Advocate

The eMagazine of the Network of Alcohol and other Drugs Agencies Issue 4: December 2021

Stigma and discrimination

NADA network of alcohol and other drugs agencies

CEO report

Robert Stirling NADA

Before COVID-19, the NSW non government AOD sector struggled to attract the funding required to recruit and retain the skilled workforce needed to respond to the demand for treatment and support. This situation is more dire than ever before. And yet, our sector has continued to demonstrate its professionalism and capacity to provide services in the face of adversity. On behalf of the NADA board and team, I want to thank you all for your resilience and leadership in adapting your services in 2021 to ensure that ongoing care and support was provided to NSW communities.

This issue of the Advocate focuses on stigma and discrimination. We know that people who use drugs experience significant levels of stigma and discrimination, and that this impacts on health access and outcomes. It is also felt by the workforce. In this issue, we hear from the experiences of people who use, or have used drugs, from frontline workers to managers, and policy makers to academics.

Stigma and discrimination towards people who use drugs also impacts on policy and funding decisions. Would we have seen a response to the Special Commission of Inquiry into the Drug 'Ice' if we were another area of healthcare? Would the community and media have rallied behind us in great numbers advocating for change? While we know that community attitudes are changing, we need to make a significant shift to improve the situation. We need to ensure that policy and funding decisions are driven by people with lived experience and informed by evidence and practice.

In 2018, NADA worked with the NSW Users and AIDS Association (NUAA) to adapt 'Language Matters' based on the local experience of people who use drugs and frontline workers. Language is powerful and can reinforce negative stereotypes. However, this is only part of the solution. We all have a part to play in challenging stigma and discrimination—whether we work in the frontline, management or administration. But what can we do?

- We can have open and honest conversations (see page 14) about drugs with people to change their attitudes and beliefs—at work, at home, and in the community
- We can demonstrate professionalism and demand to be funded and treated in the same way as any other healthcare service
- We can support people to 'live their best life'—it's become such a common phrase, yet this is what we have always done in the AOD sector—and demonstrate the positive health and social outcomes that our services achieve
- Central to all that we can do, is being informed by the lived experience of people who use drugs in the design, delivery and evaluation of the services we provide.

Would we have seen a response to Special Commission of Inquiry into the Drug 'Ice' if we were another area of healthcare?

NSW Health has recently released a report from a stigma and discrimination study that was undertaken over 2021 (see page 12). We are encouraged that NSW Health have committed to a long-term plan to address the stigma and discrimination experienced by the people that we support. We know that the NSW non government sector stands by ready to take action, and we hope that this issue of the Advocate provides an opportunity to keep this conversation moving forward.

Finally, with 2022 almost upon us, NADA has consulted with its members to understand their needs. The 2021 NADA Member Needs Assessment [PDF] will drive NADA advocacy, programs and services over the next 12 months. We look forward to working alongside you all in 2022—advocating, strengthening, and promoting the NSW AOD sector.

We wish you all a safe and relaxing festive season, and hope that we can return in 2022 revitalised and ready to continue to support people who access AOD treatment and support. And for those that continue to work over this period, we thank you for ensuring that ongoing support is provided during a time that is not always merry and joyful for all.

How does your service address stigma?

NSW Users and AIDS Association (NUAA)

Mary Harrod, Chief Executive Officer

What are the two most common experiences of stigma you hear about from people you support?
One of the most common and most pressing issues our organisation is working on is a lack of proper access to health care. This issue is multi-faceted and includes people being shamed by a health care service and either being outright denied treatment because of drug use or not returning/not accessing health services because of this treatment. One example of this treatment is being denied pain relief, something that happened to one of our members with end-stage cancer. It's a huge issue that has a significant, unmeasured impact on people's health and quality of life.

Another huge issue is police profiling. This has been particularly acute in the recent COVID lockdowns where people accessing medical treatment were threatened with, or actually fined. We have had many reports of our community being stopped by police for 'health reasons' and then searched. COVID made this long-standing issue more acute.

What does your organisation do to address the stigma experienced by people you work with?
Our role is extensive and multi-faceted. Our very existence combats stigma, our successful functioning. Everything we do is aimed at empowering our community to advocate for their rights to fair and equal treatment.

Peers are so important in tackling stigma and discrimination against people who use drugs, and we are the only people that can effectively advocate to redress the issues. To me, a stigma project without peer involvement from the inception is really missing the mark. So, there is that level, but at another more fundamental level to shift this pervasive dynamic, peers need to call it out—we, as an organisation, need to support and empower people to complain.

Glebe House

The Glebe House Team

What are the two most common experiences of stigma you hear about from people you support?
Involvement with the criminal justice system brings its own particularised stigma; clients can feel they don't belong, or that they don't deserve to be part of a community and are branded with a label not to be outgrown. Fear associated with employment, references, housing, finance, and difficulty identifying healthy, encouraging supports can reinforce the isolation often experienced, and drive desperation and maladaptation.

Drug dependence carries its own weight; shame associated with powerlessness and desperation; the loss of control and what follows while attempting to survive the discomfort. It brings guilt associated with doing something wrong, something seen as unhealthy, dangerous, risky; the moral judgement from friends, family, and the community; the loss of hope, and being trapped. Reconciling with family and self-acceptance, positive self-image, self-respect, and satisfying personal goals can be hard to identify in clients who have had experience with the criminal justice system.

What does your organisation do to address the stigma experienced by people you work with?
Glebe House supports participants while they explore causes for their substance use issues; identifying trauma, considering the strategies used to diminish pain, and recognising the sense of isolation associated with addiction. We nurture a network of peers; tolerance and inclusiveness are valued, and clients are encouraged to find self-acceptance while aiming towards healthy, responsible, community-minded living. Clients of Glebe House re-enter the community with a sense of belonging, and with restored hope in their intrinsic value and capacity for change.

Namatjira Haven
Dian Edwards, Manager

What are the two most common experiences of stigma you hear about from people you support?
One key source of stigma comes from morally based and judgemental attitudes from some of the people making referrals to our service. When the potential client states they stopped using weeks before, or they report only using on weekends, I query the reason for a referral to our service, a residential rehab. The referrer may react badly, which shows zero tolerance for any illicit substance, particularly where there is justice involvement (court order) or where there are child protection issues.

We also see self-stigma, often the result of an abstinence approach being rigidly applied. It may come from their parents, because that's what worked for them. Many of these are younger men, who come in with no ability to look at any aspect of their life that may help them cope. They focus on the total abstinence of all substances and removal of all family and friends that use a substance in any form. They are told they need the 12-step program that continues to hold them up when abstinent, but often fails them when they use again. We feel that a more holistic program is beneficial and that is why we have moved towards a harm reduction approach—but it is a challenge when the workforce may have their own experiences about 'what works' and find it difficult to be more flexible.

Stigma carries a double whammy for Aboriginal people. It's one thing to be labelled when seen using AOD, it's another thing entirely being seen and being Aboriginal. All the stereotyping and racial profiling carries consequences for Aboriginal individuals, families and communities.

Mental health and AOD is another difficult stigma; many get ostracised from the community. AOD services send people to mental health to work safely with complex mental health. Mental health and hospitals send people to AOD services, stating it is not mental health. While that continues, many fall between the gaps.

What does your organisation do to address the stigma experienced by people you work with?
We advocate for more services in the community to work with people where they are at. We encourage referrers to visit so we can talk about the program and what we offer here, so that we don't end up with people who are mandated to come, but don't actually require the intensity of treatment we offer.

We push back on judgements and attitudes, and the stigmatising language. Using AOD is a coping response, and we build resilience to help people cope in a less harmful way. We understand that until the underlying causes are addressed, there will be substances used, and some people will not see a way out of that.

We advocate for smaller 'highly specialist' services to be able to cater well for everyone; those with complex needs, dual diagnosis, intellectual disabilities and also sexual offenders, arsonists and the violent. There needs to be more specialised help for people with those experiences.

We will keep pushing for an alternative to emergency departments (ED) for people in a mental health and/or AOD crisis as EDs are not the place for this, and stigma and fear and threats exacerbates the situation and risk to everyone. There are no services for people who experience both AOD and mental health crises, particular in rural, regional areas.

Lastly, we need to ask ourselves: Is the industry a health industry or a justice industry? The last inquiry has led to an increase in mandating beds through courts under the banner of a health response. I will advocate against that, or to create mandated services as one of the boutique options funded by justice because again you cannot fill services with mandated clients.

Family Drug Support
Tony Trimingham, Chief Executive Officer

What are the two most common experiences of stigma you hear about from people you support?
Next to people who use drugs themselves, I don't think any other group is affected as much as families. People see us as someone to blame, that we have done something wrong; we already carry that burden of guilt. In the community, we commonly hear that assumption that if anything bad happens, such as a crime, then it must be someone who uses drugs—people say it without even thinking. If you hear that as a family member, at work or in a social setting, it hits you hard and you feel such a sense of shame and hurt.

A common experience of families I speak with who reach out after a bereavement tell me that people around them make comments about how 'you must feel relief'. They imply that a burden must have been lifted because they won't need to worry anymore about the family member who was using drugs. In the community, there is often a sense that if a person who was using substances dies, they probably deserved it—and that is a very painful thing to hear in relation to your child or partner.

The language people use also exacerbates the experience of stigma for families. We use Language Matters all the time in our workshops to challenge stigmatising language. Language like 'rock bottom' and 'clean' keeps people feeling shame and may stop them from reaching out for support. The worst for families is 'enabling'—implying that they are making it worse by caring. Families already have enough to deal with, but to be judged for having your child stay at home or give them money is so unhelpful.

What does your organisation do to address the stigma experienced by people you work with?
Whenever I do my presentations, I always mention stigma. Everyone uses some kind of drug; some get people into more trouble than others, dependence is difficult to deal with and that is why education is so important, speaking out.

The other important thing we do is Family Remembrance Day—to have a space people can come together and remember who they have lost and challenge the stigma they may experience.

Challenging language is also key, I will never forget a time I heard some visitors speak at Parliament House that had come over from Europe. They used language that stepped away from judgement such as 'our citizens who use drugs'—it really stuck with me—and challenging stigmatising language is something I will continue to do.

Youth Solutions
Emily Deans, Research, Strategy and Design Coordinator

What are the two most common experiences of stigma you hear about from people you support?
One of the key things we hear from the young people we work with is how they impose a hierarchy on alcohol and the different drugs in terms of risk and associated stigma. There is a clear differentiation between those drugs that are seen as harmful, heroin and methamphetamine for example, and those that are considered acceptable, or even endorsed, such as alcohol and cannabis. According to our research with young people, marketing and media representations of AOD are very influential in terms of how young people perceive people who use illicit drugs in particular and the stigma follows.

Secondly, there is lots of shame and stigma associated with the people who appear to be 'functioning' users of AOD—the judgement around whether a person can manage other aspects of their lives, and this is perceived as 'ok'. Social media has a significant role to play in how people who use drugs are portrayed—the idea of 'what someone who uses drugs looks like'. Young people sharing TikTok videos that relate to 'acceptable' drugs such as cannabis, whereas heroin is frequently perceived as an 'old' person's drug.

What does your organisation do to address the stigma experienced by people you work with?
It is for this reason that we have shaped our prevention materials to respond to what young people are telling us they want to know. Our work has, as its central focus, addressing stigma and discrimination around substance use. We focus on why a person may use drugs, incorporate harm reduction where appropriate—ensuring we pitch the information correctly, depending on the audience. But addressing stigmatising language is always a focus. We also ensure to include people who have a lived experience—young people respond to those who speak honestly to them, and it makes it real—challenging these preconceived notions of a person who uses AOD.

Sharing drug stories

Publicly sharing personal drug stories can be powerful, but is associated with a variety of risks and harms —It's tricky stuff! Liam Engel, from AOD Media Watch, shares ways to navigate these murky waters safely.

Personal drug stories

When developing news stories for mainstream media outlets, journalists are often required to provide an element of 'human-interest.' People's personal experiences make it easier for audiences to relate to a news story and increase the likelihood that a story will be watched or read. This is why personal stories frequently appear at the start of a news article—to entice readers.

People who use drugs and their communities have a unique capacity to connect to a large audience. They are a vital resource for drug communications. By working with people who use drugs, researchers and AOD services are more likely to be successful in pitching stories to journalists. In turn, researchers and AOD services are better able to control the public narrative and policy agenda.

Yet someone in, or just leaving treatment, may have a sense of wanting to 'give back' and agree to an interview, not realising that in two or three years a potential employer or other influential person may Google their name, find the interview, learn about their lived experience and discriminate against them as a result. It is important that those working with people who use drugs help their clients to understand both the potential negative and positive implications of being open and honest about their current or former substance use.

Journalists reach out to people who use drugs with their own agenda. Publicly sharing personal drug stories is associated with a variety of risks and harms. These need to be balanced according to the values of the person or people sharing their experience, rather than the values of the publisher.

AOD Media Watch can provide advice to people and organisations regarding drug communications. We have outlined four principles to guide AOD journalism: (i) the inclusion of people who use drugs, (ii) stigmatisation, (iii) accuracy and (iv) harm reduction. On one hand, we are advocating for consumer input into news stories, yet we acknowledge that it is complicated to provide advice to people who use drugs on telling their own drug stories.

No one individual or group can speak for the personal choices of all people who use drugs and their communities. AOD Media Watch encourage people who use drugs to tell their stories on their own terms, and it is crucial that drug communications provide these people with autonomy.

Politics around the use of the J-word exemplify this personal choice issue. While this term is inappropriate in many contexts, there are instances in which it has been reappropriated by people who use drugs for positive

Sharing drug stories
continued

affirmation, much like the concept of gay pride. However, we should also be mindful that it is easier for some people to be prouder than others, particularly for people who use drugs that are also discriminated against due to their race, gender or other reasons. It's tricky stuff, which is why telling a personal drug story should be viewed as an important personal choice. Only the person telling their story can understand all the factors at play.

Even if a person who uses drugs has agreed to contribute to a story, remember they are free to withdraw their consent at any time. If they are concerned about the story content, how they are being treated, do not feel they are being offered enough support throughout the storytelling process, like they're being pressured to participate, or to say things that don't represent their experience, encourage them to withdraw their consent. Keep in mind that, once a story has been published, it's out of their hands.

Stereotypical drug stories

There are always exceptions, but journalists (or their editors or publishers) are likely to have the same stigmatising attitudes towards drugs and the people who use them that exist in the wider community. These attitudes are likely to result in a negative framing of a person and their drug use story.

Depending on the type of story, journalists will often want to interview someone who currently uses a particular type of drug and may emphasise the potential harms of this use in their article as a means of generating a shock response. Another common drug news story will portray people who have ceased drug use as having a story of redemption.

If people want to tell their personal drug story, it is worth considering how it is different from drug story stereotypes. This can help ensure their story is not portrayed in a way that perpetuates the stigmatisation of people who use drugs.

Positive drug stories

An easy way to tell if a story challenges drug stereotypes is to consider if it tells a positive story about drugs and the people who use them. While it is important to reduce the harms associated with drug use, harm reduction is frequently conceptualised in a stigmatising way. A focus on harm and neglect of benefit within harm reduction highlights the influence of drug stigma upon the perception of drug risk.

This is not to say that people's negative drug stories are not worth telling. However, if somebody is thinking of sharing a negative drug story, encourage them to think not only about how they may benefit, but also how the broader community of people who use drugs benefit. There is a lot of messaging telling people who use drugs to 'just say no' already out there—how does their story add something new? Does it provide a novel strategy for reducing drug harms or improving their benefits? Does it identify a role model for safer drug use? Does it improve the wellbeing of people who use drugs?

Coming out

Sharing drug stories publicly is part of a 'coming out' process, similar to that commonly discussed in the LGBTQIA+ community. Similarly, coming out as a person who uses drugs has both advantages and disadvantages.

The disadvantages are likely the most obvious. The threat of legal ramifications associated with drug use is strongly intertwined with stigma involving a variety of moral, social and professional fears.

The advantages of coming out through telling a personal drug story firstly includes the opportunity to confront and challenge disadvantages. Being honest and open about drug use is a strategy for challenging drug prohibition and stigma. There are also psychological advantages stemming from positive affirmation and confidence in identity and expression. On a broader level, coming out improves connections between the public and drug communities, reducing harms and increasing advantages of drug use itself.

Should clients tell their drug story?

The decision to tell a drug story is a personal one. While drug stigma and prohibition is a terrible and destructive force, it is easier for some people to challenge this destruction via coming out than it is for others.

We encourage all people interested in drug communications to recognise that publishers have a greater responsibility for telling positive drug stories than people who use drugs, or even journalists. Coming out, on the other hand, must remain an entirely personal choice of the individual in question, although coming out should by no means be considered a responsibility, particularly for people already in a vulnerable position. To help people who use drugs make a fully informed decision about sharing their personal drug story, encourage them to consider the following questions:

See practical tips overleaf.

We need to treat the root issue

Terry McGrath
Team leader and registered nurse
Namatjira Haven Drug and Alcohol Healing Centre

It's important that we, as a community, should have more honest and open conversations about AOD.

People from all walks of life use drugs—both licit and illicit—and lead otherwise normal lives, from lawyers, to folks in the suburbs and bush. Yet our laws discriminate against people who use illicit drugs, forcing their behaviour underground and criminalising them. Most people do not have issues resulting from their drug use, however, for people who do, this often has more to do with other challenges they're facing than the drugs themselves. Many have experiences of trauma or suffer from anxiety and use drugs as an imperfect solution to their pain.

Our laws stop people who want help, from seeking it.

And there are more harms. In NSW, the police unfairly target people from underprivileged or marginalised population groups, and so they become unduly criminalised. They are then labelled and excluded from participating in society, via their now, criminal records. They also target Aboriginal people, and this experience of stigma and discrimination is amplified; the focus becomes the drug rather than the core social issues—lack of connection, opportunity, education, housing, transport, meaning and purpose.

All adults operate using habits. Most of these are socially acceptable (e.g., social media, gaming, shopping) but sometimes these habits become more pervasive. Yet while elite sports people are publicly lauded for their habits, those who use illicit drugs are scapegoated and demonised. At Namatjira, we have compassion for anyone who has difficulty managing any habitual behaviour, whether it is socially acceptable or otherwise. The greater community can share this compassion, and help people find better solutions, not dish out judgement and shame.

The NSW Government must heed the Ice Commission's recommendations.

We need a more humane way to address problematic drug use. We know that innovative approaches that encourage people to be honest and open about drugs, work. These are strategies like controlled drinking, prescribed drug use, medication assisted (e.g., opioid treatment) and other supports (e.g., injecting rooms, needle and syringe programs).

All of us who work to support people who use drugs must advocate on their behalf to help remove the stigma and discrimination they experience through the criminalisation of their coping mechanism, using illicit drugs. We also need to harness the benefits of these drugs. The one strategy most likely to have a significant effect on stigma and discrimination related to illicit drugs users is drug law reform, up to and including legalisation of all illicit drugs. That is my personal view.

Sharing drug stories

continued

- What is the story going to be about?
- Will I be personally identifiable in the story? If yes, what details will identify me (name, image, voice)?
- What is the context of the story? Why is it important that this story is told now?
- Who will benefit from the story? What does it support? Do I want to encourage this benefit and support?
- Who is the author? Who are they working for? What do they get out of it? What do I get out of it?
- Has this author covered AOD and/or other sensitive issues in the past? If so, have they been respectful or sensationalist? Do I trust them to tell my story?
- Will the author just be talking to me, or will there be other people contributing to the story?
- Where will the story be published (newspaper, TV, radio, online, social media)?
- How do they want to interview me (email, phone, face-to-face)?
- Will I have a chance to see the article before it is published? Will I have a chance to provide feedback?
- What can I do if I'm misrepresented in the story?

Creating space for consumer engagement

Empowerment is the process of becoming stronger and more confident, especially in controlling one's life and claiming one's rights. NADA's Liz Gal shares how the AOD sector can best empower people who seek treatment, to help reduce their self-stigma, improve client and ultimately, service outcomes.

When conversations happen about how to best empower consumers, there is often more focus on workers and service providers, and what they should be doing to make consumers feel empowered. However, that is not the worker's or service's job. Their role is to create a space and opportunities where consumers are able to take actions that lead to them feeling empowered themselves. This is one way that stigma, particularly self-stigma is reduced, by creating a space that says, 'actually we trust that you know what you need, you are capable, and we will support you to build your capabilities'.

Some ways you can create space for consumers to have the opportunity of self-empowerment are:

Consumer participation on a personal level

When you allow consumers to have genuine input and authority over their own treatment, it tells them that you trust them and that they can make decisions for themselves. As they go through the process of starting to make decisions and take action based on their own ideas, they get to learn that they don't always get it right and that it's okay not to, and most importantly they get to learn that they sometimes get it very right.

Consumer participation at an organisational level

This is really important if you want to see a decrease in stigma and an increase in self-empowerment. Involving consumers in things such as service planning, recruitment panels, and committees has a hugely positive effect on the consumers involved, future consumers and also staff and organisations.

Create opportunities for capacity building

Consumers come to services with many skills and so much knowledge about themselves and their communities. Many of these skills come from the experiences they have had through their time using substances and accessing treatment. Sometimes they have other more professional or higher educational skills, quite often they don't. They may not have computer skills, or understand how meetings run, they may never even have had the opportunity to give their opinion on things. When consumers are offered opportunities to grow, develop and add to their skills, it means that they can more effectively contribute in ways where they previously may not have been able to.

Compensate them for their work

The lived experience of consumers makes them experts in a field that only a very small number of people will ever be experts in. When consumers participate in representation, research, panels, or committees, they deserve to be compensated for their work. There are many ways to show people that their work is valuable. Compensation is one of the clearest ways for a consumer, who decides to contribute their expert perspective, to begin to realise that they can provide value, and really are appreciated.

Creating space for consumer engagement

continued

Benefits for your service

Creating the space and opportunities to allow consumers to empower themselves, may seem like a challenge, especially when there are competing priorities and seemingly not enough resources. The reality is though, that over the short- and long-term, this will lead to better outcomes for consumers, and therefore better outcomes for your service too. Some of these outcomes may include:

- more consumers engaging in and completing the program
- improvement in the quality of service
- improvement in relationships between consumers and staff.

Resources

If you would like to increase opportunities for consumer empowerment and participation in your organisation, check out these resources:

- Consumer participation audit tool
- Consumer engagement in NGO AOD services webinar featuring consumers and NADA members
- Advocate edition on consumer engagement [PDF]
- NSW Health guideline to consumer participation in AOD services [PDF]

For more information, contact Liz (NADA Consumer Engagement Coordinator) liz@nada.org.au

CHANGE THE STORY

Passing the message stick

First Nations people are the experts in our lives. We know our communities, we know what our communities need and know what will work. Despite this, successive Australian Governments continue to develop policies that impact us. Their policies remove First Nations children from their family and community, which can lead to loss of culture, identity and disconnection from Country. They place too many First Nations young people in Juvenile Justice detention, and imprison too many First Nations adults. The past and current policies that are developed for First Nations people are simply not working.

We need change

First Nations people need to be able to take control and develop real solutions, along with having the final decision powers. This will change our current situation, which stems from past histories and injustices that our people have and still endure. First Nations people must have the power to veto business and decisions by any level of government that impact on First Nation people, culture and country.

How we make change happen

The words we use matter. When we share our vision and truth—our story—we can build powerful movements. But we need to sing from the same songbook—communities, allies and organisations alike. To help us do this, Passing the Message developed a comprehensive guide. Based on research, consultations and workshops, this guide contains tested messages to build public support for self-determination and justice, paving the way for long term change.

'I feel that it is imperative that we change the language that is broadly used to identify and describe issues for our First Nations People. In my work in the AOD sector, we have adapted to a positive strength based model for a long time now,' said Lee Lawrence, Team Leader at Lives Lived Well and a Director on the Aboriginal Drug and Alcohol Network (ADAN) board.

'Our past elders used simple language as one voice for our people, for example the Freedom Ride. This message persuaded non-Indigenous people to join and make change. We need to get back to the basics of how our past Elders approached issues and made change with one voice,' said Alan Bennett, Chief Executive Officer, Orana Haven Aboriginal Corporation.

Read the Passing the Message Stick guide

The Passing the Message Stick project was a two-year research project that was led by a steering community of First Nation advocates including Dr Jackie Huggin AM, Larrisa Baldwin and Karrina Nolan alongside First Nation allies. The research project was supported by 19 First Nations fellows who completed the research on the findings.

Reducing stigma around opioid treatment

Despite being evidence based, opioid treatment is a much maligned medical intervention. To discover why and what can be done about it, NADA's Michelle Ridley spoke with Kevin about his experiences being a consumer on this program, and Carolyn Stubley (Nursing Manager) and Lyn Roberts (Manager) from WHOS.

There is ample research to support the efficacy of opioid treatment (e.g., methadone, buprenorphine) to reduce opioid use, decrease mortality, and improve health and quality of life,[1] but unlike other effective medical interventions, it is widely stigmatised.

In the more than 20 years that I've been working across the health and human services sector, I don't believe I've seen another medical intervention more misunderstood and distrusted. I recall when working in the child protection system, when it was mentioned that a parent was on opioid treatment, *this* became the focus of their assessment. It was like invisible alarm bells had been rung! But to be fair, it's not only child protection workers that misunderstand, but also health professionals including doctors and nurses, and other workers across the wider service sector.

How does stigma impact people accessing opioid treatment?

Inadequate pain relief stories are rife. Lyn and Carolyn recounted the story of a WHOS resident who was taken to the emergency department for a total of five times. On the first four visits, he was discharged because he was reported to be 'drug seeking'. On the fifth occasion, a WHOS manager accompanied the resident and refused to leave until a proper assessment and diagnosis was made. Following this, the resident was admitted to hospital for five days with post virus rheumatoid arthritis.

Kevin felt he was often treated differently because he was on this treatment, especially when accessing his dose at some chemists. It can negatively impact people's mental health and self-esteem, he said.

'Many consumers engaged in the WHOS Opioid Substitution Therapy (OST) program report limited social or economic opportunities—mostly due to the stigma,' said Lyn.

WHOS has evidenced little ongoing aftercare support in the wider community for people who've completed their residential program and wishing to maintain stability on OST. According to Lyn and Carolyn, OST clients who attract negative attention require additional socioeconomic supports and can find these services (e.g., Centrelink and housing) difficult to navigate. 'Those with additional mental and medical health issues often fall through the allied health care gaps due to lack of coordination and advocacy by NSW Health,' they added.

Why is opioid treatment and people on this program stigmatised?

Contributing factors, according to Kevin, include the criminalisation of heroin and intravenous drug use. Carolyn and Lyn added that the same negative labelling attached to people who inject drugs was attached to people who sought opioid treatment. 'OST is an evidence based treatment that facilitates change in a person's life, yet this has not been widely accepted in the wider community.'

1. NSW Health Guidelines for the Treatment of Opioid Dependence

Reducing stigma around opioid treatment

continued

How can the AOD sector help to reduce the stigma related to opioid treatment?

'There is a lot of misinformation attached to OST and educating the public and health systems to the effectiveness of OST as a treatment is essential in reducing stigma and discrimination,' Lyn and Carolyn declared.

Kevin suggested, 'People should take a tour of the MSIC (Medically Supervised Injecting Centre) to become more informed.' Kevin has already led a range of people, from politicians to business owners to tour MSIC, and they get to speak to him and others with lived experience of heroin and injecting drug use, which can help to break down stereotypes and misinformation.

Changing the language used to talk about people who use drugs, and especially about people on OST, was seen as important. Lyn and Carolyn also recommended that the sector take a trauma informed approach to educating the community and health services about people on this treatment. 'Many people on OST have suffered trauma in one way or another and the public don't hear the stories of these survivors, what they have endured and what has improved since being on treatment.'

Resources

- NUAA: Consumer's guide to opioid treatment for consumers who seek it
- Language Matters resource for best-practice guidelines on how to use language to empower people and reinforce a person centred approach.
- NSW Health Guidelines for the Treatment of Opioid Dependence
- To learn more about MSIC and Kevin's story: Inside the Southern Hemisphere's first medically supervised injecting centre | Nursing Review and Two of Us with the medical director of MSIC, Marianne Jauncey, and Kevin Street (smh.com.au)

For more information about the NSW opioid treatment program, visit the NSW Health website.

AOD stigma and discrimination report

The NSW Ministry of Health's Centre for Alcohol and Other Drugs (CAOD) is working to improve consumer experience and health outcomes by reducing the stigma and discrimination associated with AOD use and related harms in the NSW health system. This project is being undertaken in partnership with the Agency for Clinical Innovation (ACI), the Network for Alcohol and Other Drug Agencies (NADA) and the NSW Users and AIDS Association (NUAA).

As part of this work, the CAOD commissioned research to understand the attitudes, values and behaviours of NSW Health staff in the AOD sector (including non government), mental health, emergency departments and maternity services, in an effort to design a response.

The recently released report [PDF] provides a foundational understanding of healthcare workers' attitudes, beliefs and behaviours towards people experiencing harm from AOD use and suggests mechanisms to influence healthcare workers to reduce the stigma and discrimination experienced by AOD consumers. The report also suggests intervention at a policy, clinical practice and organisational level.

The Ministry of Health would like to acknowledge the support of NADA members in conducting this research and looks forward to working with NADA and non government partners to implement these recommendations through a co-design process and a process to examine and address stigma at a policy and system level.

NSW GOVERNMENT Health

Dignity is the antidote

Jake Docker, CEO

Australian Injecting and Illicit Drug Users League

Before joining Australian Injecting and Illicit Drug Users League (AIVL), I had worked in various roles in corrections and child protection. As I think back about this time, I feel really confronted about the stigma and discrimination that is applied to people who use drugs in both the criminal justice system, and other statutory contexts.

I remember about five years ago, while I was working in a child protection leadership role, sitting in the back of a courtroom waiting for a matter to be heard that my team had been involved in. The magistrate was making remarks on the case being heard before mine. The child had been removed from their parents' care because of parental drug use. From the bench, the magistrate said, 'people who use ice, cause as much risk and harm to children as paedophiles or sex offenders.' I already knew how broken the statutory child protection system was, but at that moment, my heart sank for these two parents, who were already taking steps to address their problematic drug use, to be labelled in such a heartbreaking way. I also wondered what exactly the magistrate thought that he was going to achieve, other than to make those parents feel that they were beyond making any type of change.

Sometimes, as people who work in the AOD sector, or in peer based drug user organisations, we focus on how stigma and discrimination impact upon health equity in our community. But we know that stigma and discrimination permeates into just about every other aspect of the lives of people who use drugs. How can we expect that people make positive decisions about their health, lifestyle, or anything else when it is a societal norm to strip away their dignity?

Since starting at AIVL in August 2021, lots of people have asked what my plans are for AIVL, what I intend for the organisation to do around stigma and discrimination. While we are still in the process of updating AIVL's Strategic Plan (commencing in 2022), and planning a way forward for the organisation, the short answer is: promoting human dignity.

Promoting dignity for people who use drugs is one of the best ways we can neutralise poisonous stigma and discrimination.

The challenge that I have noticed since being with AIVL, particularly in the arena of stakeholders working in areas like the blood borne virus treatment and prevention space, is that organisations (like AIVL) that represent the interests of people who use drugs need to scream to be heard. But then risk being stigmatised for shouting too loud. Moving forward, what I plan to do for AIVL to do is speak up and shout if I need to about dignity for people who use drugs—in all areas, not just health.

AIVL Australian Injecting & Illicit Drug Users League

TRANSLATING RESEARCH INTO PRACTICE

Talking about drugs

Reducing stigma towards people who use drugs

Mark Chenery Common Cause

Stigma is a common and complex problem for people who use drugs and it is a key challenge to minimising the potential harms associated with drug use. Stigma can make people feel unwelcome and unsafe, and may prevent them from seeking health and support services. It can have negative impacts on a person's wellbeing, employment and social outcomes. Stigma can also intentionally or unintentionally impact on policies and systems, which can restrict opportunities for people who use illicit drugs or experience dependence. It can hinder efforts to reduce drug related harms and result in reduced access to health services. The way we talk about illicit drug use and people who consume drugs plays an important role in helping to reduce stigma.

How do we combat stigma?

Research from fields like social psychology, cognitive linguistics, behavioural economics tells us that most people are able to think about any issue from multiple and often conflicting perspectives (also known as frames). Importantly, these different perspectives operate mostly at a subconscious and emotive level, which means people's attitudes and behaviours are often driven by factors beyond their conscious awareness.

In 2018 the Alcohol and Drug Foundation, Uniting and New Zealand Drug Foundation partnered to research and test messaging that can reduce stigma towards people who use drugs. They wanted to identify the dominant frames people in Australia use to reason about drugs and the people who use them and which frames made people feel at a gut level that people who use drugs deserve the same level of respect, care and support as everyone else. They also sought to understand which frames moved people into an oppositional mindset in which people who use drugs deserve to be punished and shamed.

Frames analysis

Their research began with a nationwide frames analysis, collecting over 17,000 words of public discourse on the topic of drugs from media articles, political debate, social media discussions and popular culture. They also conducted 15 one-to-one interviews with advocates that included AOD sector workers, policy advocates, doctors, lawyers, politicians and people with experience of being stigmatised because of their use of drugs.

This language data was then coded and analysed based on key metaphors, values and story logic in order to identify the dominant supportive and oppositional frames used by Australians to think and talk about the topic.

Advocates	Opponents
• Psychoactive substances • Not inherently harmful or addictive • Arbitrary legal status not based on harm • Natural for humans to use drugs • Harm comes to minority of people. It's the legal status that causes most harm. • Stigma forces drug use into shadows and hurts those already vulnerable	• Evil, predators, disgusting and dirty • Inherently dangerous and addictive • Legality of drugs is based on harms they cause • Only stupid risk takers would use drugs • Addiction, death and ruined lives are common • Stigma is both deserved and useful

Dominant supportive and oppositional frames

The dominant narrative around illicit drugs in Australia, told by the opponents, is extremely unhelpful. Many journalists and public commentators frame drugs as evil, dirty and dangerous. Far too often, these characteristics are then carried over and applied to the people who use these substances. Reducing the stigma our society places on people who use drugs requires us, therefore, to avoid messaging that reinforces this unhelpful narrative about drugs.

Unfortunately, the discourse analysis suggests that advocates often use language and framing that unintentionally panders to this dominant narrative which increases stigma for people who use drugs.

Message development and testing

Survey participants

From a pool of survey respondents, the researchers drew 1,474 people, weighted to be representative of the Australian population by age, state and gender, with an oversampling (+315) of healthcare and social assistance workers.

They identified three key attitudinal groups related to drug stigma:

- Supporters: people who strongly agree with messages suggesting people who use drugs deserve the same respect and care as everyone else and should not be punished
- Persuadables: people who hold weaker attitudes overall and tend to move between oppositional and supporter perspectives.
- Opponents: people who strongly agree with messages suggesting people who use drugs need to be punished and shamed

Survey

Based on the discourse analysis, the researchers chose a number of promising frames to put forward for testing. The 20-minute survey included a range of question formats, including forced choice2 and split sample3 questions. They also tested five 30-second audio-recorded messages in which participants moved a dial up and down on their screens as they listened to the messages to indicate their level of agreement with what they were hearing in that moment. This provided the research team with a moment-by-moment view of the persuasive effect of the messages they tested and allowed them to isolate specific words and phrases that most resonated with audiences.

Their survey found that supporters and opponents each represent less than one-fifth of Australians, while the remaining two-thirds of the population is persuadable.

The researchers then analysed the results of the survey based on the responses of these three groups to each of the questions and messages. Messages that appealed strongly to supporters and also shifted persuadables were identified as most useful for future messaging. These are messages that move persuadables into a supporter mindset. On the flip side, messages that appealed strongly to both opponents and persuadables were identified as harmful messages because they move the latter into an oppositional frame of mind.

Message guide

If we want to change the way Australians think about people who use drugs, we need to tell a different story about drugs and the people who use them. The following is an overview of the key recommendations that emerged from the research.

Don't

1. Don't scare people Heightened fear and disgust around drugs correlates with higher levels of stigmatising attitudes towards people who use them, so we should avoid messaging that activates fear and disgust or implies that all drug use is necessarily problematic.

2: Avoid law and order framing Law and order appears to be a key element of the opposition mindset, which suggests that when people think about drugs from the perspective of maintaining law and order or reducing crime, they are more likely to stigmatise people who use drugs. Avoid justifying drug policy reform or treatment services from the perspective of reducing crime or increasing community safety.

3: Don't mythbust Research shows that every time we are exposed to a concept (even when framed as untrue) it is strengthened as a frame in our minds. Mythbusting, therefore, has the counterproductive effect of activating and strengthening the very same ideas we are trying to dispel. Stop reminding people of unhelpful ideas and tell your story instead.

4: Abandon the war on drugs Advocates often talk about the war on drugs having failed and the need, therefore, for 'a new approach'. Unfortunately, reminding people of the war on drugs—even to say it has failed—does nothing to

shift the frame for drugs as an issue. Stop talking about the failed war on drugs. It traps us in an unhelpful frame and fails to move persuadable audiences.

5: Don't build empathy through enjoyment People who hold highly stigmatising attitudes towards people who use drugs already strongly agree with the statement that 'people take prohibited drugs because they enjoy how it makes them feel'. Repeating this message, therefore, does not appear to help us tell a more helpful story. Framing drugs as enjoyable does not build empathy for people who use drugs.

Do

6: Frame by values Messages based around altruistic and community oriented values including honesty, helpfulness and equality tested well. Combining this with messages around love and support for people who need it, worked particularly well. Use messaging that connects strongly to altruistic and open-minded values.

7: Put people who perpetuate stigma in the frame Shift focus and blame away from people who use drugs and onto external actors. This means shifting the problem from 'drug use' over to 'drug stigma' and the people who perpetuate it—prominent people who support punitive policies and sensationalist media coverage.

8: Paint a new picture of people who use drugs It is easier to stigmatise a group of people who don't look like 'us'. A more realistic and diverse picture of the people who use illicit drugs in Australia undermines stereotypes, so paint the diversity of occupations, ages, social status and outcomes.

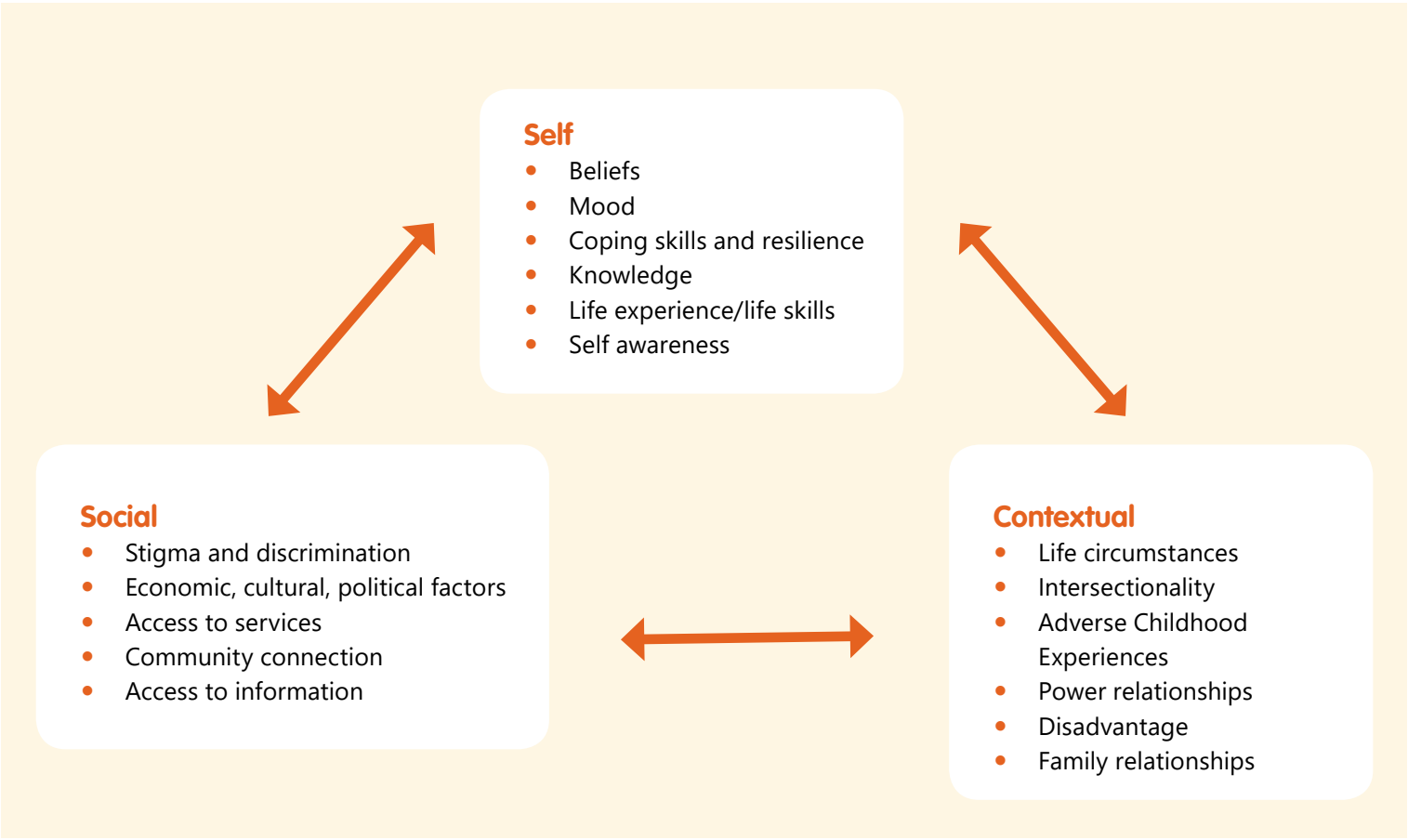
9: Point out that preventing all drug use is unrealistic One way to shift the conversation from preventing drug use to improving the health and wellbeing of those who do, is to point out that stopping all use of illicit drugs is unrealistic. This is common sense to most persuadable people.

10: Bring alcohol into the frame One of the key differences between supporters and opponents in our research was the degree to which they believed the legality of drugs is related to the harms they cause.

Reminding persuadable audiences that alcohol is a harmful drug, therefore, is one way to activate a supporter mindset, by demonstrating subtly that the legality of drugs is not a reliable indicator of the harms they cause.

11: Frame dependence as a symptom The vast majority of the supporters in our research believed that substance dependence was a symptom, not the source, of people's problems. While the opposition disagreed, persuadables were marginally more likely to agree with supporters on this part of the narrative, so frame substance dependence as an outcome of other life challenges, rather than something caused by the drug itself.

Download the drug stigma message guide [PDF] that contains a full explanation of the recommendations, story structure, an example message, and words to replace and embrace.



Shame and self-stigma

By Christine Minkov NADA

Some people who use or are dependent on AOD can feel self-stigma—negative and internalised self-judgements resulting in shame, worthlessness and self-blame. For those people seeking support for their AOD use, this self-stigma can negatively impact self-agency, quality of life, access to services and participation in treatment.

Self-stigma is a result of complex interactions between social, contextual and self-factors.[1] The framework above identifies these complex interacting factors which influence the development and perpetuation of self-stigma.

There is a link between shame and substance dependence,[2] however the understanding of its impact on recovery is limited. While shame can be a hindrance to recovery, it has also been found that addressing shame may also enhance recovery.[3]

What is shame?

Dr Brené Brown has researched shame and vulnerability for over 25 years using grounded theory methodology. She describes shame as 'the intensely painful feeling that we are unworthy of connection, love and belonging.'[4]

Dr Gabor Mate has spoken many times on the subject of shame, particularly as it relates to AOD use and dependence. He describes shame as a loss of contact with the self. People experiencing shame may believe, 'I am not good enough. There's something wrong with me.'

Shame feelings can be associated with low self-esteem, hostility, and psychological distress.[5] Someone dealing with shame might also feel:

- inferiority
- humiliation
- remorse
- embarrassment
- inadequacy
- unworthiness
- powerlessness.

These feelings in turn, can result in withdrawal from others and/or aggression, in an attempt to deflect feelings of shame.

Shame
continued

Shifting from shame back to self

How can we support consumers who experience shame?

- Understand and acknowledge shame and how it presents—secrecy and silence encourage shame
- Support consumers to view themselves as more than their past behaviour
- Use a strengths based approach
- Show empathy and non-judgement—empathy is the antidote to shame
- Use non stigmatising language[6]
- Support consumers to overcome negative thoughts and beliefs by using motivational interviewing and cognitive behavioral therapy techniques that identify and modify unhelpful thinking patterns, underlying assumptions and thoughts about the self, the world and the future.
- Employ and support peer workers
- Ensure your practice and service is trauma informed by committing to the six core trauma informed principles:
  - **safety:** emotional as well as physical e.g., is the environment welcoming?
  - **trust:** is the service sensitive to people's needs?
  - **choice:** do you provide opportunity for choice?
  - **collaboration:** do you communicate a sense of 'doing with' rather than 'doing to'?
  - **empowerment:** is empowering people a key focus?
  - **respect for diversity:** do you respect diversity in all its forms?

Resources

Providing trauma-informed care: a case study of Weave Youth and Community Services This video explains trauma informed care and the importance of personalised support when delivering this care.

Brené Brown's TED Talk 'Listening to shame'.

The difference between empathy and sympathy

NADA's Language matters

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Workforce capability framework
Stigma and discrimination

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

The *Workforce Capability Framework: Core capabilities for the NSW non government alcohol and other drugs sector* describes the core capabilities and associated behaviours expected of all NSW non government AOD workers.

Where does 'Stigma and discrimination' fit? Start with capability **3.2 'Incorporate strategies to promote social inclusion and to eliminate stigma and discrimination'**

a. Recognises and understands the pervasive impacts of stigma and discrimination on people who use AOD, their families and significant others
b. Supports people to remain engaged in services, and counters the stigma and judgement that people may face by creating a welcoming, safe and supportive environment
c. Acknowledges the impact of language with respect to stigma and discrimination, and role models language that is non-judgemental, person centred, strengths-based and empowering
d. Recognises and takes steps to overcome biases and safeguard people against stigmatising and discriminatory behaviour
e. Actively pursues and engages in activities that promote social inclusion, anti-discrimination and the de-stigmatisation of AOD use and of AOD related health conditions

ACON's needle and syringe program

People who inject drugs (PWID) experience a great deal of stigma and discrimination in many walks of life, including in health care settings. These experiences of stigma can prevent people accessing the care and support that they need. Because needle and syringe programs (NSPs) are often a first point of contact with health systems and services for PWID, it is therefore so important that these environments provide person centred and non-judgmental services.

ACON's NSP in Surry Hills prides itself on its holistic, person centred approach to minimise any experiences of stigma and discrimination, providing our communities with a vital service in a manner that is friendly and welcoming.

ACON has a long history of engaging in peer work: throughout the beginning of the HIV epidemic in the 1980s to now, our work has always been peer led, embedded in the communities we serve. Our NSP is no different: because it is staffed by peers, the NSP provides a place where clients can access their equipment from people with a lived experience of drug use. Peers create a space for connection and understanding that helps to reduce stigma and improve the experience for clients.

At ACON's NSP, we work with a number of communities that our peers are part of, including communities of people who inject drugs, sexuality and gender diverse communities, and people living with HIV. Stigma experienced by our staff and our clients can be multiple and intersecting, because of their drug use, sexuality, gender, Aboriginality, culture or ethnicity, HIV status, occupation or employment situation, housing status, age, or disability.

While broader, society-wide efforts need to be made to reduce the stigma experienced by these communities, we work to prevent stigma at ACON's Sydney NSP by creating a peer workforce that is intimately aware of our communities and can provide services from a position of knowledge and experience.

The Surry Hills service provides a space for clients to collect sterile injecting equipment to reduce the risk of blood borne virus transmission through sharing of equipment. But that's not all we do. Clients can also come and have a chat, receive health promotion advice such as safer injecting education and vein care, or referrals to other services. Referrals include services for BBV testing and treatment, drug treatment, other health advice, and referrals for housing and other welfare. Our NSP is also able to provide clients with naloxone, a life-saving opioid reversal medication. Our staff know of at least 10 lives saved with naloxone we've dispensed since we began providing that service earlier this year!

Like many of us, our NSP has experienced periods of uncertainty and difficulty since the pandemic began, but we've adapted our services to provide the best health promotion and harm reduction that we can while maintaining social distancing and COVID safety.

Compared to other NSPs, because of the communities we serve, ACON sees a comparatively high number of people who use performance and image enhancing drugs (PIEDs), people taking gender-affirming medications, and people who engage in kink practices such as needle play. It's important for our NSP staff and clientele to recognise the diversity of practices with needles, and the need for sterile injecting equipment for everyone. No matter who you are and what you are doing with the equipment, everyone needs access to free sterile injecting equipment as well as information and advice to prevent BBVs and inject as safely as possible.

Of course, there are people outside of Surry Hills who need access to NSP services that are safe and non-judgemental. ACON provides secondary NSPs for our communities in Lismore and the Hunter. The Hunter NSP also provides an outreach service, an effective way of reaching clients who might not otherwise be able to come in person. The outreach service means we can meet with clients at their homes, provide their equipment, have a chat, and help them with anything they might need.

NSPs provide a core part of AOD health services, and ACON's NSPs are no different. A major part of ACON's work is about reducing the stigma experienced by people in the communities in which we live and serve, and we bring this approach to our NSP by working with peers to create a knowledgeable service that is non-judgemental and person centred: we care about each and every client that we serve.

NUAA Forums—where peers are the experts

Leah McLeod, NUAA

At NUAA Forums, where peers are the experts, we take great pleasure in welcoming both the community of people who use drugs and our supportive partners to share important conversations on topics at the heart of the drug user experience. NUAA's third Peers' and Consumers' Forum, held on 11–12 October 2021, has been our most successful so far—so say the participants!

Sydney's long lockdown meant having to transform an event characterised as a gathering—bringing together peers, consumers, service providers and health professionals—into an entirely online experience. The forum, with the theme 'Peers as Leaders', was attended by 186 participants (out of 225 registrations) and provided peer leaders a platform to inspire, by sharing around their lived experience and their vital and innovative work supporting our community.

Deputy CEO Charles Henderson ably MC-ed the forum. Topics spanned health, stigma and discrimination, criminalisation, the COVID-19 pandemic, and issues facing particular groups of people who use drugs, such as mothers, Indigenous people, people living in rural and regional areas, and people in custody. There was also a well-attended workshop on drug testing.

The move online presented challenges—the social and networking opportunities of an in-person gathering have been a main feature of previous Peers' and Consumers' Forums. But it also created opportunities. It allowed for a truly international range of speakers, including from Canada, the US and Britain, and participants from as far afield as Uganda, Kenya and Ivory Coast. It also delivered a comprehensive state-wide event, with regional NSW as well represented as Sydney, and brought together members of our national community.

The online event was made as accessible as possible. Many scholarships were provided to enable peers to attend and subsidies were offered to pay for the internet connection costs of participants who needed it. Importantly, attention was given to ensure panels represented a broad cross-section of the grassroots community of people who use drugs.

International speakers included Judy Chang, Executive Director, International Network of People who Use Drugs (INPUD), who gave a keynote presentation on 'Prioritising the health and wellbeing of people who use drugs: Pathways to person-centred care'; Shanell Twan, an outreach worker for Streetworks (Edmonton's harm reduction program) from the Tsilhqot'in people and Esdilagh First Nation in Canada who spoke on the panel on First Nations Peer Leadership; Carissa McGee, Team Lead for the New Mexico Peer Education Project, Echo Institute, University of New Mexico Health Sciences Center, who drew on her own lived experience to speak on the panel on peer leadership in prisons; Jake Agliata, Policy and Communications Officer of INPUD, speaking on lessons of the COVIDvid-19 pandemic; and Zoë Dodd, harm reduction and support worker at the South Riverdale Community Health Centre in Toronto, who gave what was very much a frontline report from Canada at the session on COVID-19 and the overdose crisis.

Representatives of NUAA also spoke alongside representatives of our sister organisations such as QuIHN in Queensland, Harm Reduction Victoria and CAHMA in the ACT; peers and consumers from across NSW; and health and research professionals supportive of the community of people who use drugs. NUAA CEO, Dr Mary Ellen Harrod gave a thoughtful and inspiring keynote address on 'The involvement of peers in research and service delivery—how to act locally and think globally'.

The forum was held in partnership with the International Network on Health and Hepatitis in Substance Users (INHSU) and made possible by the support of sponsors and supporters. Camarus™ was a Platinum Sponsor; the Central and Eastern Sydney Primary Health Network, Indivior™ and Terumo™ were Gold Sponsors; and AbbVie™, Harm Reduction Victoria and the Kirby Institute were Silver Sponsors.

Prepping for the year's end

With the end of the year fast approaching, it's time to plan and prepare. NADA's Michelle Ridley has written a helpful to-do list to help ensure your holiday period is as stress free as possible.

Many services, including NADA, shut down for a short period between Christmas and New Year. And even if your organisation remains open, we all need to make plans and preparations, so this time is as stress-free as possible, for staff and people accessing our services.

For many of us, Christmas and New Year gives us a chance to take a break, indulge, spend time with family and friends and reflect on the year that's been. It can also be a difficult time that can impact mental health and AOD use, especially after this challenging year. So, thinking about this holiday season, I've come up with some tips and information to assist:

- Be prepared. Make up a checklist of tasks you need to get done before Christmas/New Year.
- Talk with your staff and colleagues about the holidays and how they're feeling. Given this year has been unique due to COVID-19, it's important to check in with those around you. For tips on how to have these conversations, download the R U OK a workplace practice guide [PDF].
- Speak with your clients about how they're feeling about the holidays, what are their plans and assist them to prepare. If they identify concerns, help them to develop a plan of strategies to cope, such as a relapse prevention or harm reduction plan. For some relapse prevention and harm reduction advice see, Smart Recovery worksheets and tools, Dovetail stay on course tools and NUAA harm reduction/safer using.
- Provide the contacts for relevant services available over the holiday season and encourage your client to save these details in their phone to have them handy. You could also print and laminate wallet size cards with the most relevant services listed; don't forget to provide these contact details on your organisation's telephone message service and mobile phones while you're on leave.

Some useful services for anyone needing information, advice or support are:

- **Alcohol Drug Information Service** (ADIS) assists with information, advice, support or referrals about AOD. Sydney call (02) 9361 8000 or outside Sydney free call 1800 422 599. Refer to ADIS site.
- **NUAA** provides lots of useful information and services; including needle syringe programs (NSP), a Peer Help Line and DanceWize NSW (a peer based harm reduction program provided at festivals). If someone cannot access a NSP in person due to COVID-19, NUAA are offering to mail out NSP equipment across NSW and also Naloxone.
- **Family Drug Support** (FDS) provides telephone support to families and significant others impacted by AOD. Call 1300 368 186. Refer to FDS site.
- **Ask Izzy** is a free and anonymous website that helps you find nearby services (e.g., food relief, housing). There are over 360,000 services you can search and if you're on the Telstra mobile network, you can access Ask Izzy even if you don't have credit. Refer to Ask Izzy.
- **Domestic Violence** (DV) Line is a telephone crisis counselling and referral service for women who are victims/survivors of DV. Free call 1800 656 463. See the DV helpline.
- **Mental Health Access Line** provides referral information and support 24/7. Call 1800 011 511.
- **Lifeline** is a crisis telephone support service available 24/7. Phone 13 11 14.
- **Kids Helpline** provides free, confidential 24/7 phone and online counselling service for people aged 5 to 25. Phone 1800 551 800.

NADAbase update

Tata de Jesus NADA

Reporting

Annual data reporting to the AIHW

The annual 2020/21 National Minimum Data Set (NMDS) for AODTS was submitted to the AIHW in November 2021 on behalf of members who are funded by the Primary Health Network/Department of Health.

Regular reporting

October and November are busy months for the NADAbase team because we submit a handful of reports to funding bodies, namely:

- Monthly data reports to InforMH for members who receive Ministry of Health funding
- Quarter 1: July to September data report for members who receive Primary Health Network funding
- Annual aggregated report to Department of Health

Catch up with the data webinars

How to use ATOP in your clinical practice

Professor Nicholas Lintzeris, Clinical Lead and Chief Investigator of the COQI project, described multiple uses and benefits of using ATOP as a clinical screening tool, to monitor a person's progress throughout treatment and to help standardise treatment and communication between service providers. Watch now.

How to use ATOP data for service evaluation, quality improvement and research activities

Dr Rachel Deacon, Lead Researcher of the COQI project, presented on how to utilise the information from ATOP for service evaluation, quality improvement and research activities. Watch now.

Saving lives with Take Home Naloxone

Non government organisations across NSW are helping reduce deaths from opioid overdose in their communities by participating in the NSW Take Home Naloxone program. 47 non government services are already participating, and have provided 322 units of naloxone to their clients since March 2021.

Naloxone quickly reverses the effects of an overdose and gets people breathing again. It can be competently administered by community members with only basic training. By providing education and naloxone, the program empowers clients to keep themselves and those around them safer. The NSW Take Home Naloxone Program trains workers for free and enables services to supply naloxone for free to clients, increasing the number and range of workers and volunteers who can supply naloxone to clients.

We know from Penington Institute data that unintentional drug induced deaths from opioids have almost tripled in the past 14 years. This means there are many people in the NSW community that may experience or witness an opioid overdose, and so could benefit from having access to naloxone.

Clients are more likely to trust services they're already familiar with. Services are encouraged to discuss naloxone with all clients. This can help destigmatise opioid related conversations and can remind workers and clients that preventing opioid overdose harms is a community issue. Many people would benefit from having naloxone on hand.

NSW Health would love to have more non government organisations providing naloxone. Read more about the program, visit or email us.

NSW GOVERNMENT Health

NADA network updates

NADA practice leadership group

The NPLG worked on their action plan for 2022–2024, with the access and equity research remaining very much a focus. The group is now working on the upcoming practice forum.

Meeting highlights:

1. DCJ roundtable has been very helpful to NADA members, especially understanding where to raise issues and escalating to the correct channels.
2. Warm referrals between services help streamline referral pathways and bridge the gap between the early intervention and treatment space.
3. Uniting presented on their Fair Treatment campaign on how we can achieve drug law reform.

The network bid farewell to Grace Rullis, a passionate and intelligent leader, and wish her the very best. She parted with these words of advice: 'Develop and balance leadership, working from your heart, advocacy and clinical innovation. Build inclusive and diverse partnerships to inspire staff and organisational development. Through evidence, innovation, kindness and a shared ideological shift, we can transform the sector.'

Women's clinical care network

The October meeting featured a presentation by NADA's Tata de Jesus about an important cultural and linguistic diversity audit project being developed. This project, organised by NADA and the Drug and Alcohol Multicultural Education Centre (DAMEC), will increase the capacity of AOD treatment services to support culturally and linguistically diverse people and their communities.

The meeting also provided a space for network members to discuss some service provision difficulties associated with COVID-19, and the move to seeing clients face-to-face for some services.

The network organiser, Hannah Gillard, is currently organising professional development training for the network, based on group demand. The Women's Network is open to any NADA members who are working with women. If you would like to join, please email hannah@nada.org.au.

Youth AOD services network

The October meeting featured insight into cutting edge youth AOD research by Emily Deans of Youth Solutions, and doctoral researcher Meg Wells from the University of Wollongong.

The network organiser, Hannah Gillard, is currently coordinating a half day of training for the network on effective interventions into common AOD use by young people, based on network demand. This training is planned for early to mid-2022.

If your service supports young people and you would like to join the network, please contact hannah@nada.org.au.

Continuing coordinated care program

It's been a challenging year, so to help the Continuing Coordinated Care Programs take time out, NADA's clinical program manager facilitated a meeting with a difference. For this meeting, six teams battled it out in an online trivia competition. The stakes were high with a prize for the winner, and after a nail-biting game, the 'Alcohol and other Thugs' took first place. The 'League of Extraordinary Guessers' came in close second, and 'The A Team' just behind. The trivia match gave the teams a chance to connect with colleagues about something completely unrelated to COVID-19 and work. It was a lot of fun!

For more information about how you could facilitate trivia for your team, contact michelle@nada.org.au.

NADA network updates
continued

Gender and sexuality diverse AOD worker network

This network provides a space for AOD workers in gender and sexuality diverse (GSD) communities to support one another in their everyday work with co-workers and clients, and to foster discussions about how to make AOD services more LGBTQ+ inclusive.

During the October meeting, the network discussed planning for a half-day forum in May 2022, amongst other topics. This forum will better equip AOD workers with information on how to foster gender diverse and trans inclusive practice, in addition to promoting LGBTQ+ inclusion in AOD services generally.

The network has been extending invites to other NADA networks to attend GSD Network meetings. This invitation is intended to promote connections between specialist AOD groups, and to broaden the dialogue about LGBTQ+ inclusivity within AOD services. If you work in AOD, are gender and/or sexuality diverse and would like to join the network, please email hannah@nada.org.au.

NADA data and research advisory group

During the NADA Data and Research Advisory Group's October meeting, members gave an update on how their organisations were operating during lockdown and what they were doing in terms of data. Members reviewed the network's action plan and discussed priorities for the next twelve months in terms of activities and support required. They were informed about events relevant to the network, such as the Data Forum 2022 and the integration of benchmarks into NADAbase.

During this quarter, network members Dez Hoy (Namatjira Haven) and Junhua Li (Odyssey House) took part in the popular webinar, 'Using NADAbase outcomes data to inform practice'.

For more information on the network and its future activities, please email suzie@nada.org.au or sanjana@nada.org.au.

Community mental health, drug and alcohol research network

Tell us about your research
CMHDARN want to read, promote findings, and support participation of new research happening in the community mental health and AOD sectors. We can broadcast your research in our Research showcase [PDF] bibliography, as well as promote through our newsletter and Facebook page. Please email your research to the CMHDARN Coordinator.

Receive ethics guidance through CMHDARN
We seek to encourage researchers to participate in a peer-review process focusing on ethical issues in order to promote ethical conduct in practice based research in mental health and AOD sectors. This process helps to improve the quality of research related to these sectors, which, in turn, makes the research more useful for our members.

The CMHDARN Research Ethics Consultation Committee (RECC) provides ethical guidance to researchers and research participants. They provide ongoing consultation and guidance in matters of ethics regarding human research enquiries within the mental health and AOD sectors. Learn how the RECC can support you.

Become a CMHDARN member today! It's the easiest way to receive updates on CMHDARN activities, and it's free to join.

CMHDARN
Community Mental Health, Drug & Alcohol
RESEARCH NETWORK

Profile

NADA board member

Norm Henderson Senior AOD Worker
Weigelli Aboriginal Corporation

How long have you been associated with NADA?

I've worked for services that have been NADA members for 23 to 24 years.

What does an average day look like for you?

It's not the same old same old all the time. I come to work and I get a little bit of feedback on what sort of chaos has been happening over the last 15 or so hours. I have a semi- managerial role where I do things like organising staff and shifts, and liaising with the CEO about what's going on.

What experiences do you bring to the NADA board?

A lot of years working in rural, regional and predominantly Aboriginal communities. I also bring a common sense, practical point of view to things. I was a user of the [AOD] system as well beforehand, so I bring a lived experience with addictions.

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

The board has opened me up to learning more about the industry. It's given me a lot of insights into how processes work, and the behind-the-scenes way of doing things. I can take that information back out to the regions with me.

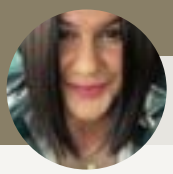
What else are you currently involved in?

I'm Chairperson of ADARRN—the Aboriginal Drug and Alcohol Residential Rehabilitation Network. I'm on the Aboriginal Health and Medical Research Council (AH&MRC) committee that reviews all the AOD course content of the college. Additionally, I'm part of the New South Wales Health Blood Borne Virus Committee and the NADA Advocacy Subcommittee.

Also, I've been working with NADA on a campaign about the Special Commission of Inquiry into the Drug 'Ice'.

A day in the life of...

Sector worker profile



Erin Reberger Support Worker
Mission Australia AOD CCC program

How long have you been working with your organisation?

I have been working with the CCC program in Broken Hill for the past 18 months. I originally shared this role in a part-time capacity, however I became full time in June.

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

I gained case management experience working in the community services sector. In 2019, I decided that I wanted to focus my career on AOD and help people access services in remote areas.

What does an average work day involve for you?

We support our clients with so many aspects of their journeys. Being in a rural and remote community, we do a lot of advocating with services both locally and Australia-wide to help clients to achieve their goals. Often clients will need to be away from their homes and families if they want to pursue residential treatment options, so we help make this transition as smooth as possible.

What is the best thing about your job?

Seeing people motivated to make change and being proud of themselves is such a rewarding aspect of this role.

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

I would like to see more treatment options available to those who live in remote areas. Travelling long distances and being away from home and their families is a huge barrier for people wanting to pursue residential treatment options. If remote areas had access to AOD specific treatment, I think more people would be able to access the support they need and benefit from a therapeutic community environment.

Member profile

AOD Continuing Coordinated Care
Artarmon, Mission Australia

Service overview

The Continuing Coordinated Care service in Artarmon (NSW) provides case coordination and wraparound services for clients with high needs who are receiving community based AOD treatment and require continuing care and intensive support to maintain engagement with treatment. The service supports people to maintain links with AOD and primary health services, develop functional living skills, and access to vocational and educational opportunities. The service also supports people to access medical and community services, and establish or maintain family and community connections.

Eligibility criteria

The service is available to people 18 years or older with:

- current or recent harmful AOD use; or
- current or recent (within the last month) engagement with AOD treatment or requiring support to access AOD treatment
- complex psychosocial support needs that require intensive case management to support achievement and/or maintenance of AOD treatment goals.

Referral process

Referrals to CCCP can be made by any AOD, health or social service practitioner, self or family/friend. Call 02 9480 2560.

MISSION AUSTRALIA together we stand

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Sinead Sheils wins 2021 Hepatitis NSW Cheryl Burman Award

Sinead Sheils, a hepatology Nurse Practitioner with Sydney Local Health District, is the recipient of Hepatitis NSW's 2021 Cheryl Burman Award. The Cheryl Burman Award acknowledges outstanding work or achievements by an individual or team in NSW within the viral hepatitis sector.

Hepatitis NSW CEO Steven Drew said, 'The Cheryl Burman Award this year recognises Sinead Sheils for her substantial contribution to improving the quality of life of people living with viral hepatitis.'

Sinead's clinical approach has resulted in great, positive outcomes for all stakeholders, including clients. As a Hepatology Nurse Practitioner at the Royal Prince Alfred Hospital, she has built workforce capacity and initiated evidence based best practice.

Mr Drew said, 'Central to Sinead's successes is her passion for working within a social justice and equitable framework.'

NADA updates

Advocacy news

In October, NADA delivered a submission addressing the Post-Market Review of the PBS Opioid Dependence Treatment (ODT) Medicines. Thank you to those members who participated in the consultation. Key points included:

- That the principles of human rights and person centred care are paramount.
- That appropriate staffing and adequate funding are available.
- NADA supported a more consistent approach across jurisdictions, regions, pharmacy and non-pharmacy settings.
- NADA highlighted the role and importance of the NGO AOD sector in delivering ODT in a supportive environment capable of addressing the considerable and complex physical, social, emotional, financial, and relational challenges often faced by people who are dependent on illicit or pharmaceutical opioids. These include supports to access employment, housing, education, financial support, childcare, and cultural connection. NADA recommended expansion of these models, with adequate funding to deliver outcomes. Expansion of ODTP nurse practitioner models was also highlighted.
- That opioid dependence is recognised as a health condition that is managed in the same way as other chronic health conditions, where pricing of medicines is consistent and equitable.
- Any economic analysis should include analysis of the cost-savings of the program.
- Members report a significant lack of prescribers.
- ODTP harm reduction strategies should include the provision of Naloxone to all ODTP consumers and their family and friends
- NADA strongly advocated for a reduction in administrative burden of ODTP
- Workforce development was identified as an important part of ODTP

Our new board members

During the 2021 NADA Annual General Meeting, members voted on candidates for the NADA Board of Directors. We are pleased to announce the following new board members.

Gerard Byrne has over 30 years' experience in the AOD field, holding counselling to senior management roles. Now the operations manager for WHOS Treatment Services. Gerard holds qualifications in social sciences, AOD work, psychotherapy, clinical supervision, business management, human resource management and workplace training and assessment. He currently holds board positions in AOD peak bodies and services.

Leone Crayden is the Chief Executive Officer of The Buttery, a not-for-profit, charitable AOD rehabilitation, addiction and mental health services organisation. With a background in nursing, social science, leadership and governance, Leone has a long and distinguished career in executive and frontline positions in mental health, community housing and homelessness, social welfare and disability.

Mark Buckingham is the Chief Executive Officer of Kedesh Rehabilitation Service and has worked in the AOD sector for over 20 years, both in specialist treatment and managerial levels. Mark is a graduate of the University of Wollongong's Faculty of Commerce, where he focused his studies on health management. He has served on the NADA board as an executive for close to a decade.

Learn online with NADA

Learn online

Courses available

- Coping with stress and uncertainty during COVID-19
- Engaging with families and significant others
- Asking the question (now on the NADA website)
- Magistrates early referral into treatment (MERIT)
- Complex needs capable
- AODTS NMDS

NADA practice leadership group

Meet a member

Dylan Clay Program Manager—Speak Out Dual Diagnosis Program, Weave

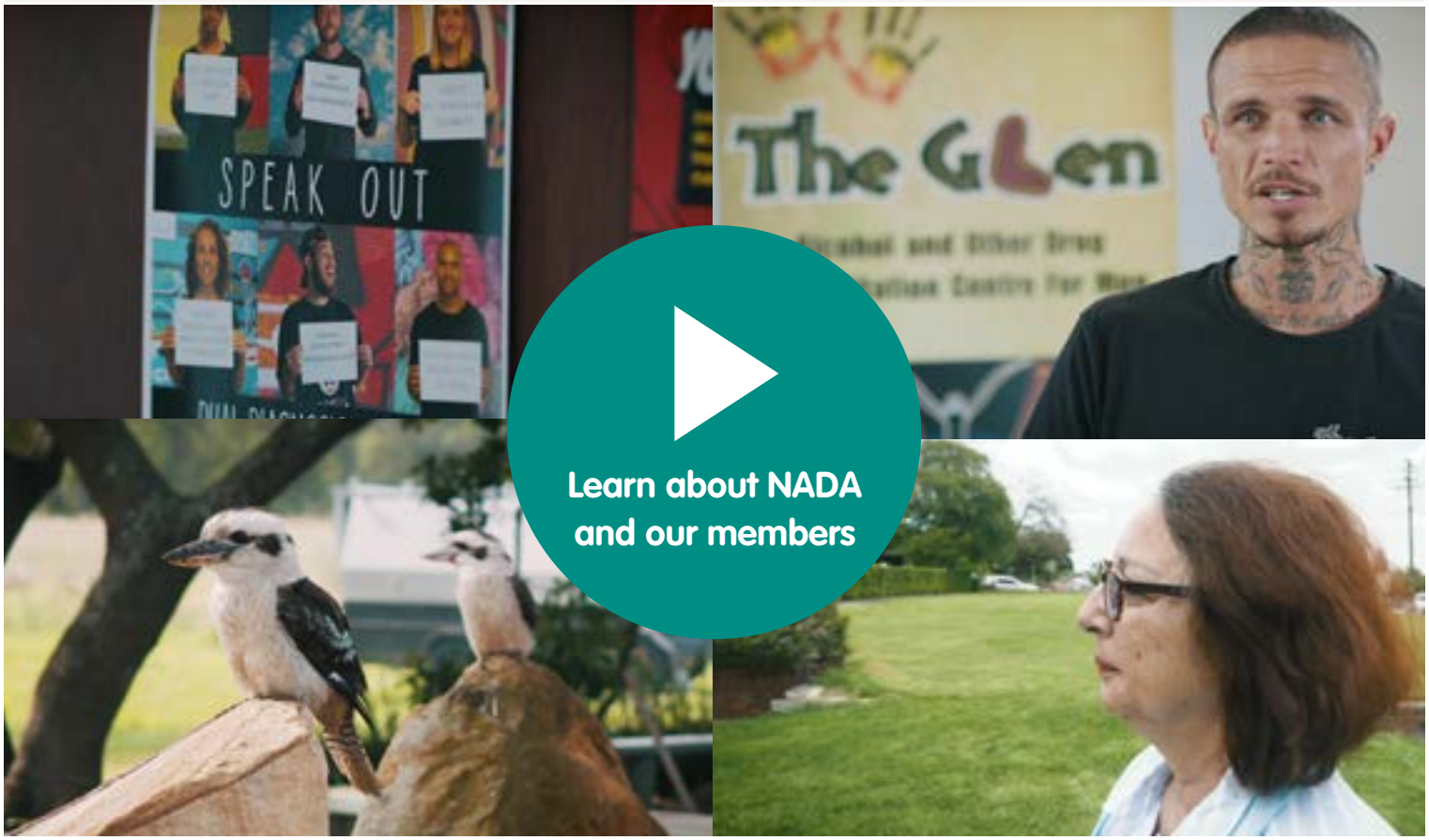
How long have you been working with your organisation? How long have you been a part of the NPLG?
I've been working in AOD and mental health for the last seven years and have been in my position with Weave since mid-2020. I have joined the NPLG six weeks ago!

What has the NPLG been working on lately?
For me, having joined the NPLG recently, it has been interesting to catch up on the fantastic advocacy and work of the group over the last few months. The work has been diverse, however recently there were interesting discussions centred around recognising and advocating for the efficacy and evidence base of different types of AOD treatments available in the community, outside residential rehabs.

What are your areas of interest/experience—in terms of practice, clinical approaches and research?
I'm passionate about a strengths based approach and allowing people to take ownership as the experts in their own lives. Within this, I'm interested in narrative therapy approaches and recently, I'm increasingly interested in response based approaches.

What do you find works for you in terms of self care?
I believe self-care is always important for longevity in our sector. For me, I try to stay in a good rhythm of playing music, seeing family, and learning from and connecting with my colleagues inside and outside of my organisation.

What support can you offer to NADA members in terms of advice?
I'm happy to take calls or emails if I can support NADA members. Particularly if I can support members around co-occurring mental health experiences and AOD use in young people, holistic and therapeutic case management, or support with service navigation, specifically for young people.



Advocacy highlights

Policy and submissions

- NADA, in partnership with ACON, Family Planning NSW, MHCC and Women's Health NSW, wrote to Minister Hazzard requesting clarification over mandatory vaccination of healthcare workers.
- NADA put out a media release about the impact of COVID-19 on the sector, and called on the NSW Government to respond to the Special Commission of Inquiry into the Drug 'Ice'. As a result, NADA CEO was interviewed on ABC Newcastle Radio (listen from 1:05:00). NADA was also mentioned in The Sydney Morning Herald article, 'Just as easy as before COVID': Cocaine's rising popularity during the pandemic.
- NADA wrote to the NSW Premier to seek a meeting to discuss the NSW Government's response to the Special Commission of Inquiry into the Drug 'Ice' and the need for an AOD strategy in NSW.
- NADA consulted with members and the Advocacy Sub Committee to develop a submission to the Post-market review of opiate dependence treatment program (ODTP) medicines.
- NADA signed on to the NCOSS Health Equity Alliance Climate Statement.
- NADA signed on to the open letter to the Prime Minister from Equality Australia regarding the Religious Discrimination Bill.

Advocacy and representation

- Key meetings: NSW Ministry of Health, NSW Department of Communities and Justice (DCJ), Department of Health, National Indigenous Australians Agency, Australian Alcohol and other Drugs Council, AOD Peaks Network, NUAA, AIVL, NCOSS, MHCC, Health Justice Australia, Yfoundations, PARVAN and NSW/ACT PHN AOD Network.
- Ongoing meeting representation: NSW Ministry of Health COVID-19 Clinical Council, NGO CoP and AOD CoP. DCJ Peaks and Partnerships weekly meeting.
- NADA arranged for Justice Connect to host a webinar for NSW NGOs funded by NSW Health to understand the legal issues associated with the mandatory vaccination Public Health Order.
- NADA with the Department of Health and the Australian Institute of Health and Welfare to discuss the inclusion of gender and sexuality diversity in the NMDS, as well as NGO representation on AOD data governance structures.
- NADA, in partnership with Members from the HNECC PHN region have represented the sector regarding the implementation of Real Time Prescription Monitoring SafeScript NSW
- NADA continues to represent NGO AOD services on the National Alcohol and other Drug Workforce Development Strategy Project Advisory Group.

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

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Feedback **Training grants**

Photo by Kris Ashpole