Health, NSW Council of Social Services Forum of Non Government Organisations, AOD Peaks Network
- Meeting with the AOD Advisor to the NSW Minister for Health to discuss member advocacy priorities and the final report of the Special Commission into the Drug 'Ice'
- NADA participated in monthly Peaks Capacity Building Network teleconference and will undertake a workforce developing mapping exercise to identify strengths and gaps at a national level
- NADA presented on language and stigma at the Hepatitis NSW workshop Get Bloody Serious—A Hepatitis Workshop
- NADA attended a NSW Ministry of Health sector wide workshop to develop a strategic prioritisation framework for AOD research and evaluation in NSW
- Established a Gender and Sexuality Diverse AOD Worker Network to support workers and improve services for gender and sexuality diverse people
- Coordinated a consultation with members regarding Take Home Naloxone and participated in the review panel for a THN training provider

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

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[Feedback](#) [Training grants](#)