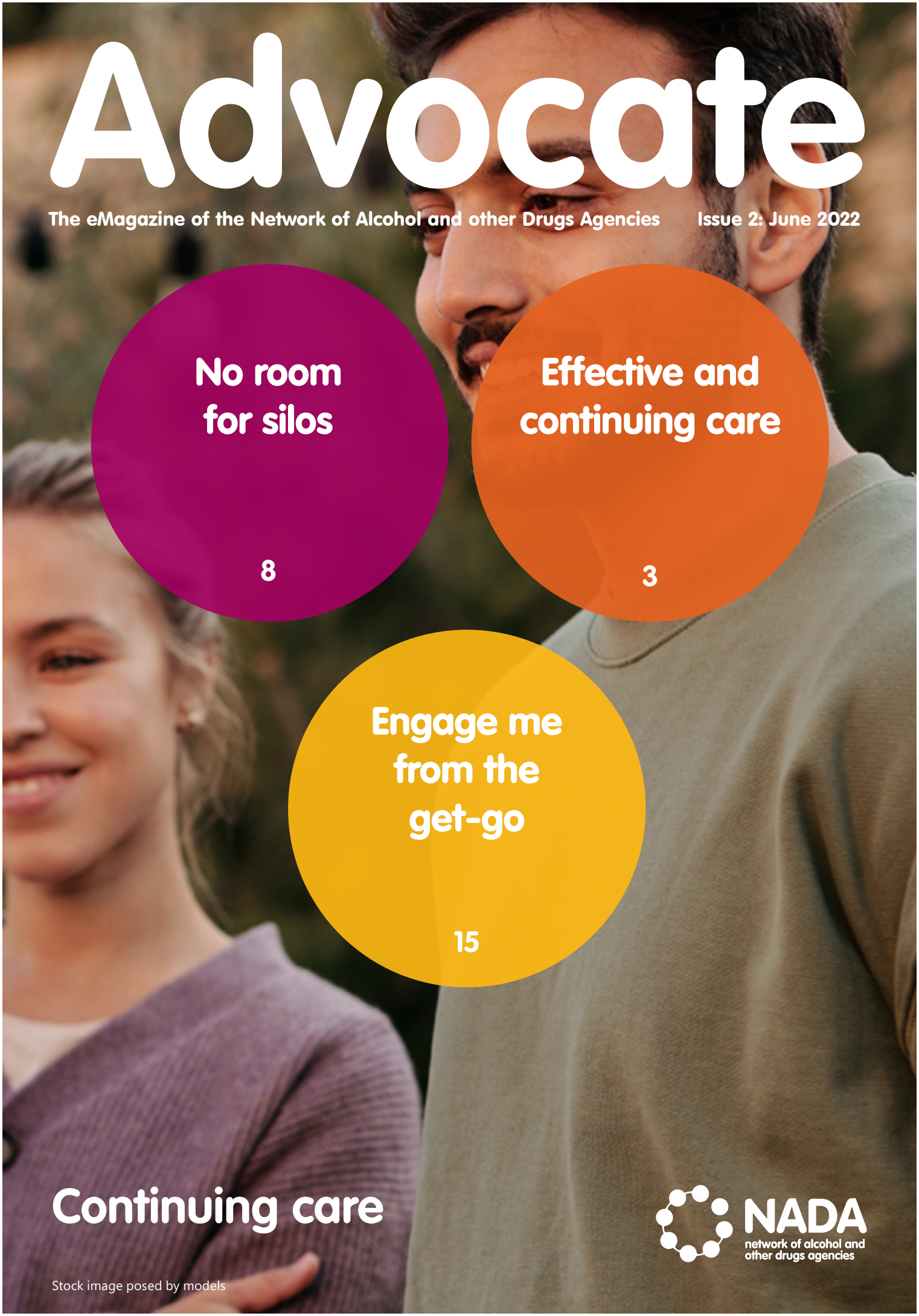
Advocate

The eMagazine of the Network of Alcohol and other Drugs Agencies Issue 2: June 2022



Continuing care

NADA network of alcohol and other drugs agencies

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CEO report

Robert Stirling NADA

NADA is hopeful. We hope that a change in leadership at the national level will see a renewed interest and prioritisation of AOD policy, to progress the needs of the sector. We are optimistic—the new government is committed to improving the health and wellbeing of Aboriginal and Torres Strait Islander people, and the Uluru statement from the Heart.

NADA's key election priorities and calls to the incoming government, outlined on Croakey, are:

- invest in strategies that actively reduce stigma and marginalisation and prioritise the voices of people with lived experience
- establish governance structures that include the non government sector, that provides 70 percent of all episodes of care in Australia
- commit to incremental increases in treatment and harm reduction funding over the next 10 years to ensure a skilled workforce can be attracted, developed and retained
- develop a workforce strategy with an implementation plan that includes investment to offer incentives for people to work in the AOD sector.

NADA is disappointed with the NSW Budget and continues to apply pressure to the NSW Government to respond to the Special Commission of Inquiry into the Drug 'Ice' and call for a plan to incrementally increase treatment funding over the next 10 years. I recently delivered a keynote address on workforce challenges and opportunities, and outlined a roadmap for addressing the workforce issues the sector has been experiencing for many years, now at crisis point. Many of the issues were outlined in the Special Commission recommendations and need urgent action. We continue to raise these issues and solutions with both levels of government via our issues paper [PDF].

This issue of the Advocate focuses on continuing coordinated care, defined as 'the delivery of a seamless service through integration, coordination and the sharing of information between different providers' (Gulliford et al. 2006, p. 248). Our sector provides a range of valuable AOD services, but we also need to support people to navigate across a range of other health and social services. While some members can provide a range of services themselves, for most, partnerships are essential.

Each year, in our feedback survey, we ask whether we are effective at facilitating networks and partnerships. Interestingly, 90% of stakeholders and 86% of members report that we are effective, however only 57% of frontline workers agree. That suggests that we need to continue to look at strategies to ensure that those on the frontline are able to support transfers to other appropriate care, or provide a shared care approach.

Our sector provides a range of valuable AOD services, but we also need to support people to navigate across a range of other health and social services.

In my time at NADA, improving pathways within the sector, such as between withdrawal management and residential rehabilitation, and across LHD and non government services has been a priority for the sector. Externally, pathways between mental health and housing services have been areas that continue to challenge us. These are reflected in the past three member needs assessments [PDF], *with increased access to services and improved referral pathways* being a priority for service delivery, policy and advocacy.

NADA will continue to support collaboration and partnership across health and social services for our members. We hope that this issue of the Advocate provides valuable insights to both members and our key partners in delivering the best possible care to people, their families, and communities.

Effective and continuing care

There's mounting evidence about the efficacy of continuing care, and the range of supports and services it encompasses continue to expand and evolve. NADA's Michelle Ridley reviews the evidence and shares practice points for this approach.

Continuing care is a model we're hearing about more frequently in the AOD sector. This approach helps people achieve better outcomes across a range of AOD treatment settings.[1] It can provide support in various ways including assistance to maintain initial treatment goals, relapse prevention, providing referrals and connections to other sources of support, and addressing co-occurring issues.[2]

What does continuing care involve?

Previously, continuing care was associated more with 'after care', such as the support provided after an intensive initial period of AOD treatment (e.g., residential rehab). However, 'after care' support did not always respond to the ongoing care required by people who are experiencing AOD use issues.[3] While 'after care' interventions are still important, recognising these services are part of continuing care, effectively conveys 'a philosophical shift' in thinking from something that sounds more like an afterthought to something that is part of the whole journey.[4] For example, continuing care now also commonly includes services that assists a person to connect and maintain engagement with AOD treatment, like waitlist support.

Continuing care also provides support across a wider range of areas, including assistance with co-occurring issues like homelessness, isolation, mental health problems, family and domestic violence, criminal justice, and child protection involvement.[5] Providing a person with support for co-occurring issues is an integral part of best practice AOD service delivery and continuing care to improve treatment outcomes.[6]

Continuing care can provide 'wrap around support' and be delivered through community based programs and primary care, for example the Continuing Coordinated Care (CCC) program available across NSW. Practice example of continuing care support include:

- case management
- waitlist support
- providing a drop-in facility
- telephone delivered check-ins and counselling
- outreach workers who meet with the person in the community to provide support
- coordinated recreational activities
- providing occasional sessions and activities at the service (e.g., BBQ for clients, lunches)
- living skills and peer support groups, like Smart Recovery.

Engaging people in continuing care

While continuing care is proving to support better outcomes, engaging people with this support can be challenging. Some research suggests that only 21–36 percent of participants commence continuing care following residential or outpatient AOD treatment.[7] This low uptake indicates that many people who could benefit

Effective and continuing care

continued

from these supports and interventions are not accessing them. Unfortunately, there is limited research that looks at why people do or do not engage in continuing care.[8]

Although greater research is needed, there is some evidence that suggests factors that can influence engagement and retainment in continuing care. One is community affiliated social support.[9] Social support and feelings of acceptance and belonging are important factors in improving outcomes for people who have experienced AOD use issues.[10] Connectedness, active engagement in the community and supportive social networks are key to changing problematic AOD issues.[11] Continuing care that provides these elements as part of the intervention can be more effective at supporting people to maintain their goals and treatment outcomes.

Continuing care that includes more assertive approaches and rapid initiation also influences greater engagement in the program and supports better outcomes overall.[12] The longer continuing care is provided with more active efforts to keep people engaged in the program, the better engagement and consistently positive results, particularly for people at higher risk for relapse.[13] For example, continuing care should be prioritised for all people leaving residential treatment and is equally appropriate for people who complete treatment and for those who do not, including those who leave the program early and those who are discharged due to issues while at the service.

Whatever types of interventions are provided as part of continuing care, each person's needs and situations are different, so the support provided must be tailored to each client. There is no one size fits all for any AOD interventions, and this is equally true for continuing care. To enhance engagement and outcomes of continuing care, it is also crucial that regular reviews are conducted, as everyone's situation changes, and therefore the supports and services provided need to be adapted when required.[14]

Practice points

Effective continuing care:

- is respectful and non-judgmental
- is tailored to reach a broad range of people, including Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds, to ensure that all people who might benefit from this support can access it
- is of longer duration and includes active efforts to keep people engaged
- comprises more assertive approaches, starting as early as possible
- is an integrated care approach that is adaptable and responsive to the person and includes regular review of their situation
- tailors support to suit the person, such as phone calls scheduled to check in around school/study or work commitments
- involves cross sector services and programs, including housing, domestic and family violence and legal.

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WE ASKED YOU

How do you support people with co-occurring needs

Recovery Point, Samaritan Foundation

Paiige Williams

What additional supports do you provide people accessing your service who are experiencing other issues alongside their drug use, such as criminal justice involvement? People can access our service post-release from corrective services or through a resi rehab facility. Many would have stopped using AOD, but may experience stress when they re-enter the community—and this can increase their risk of AOD use. Stressors include housing or financial issues, accessing medical and mental health care, and even just meeting probation and parole requirements. People can just kind of crumble and go back to their default position of, 'How do you deal with this? I've got no hope.' It's easier to go back to using again. And sadly, a lot of the time, people become so institutionalised.

So, we provide one-on-one case management for people upon re-entry into the community. We walk alongside them to help them to secure housing, to sort out their Centrelink and bank account, access emergency relief or mental health care, and pay state debts with work development orders. We can help them to access complex support through NDIS, link them with other services, and support them to reconnect with their family.

We also run complementary programs that promote alternative strategies to cope, with a focus on self-care and build their confidence, to get on that recovery journey and stay on it as best as they can. Like the 'Alternatives to violence' program where people learn skills and strategies to deal with conflict in a nonviolent way. Also, 'Headstrong', a wellness program, which uses fitness as a part of recovery. And then we've got the chaplaincy service, which can support people with pastoral care and mentoring.

Recovery Point is very much a family of choice for a lot of people—people feel included—many staff members have lived experience. We meet people where they're at: whether you're still using, you've relapsed or coming back in with your tail between your legs—they can come back.

How does this additional support assist or improve your client's engagement with AOD treatment? People who participate in the complementary programs have a higher adherence to the peer support AOD groups. They're the people that are getting the regular and ongoing support, and coming in at least three days a week. We've designed the programs in for that reason, so people can come every day if they wish.

It's also looking at their journey from a holistic perspective; they're looking at their health and wellbeing, their choices and their behaviours. Because if you don't look after that, they may rebound to try to cope some other way. There's always going to be triggers and stress in your life, and there's always going to be access to the substances. You can't eradicate that, so it's building yourself up in a manner that you're able to deal with all of that.

Do you have a case example about someone who engaged in your service and how they benefited from accessing holistic, wrap around supports? Four years ago, Steven* came to Recovery Point as an active 'ice' user, and began attended the 'ice' recovery groups on a regular basis. He wanted to reduce his drug use, and was able to harm minimise initially. Over time, he wanted to become abstinent from 'ice', and over a couple of years of attending the program, he succeeded. He has been abstinent from methamphetamine, and also from alcohol, and pot—all illicit substances—for the past two years.

He enrolled in Headstrong, then the Headstrong graduate program. He has since finished his Certificate 4 in Community Services with our support, and now works as a disability support worker. After multiple years of hard work, he is now reaping the rewards. He has reconnected with his children, and recently met grandchildren, that he hasn't met before. He's now a mentor in our 'ice' recovery group. He's made sure that he gets Monday mornings off work to be able to continue. All the guys look forward to knowing that there is someone who is successful there, like wow, 'That that can be me. I can do that'.

* Name has been changed to maintain privacy

Elouera, Lives Lived Well
Elizabeth Priest

What additional supports do you provide people accessing your service who are experiencing other issues alongside their drug use, such as involvement with child protection? The Department of Communities and Justice (DCJ) refer a lot of clients to us. Our clients can be mums who have children in their care, or who have children in the community with DCJ involvement.

Once the client completes the intake process, if they wish, they can be engaged in some form of AOD treatment from the get-go. This could be case management, to harm minimisation to relapse prevention. With the client's permission, we start liaising with DCJ to obtain their family action plans and any other documentation, so when we're working with the client at the goal setting stage, we can encourage them with this, like, 'This is what DCJ are looking for, so how can you achieve that?'

Once the mum is in-program, a lot of our work is based around her contact with her child, and what this looks like. That may be the first goal that we make with the client. For example, if her child is in another town, we liaise with whoever is caring for the child and/or DCJ, to ensure there is regular contact for the mum, to rebuild/foster that relationship.

Once the client completes the program, we tailor support to her needs; contact could be daily, or once a fortnight, depending. Nevertheless, we continue to focus on the mum and child aspect.

We find a lot of women's relationship with DCJ is strained, for obvious reasons. We also try to help her strengthen that relationship because it's important that she has multiple supports in the community, rather than just us. She needs to feel comfortable with her DCJ worker, to be able to work through things with them. So that can be in the form of, 'DCJ can come to Elouera,' or 'We could FaceTime together.' Whatever it takes.

How does this additional support assist or improve your client's engagement with AOD treatment? If we can set up a good routine for mum and child contact—whether it is by phone or face-to-face—this tends to keep mum motivated. Even on those hard days, we can encourage her by saying, 'It's okay, your child is coming tomorrow, let's focus on resetting.'

Interaction with her family gives her that 'next level' motivation. A lot of women's motivation for coming in is for their children. And when they start to build that relationship, their mentality starts to shift from 'having to be there' because of DCJ, to 'wanting to be there'.

Do you have a case example about someone who engaged in your service and how they benefited from accessing holistic, wrap around supports? Kylie,* aged 22, entered the program without her three-year-old child. When she entered the program and saw other children, she deregulated quite severely. Nevertheless, we were able to encourage her to stay and give the program a go, by setting up DCJ visits for her, and by working with her.

Her relationship with DCJ was strained; we taught her self-regulation skills, so she was able to work with them. She was also at risk of losing her housing, but after three months, she was able to work alongside us, DCJ, and housing to keep her home.

She had court and criminal court, but because she made phenomenal progress, she ended up with a community corrections sentence rather than jailtime, so she was able to see her child once a week. Our team can pick her up and facilitates that visit once a week.

At baseline, her QOL score was 4, after 3 months it was 10. A lot of her case management was based around her child and ability to regulate her emotions. She participated in our 'Circle of security' program and was able to link some of that to her as a child and work out how to implement that with her daughter.

Her other services came to Elouera during her stay to maintain their contact. We basically supported her to strengthen her bond with her child and supporting services; we also connected the service to us. Now in the community, she has to be able to do it herself, and she can, knowing that she can call on support.

* Name has been changed to maintain privacy

Weave
Dylan Clay

What additional supports do you provide people accessing your service who are experiencing other issues alongside their drug use, such as trauma? We work in a multidisciplinary team comprising case workers, counsellors, a project worker and an art therapist. This means we can provide wraparound support, usually holistic case management and trauma therapy, concurrently for an individual. We also offer opportunities to engage in group projects, events, advocacy opportunities and group therapies, including art therapy groups.

How does this additional support assist or improve your client's engagement with AOD treatment? It means we can be highly responsive to the presenting issues and needs of a person that we are supporting. We can pivot between AOD support and other holistic supports that can make it more likely or easier for an individual to engage in their AOD treatments. For example, supporting someone with their mental health experiences through counselling, often has an impact on AOD use, or potentially on the willingness or ability to engage with AOD treatments. It's difficult, I think, to engage with a number of different services, different places and different professionals. When you can provide additional supports, or holistic support to someone, I think it takes some of the pressure off and makes it a little easier for a person to engage in support and their own recovery or wellbeing journey.

Do you have a case example about someone who engaged in your service and how they benefited from accessing holistic, wrap around supports? Many of our clients are positively impacted by the wraparound and holistic nature of our service and receive case work as well as counselling or other mental health support from the program.

I am thinking of a particular client that was engaged in trauma therapy with one of our counsellors and receiving holistic case management from another case worker. The person entered the program homeless and actively using AOD, however through a combination of therapeutic, holistic case management and counselling, they were able to secure a transitional accommodation and a priority status application for housing, as well as report they were feeling progress in their mental health experiences and that it opened space for them to begin addressing their AOD use. Entering trauma counselling with us also led to them engaging with specific AOD counselling and considering residential rehab for the first time.

CORE Community Services
Ashleigh Hay

What additional supports do you provide people accessing your service who are experiencing other issues alongside their drug use, such as trauma? Our clients are aged between 12 to 24 years old. After we assess them, we can provide case management and a wide range of supports. Supports may include material aid, like food assistance (e.g., hampers or vouchers), travel (e.g., Opal cards), and help with work development orders (so they can pay off their fines). We can help with housing (e.g., crisis accommodation, transitional housing, assistance to apply for Rent Choice). We have access to a bulk billed psychiatrist, and a program to prevent relationship breakdown.

We have developed a range of engagement activities. For example, during the recent lockdowns, we held a 'Stay at Home' drive. We delivered 1,572 survival packs to young people, which included books, and mindfulness and creative activities. We hold soccer comps, free music lessons, and movie giveaways. We also hold free weekly barbeques in Liverpool and families from all over come, and leave with a free themed pack (e.g., COVID safety).

How does this additional support assist or improve your client's engagement with AOD treatment? The creative engagement activities I mentioned is targeted early intervention. These help us connect with young people (or their families) early, and let them know that we care about, and respect them. In doing, it overcomes the barrier of stigma and helps us to identify issues earlier. The material supports, like food and accommodation, address clients' base needs. It's like Maslow's Hierarchy of needs, you need to address the foundational issues first.

Do you have a positive case example about someone who engaged in your service and how they benefited from accessing holistic, wrap around supports? Supported by case work provided by our AOD and early intervention case worker, a 19 year old person stopped smoking marijuana (from daily use to nil). He is currently working full-time. He has stopped interacting with negative influences and created a new social circle for himself. He has avoided prison from previous charges and remains in contact with staff to provide regular updates.

No room for silos
Responding to domestic and family violence

By Rodney Vlais

Parameters and boundaries around our services are inevitable, and necessary. Straying into territory and issues that we have not been trained in, and that we are not equipped to respond to, can cause harm for our clients and their families. Being honest with our clients and other agencies about what we can and can't safely and responsibly work with, is a crucial part of minimising the risk of inadvertently causing harm.

Yet silos have real consequences for clients and their families. When we try to silo the complexity of our clients' lives, and impose a hard boundary of, 'I only deal with X—I don't want to know about Y or Z,' we can end up self-sabotaging our own best efforts. Ignoring complexity can come back to bite us.

There's perhaps no form of complexity that tests practitioners to find a balance—between, on the one hand, needing to respect the limits of one's expertise and role, and on the other hand, to stretch one's practice into new territory—more than responding to domestic and family violence (DFV). As a sector of passionate and committed practitioners who are often called upon to 'go that extra mile', over the past decade AOD services have begun to come to terms with what it means to not 'silo off' the experiences of clients who are experiencing DFV.

Is your client experiencing violence?

For most if not all AOD services, identifying that a client is a victim/survivor of DFV can change the work with that person dramatically, and supporting them in regards to DFV, should be part of a continuing care approach. Knowing the limits of what the AOD service can do to support the client is crucial, as is how to warmly refer them to specialist DFV services. At the same time, responding sensitively to them, assessing DFV risk, following their lead[1] and working towards safety becomes the centre point of the AOD service's work with them. Attempting to 'silo this out' can result, at worst, in missed opportunities to save lives; or at least, in closing perhaps the only door they haves for support to create a safer and better future for them and their family.

Is your client perpetrating violence?

When a client is a perpetrator of DFV, as distinct from being a victim-survivor, the balance between staying within the parameters of one's skillsets and expertise, and needing to stretch oneself to incorporate a focus on his harmful behaviour into your work, becomes even more challenging. No-one wants to cause harm, or to stretch themselves into half-baked practice that potentially compromises the safety of those experiencing the client's violence.

Not siloing out, nor 'burying your head in the sand', about a client's use of DFV is important for all AOD services. This does not always mean directly engaging him on his use of DFV—in some situations, taking a direct approach towards engaging him on his behaviour might not be a safe option. There are, however, some minimum practice considerations that all AOD services and practitioners should keep in mind, even in situations where the client is not directly engaged about his behaviour towards family members[2] including:

- knowing the signs and red flags that a client is or might be perpetrating DFV
- looking out for indicators and evidence based risk factors that point to serious or immanent risk
- knowing how to minimise collusion with a perpetrator's violence supporting narratives and belief systems
- sharing information with the DFV Local Coordination Point or another service to explore if there is an option for a professional to safely reach out to his (ex)partner to assess risk and offer support.

No room for silos: Responding to family and domestic violence

continued

In some situations, there is potential for an AOD service to do more, and in many circumstances it would be appropriate to create a space in the engagement with the client to focus on his behaviour in his relationships, with the view towards referring him to a registered men's behaviour change program.[3] As reported in the NADA Practice resource, creating this space in the engagement requires the AOD practitioner to:

- bridge from the client's AOD concerns and presenting needs to a conversation about how he relates to his intimate partner or family members—in ways that do not infer that his AOD use is the cause of his harmful behaviour, but so that he can understand why he is being invited into these explorations (rather than this focus appearing 'out of the blue')
- use *mid-point skills* (outlined in the practice guide and accompanying resources) to build these explorations in ways that do not collude with his violence-supporting thinking and belief systems, but which also do not leave him feeling persecuted, moralised at, or shamed
- use motivational interviewing skills to invite him to consider how taking up the referral would help him to work towards what he aspires to as a partner, father, family man or member of his community
- listen carefully to how the man responds to attempts to invite him into these explorations, both to know how far to go with the conversation at any point in time, but also to identify any red flag indicators that he might be posing a serious risk to those impacted by his violent and controlling behaviour.

How a practitioner might do this will depend on how often, and over what period, they might be engaging the client. Continuing care and other AOD treatment contexts enable engagement opportunities spanning months. In these situations, opening up and extending explorations with the client about his harmful behaviour, monitoring for indications of risk, and working out what information to share with specialist DFV services so that they can (if possible) safely reach out to his (ex)partner to offer support, are not simple endeavours for any practitioner without specialisation in DFV.

To help equip us with the supports and skills to do so, there is something of a parallel process here. As practitioners, we are often mindful of the client's support 'ecosystem': who in the client's life can offer them support—who can be an ally in their efforts towards change. Of course, we work with our clients to strengthen their inner resources and capacities, but it's not just about helping them to become more 'resilient'. We also consider how they can be supported by others.

In a similar way, AOD practitioners can reflect, 'What supports do I need to be able to extend my confidence, understanding and skills, so that I can safely lean into conversations with my clients about their harmful behaviour?' This is, to an extent, about undergoing training. However, it's also about reaching out to program providers and practitioners who work with men who use DFV, to build support systems to extend your practice.

Most of the work conducted by Mens Behaviour Change Program (MBCP) providers and other specialist DFV perpetrator-focused services would not be appropriate for AOD practitioners to attempt. Similarly, most of the highly specialist and nuanced work of AOD practitioners and services is not within the realms of what MBCP practitioners can do. There is definitely potential, however, to develop meaningful partnerships to support practitioners from each sector to extend their capacity to lean a little into each other's work.

Sometimes, there isn't a referral option that will work for the client, due to geographical isolation, wait lists, or because the client is not yet willing to act on the referral. In these situations, an AOD practitioner or service might be left 'carrying the can' of the risk that the client poses to those experiencing his violent and controlling behaviour. Meaningful partnerships and willingness and organisational support to reach out for (multiple) secondary consultations through the Men's Referral Service or other specialist DFV perpetrator-focused services, are therefore crucial. Linking in with and partnering with specialists DFV services, helps you to have your own ecosystem of support to extend your practice, and to work collaboratively to manage the risk and provide effective continuing care services.

No room for silos

continued

For practice resources to assist you to respond to DFV as part of continuing care see:

- NADA Practice resource: Engaging men who perpetrate domestic and family violence in the AOD treatment context and refer to the following recorded webinars that should be viewed in conjunction with this resource:
  - Engaging men who perpetrate DFV in the AOD treatment context
  - Engaging men who perpetrate DFV in an AOD treatment context—practical techniques and considerations for minimising collusion
  - Engaging with clients causing DFV harm during the COVID-19 pandemic
- Men's referral service provides telephone and online advice, information and resources for men who are using violence—it provides details of locations for Mens Behaviour Change Programs
- Working with women engaged in alcohol and other drug treatment—NADA Practice Resource provides information and advice on working with women and women who are experiencing DFV
- Domestic violence line and other resources—provides a range of different services and information for victims/survivors of DFV

Bibliography

1. See insightexchange.net/follow-my-lead/
2. See the NADA practice guide and a range of accompanying resources.
3. A MBCP that has been registered by the NSW Government. See this list.

Responding to violence in residential rehabs

AOD treatment in a residential setting may provide an opportunity for respite from a situation involving DFV, and specialist AOD treatment providers play an important role in identifying and responding to this issue.

It is vital to screen for the experience of DFV and to have the results inform the care planning for a person accessing treatment. Also essential is ensuring a person's safety with regard to contact and visits by a person who may have exerted power or control or been violent with them.

NSW Health's Integrated Prevention and Response to Violence, Abuse and Neglect (IPARVAN) Framework requires integrated responses to working with people with experiences of violence, abuse and neglect to be person centred, to be family focused, to provide seamless care across multiple services, and to use a multidisciplinary and trauma informed approach designed around the holistic needs of the person and their family throughout their life course. To help achieve this, Phase 2 of IPARVAN Framework implementation includes NSW Health workers having access to education, training, professional development and workplace resources to build the skills, knowledge, attitudes and values to provide holistic and integrated services.

Providing integrated and collaborative care for AOD clients with experiences of violence, abuse and neglect requires the development of further guidance and referral pathways including shared clinical assessments, integrated models of care and other resources to support AOD and VAN services to work better together.

Excerpt from the upcoming 'NADA Practice Guide: Providing alcohol and other drug treatment in a residential setting'.

Stock image posed by models

Integrated care with a whole life view

The Weigelli/Orana Haven Hub project delivers holistic, comprehensive, and culturally appropriate health care with a whole-of-life view that focuses not just on the physical wellbeing of an individual but the social, emotional, and cultural wellbeing of the whole community. There are hubs in Bourke, Walgett, and Forbes that offer support to the community around AOD use issues, which can include referrals, case management, outreach, or whatever support the person needs to assist them. NADA's Raechel Wallace spoke to Michelle Crowe and Tracey Gordon from the Weigelli/Orana Haven Hub project to learn about the service.

What are some benefits of integrating support for AOD issues into the service you provide? AOD issues are our primary concern of focus for us at Weigelli/Orana Haven Hub project. Our focus is to ensure that we integrate support for the social and emotional wellbeing of our clients such as mental health, accommodation, education and training, and then leading into employment. Each hub obviously has a range of services they work closely with to ensure that our clients have the best access to follow up and ongoing support to continue their journey in their recovery and continued wellbeing.

The workers at the hubs encourage the clients to start working on what's important to them. This can include getting them along to their appointments and supporting them in any way that's needed, also referring them to relevant services that they require, including legal representation, they can walk besides the clients on their journey to give them a bit of support and help them to start managing their own lives.

How does your service act as a pathway into treatment for people experiencing harm from AOD use? We are extremely fortunate that Orana Haven has a detox and male residential rehabilitation service near Brewarrina which provides culturally sound AOD treatment to both Aboriginal and non-Aboriginal people living in Western NSW. This allows us to provide a seamless pathway for local mob who are experiencing difficulties in managing their substance use. If residential services are not required, we support Aboriginal people to tap into services that aim to support people to change and modify their behaviours to lessen their harmful substance use.

What has worked for you and your team when building partnerships with other service providers to provide integrated care? Turning up! I think the key to building partnerships is to get out there visit people and services, go to interagency and other community meetings and events. Networking and partnership building needs to be a part of our everyday work.

Then take the time to get to know your services, what they can provide. Partnerships are vital to a client's continuing path to wellness and recovery. We cannot be the only service in a person's life, and we need to tend to our partnerships like you might a garden. In a garden you don't just throw in some seeds and hope for the best. It takes care and patience, fertilising and watering. The more time we spend on nurturing our partnerships, the better service our clients can expect and the more positive, and some might argue sustainable, their journey is.

Top 5

Supporting people experiencing homelessness

Too many people experience homelessness in Australia, and many only develop problematic drug use issues because of this. Homelessness greatly impacts a person's access and retention to AOD treatment, so it is vital to explore and support people with their housing situations, as it is most significant. Fiona Murray, Senior Service Manager from NEAMI—STEP Program, suggests five ways.

1. **Take time to understand what the person needs right now**
Someone who has expressed that they are experiencing homelessness might have specific needs at the time, for example if they have urgently fled domestic violence, they may need to access essential items such as clothing, food, and toiletries. A physical or mental health response may be necessary before having further conversations about housing.

2. **Take time to understand the reason for their current homelessness** The causes of someone's housing crisis could inform the response and what they are eligible for from the housing system. Domestic and family violence is the main cause of women's homelessness, and they may have particular considerations around their children, or be eligible for specific support from the legal system. If someone has left a situation because of fear of being evicted, they may still have tenancy rights or be eligible for assistance with rent payments.

3. **Take time to understand what the person wants in the future**
The person experiencing homelessness might have a range of considerations about their future housing that aren't immediately obvious. For example, they may have children they are planning to have in their care, or other family members who are part of their household. People might have their own plans or solutions to their situation and simply need practical support, for example funding travel interstate to stay with family.

4. **Resist assumptions about the situation** People may have different ideas about how they define their situation—for example, someone who is couch surfing or staying with relatives may not consider themselves homeless, despite being eligible for homelessness services. Someone's precarious housing situation may sound alarming to a listener, however the person themselves may not see that as the most urgent issue they are currently facing.

5. **Refer to other services and supports** These services can specifically assist people to navigate the housing and homelessness services.
   - **Link2Home** for crisis accommodation if someone needs a bed that night 1800 152 152
   - **DV Line** can provide accommodation and advice specifically for people who are homeless because of DFV 1800 737 732
   - **Wayside Chapel** Can provide practical crisis support, such as shower, food and toiletries as well as advice for next steps to address homelessness 9581 9100

Best practice continuing care

Hearing the views of people with lived experience of AOD use issues and accessing services, and being guided by their feedback, is vital for enhancing best practice service delivery. Members of NADA's Consumer Advisory Group spoke to Michelle Ridley to share insights to guide best practice continuing care.

What kind of continuing care support helped you most when you were experiencing issues with your AOD use?

Kevin: Having good ongoing counselling helped me. Finding fulfilling things to do has been a blessing. Support from a psychiatrist helped me confront and address what was behind my substance use issues.

Alex: The most important factor was the support from my family, particularly when I was recovering from my car accident and the AOD unit was pressuring me to sign back onto maintenance treatment. Having the open dialogue I'd established with my parents during the hospital stay, and having my logic about why I didn't want to go back on opioid substitution therapy believed, validated, and put into practice, was immensely supportive and powerful.

Anne: Mental health support is a big one and important, also peer groups and workers who identified with having lived experience were helpful.

Fabian: For me, it was the support from my loved ones. That gave me strength. I also benefited greatly by talking to a psychologist and trying to be involved in different groups that allowed me to not feel so isolated.

Why do you think it's important, as part of continuing care, to assist someone experiencing AOD issues with other co-occurring problems?

Alex: Increasingly we are realising that AOD issues tend to occur co-morbidly, often a symptom or a flawed solution to other issues, like a mental health, or a maladaptive coping mechanism for dealing with trauma/post-traumatic stress disorder. Treating the AOD use in isolation likely fails to address the reasons for the use in the first place.

Anne: If other things/issues aren't getting attended to, whether it be legal, financial, housing or family issues, then there is potential for a person's situation to not improve.

Kevin: Support is paramount when a person is accessing treatment. It's not just about dealing with the specific drug. Don't get me wrong, detox, rehabilitation or pharmacology are important. But none of these can be successful if underlying issues are not addressed, e.g., lack of safe, affordable housing.

Fabian: There could be many reasons why people use AOD. But we need to look at what other factors are contributing to a person's drug use. Stable housing is so important. Untreated trauma or mental health issues can lead a person to use AOD to cope. We need to look at the whole picture and get all the pieces to the puzzle.

What would be your main piece of advice to AOD workers regarding best practice when supporting someone experiencing AOD issues?

Anne: Respect is just the most important and nothing less. To me, respect is broad and covers no stigma and non-judgmental treatment. Also, actively listening and hearing, without thoughts of KPIs skewing a worker's interpretation.

Kevin: Treat everyone as an individual and not one size fits all. Some seek abstinence, others seek pharmacology support. Others just want to decrease their AOD use. Listen to what the client is saying and what they want. Keep it in the moment, things may change in the future.

Alex: Respect, lack of stigma and judgment is crucial.

Fabian: Imagine it was a loved one going through the same journey. Give them respect and understanding. It is your responsibility to not be so quick to judge.

In summary, members spoke to:

- the importance of respect, lack of stigma, and judgment
- the value of the peer workforce and consumer representatives
- involving family: family inclusive practice
- holistic care: treating more than AOD use.

To support your practice in line with the advice, see the following resources:

- Access and equity: Working with diversity in the alcohol and other drugs settings – second edition [PDF]
- Stigma - Alcohol and other drugs [PDF]
- Consumer audit tool and related videos and webinars
- Working with families e-learning and other resources

The Consumer Advisory Group provides NADA advice on activities like policy, project and resource development and advocacy, based on the lived experience and expertise of members. Please contact michelle@nada.org.au to learn more about this group.

Health justice for all

In Australia, many people experience legal problems each year. These tend to cluster around experiences like family violence, money problems (such as credit and debt, consumer transactions, welfare, and benefits) or problems with poor quality housing. Yet many people aren't aware that legal help is available for these problems or that they can access it for themselves, writes Cathy Bucolo from Health Justice Australia.

In a growing movement called health justice partnership, legal assistance services are collaborating with healthcare teams and non-legal practitioners to provide free legal help in the healthcare settings that people are more likely to be accessing. There are now more than 100 health justice partnerships across Australia, including in health services responding to AOD and mental health needs.

Why could health justice partnership be useful in an AOD context?

Legal help can support a range of issues likely to exist among people accessing AOD services, such as helping people who are experiencing poverty to access income support; supporting people who are experiencing family violence to be safe at home; and supporting people who are experiencing stigma or discrimination to seek an end to that discrimination.

Creating a health justice partnership in an AOD setting might mean embedding legal assistance into that AOD service; or developing a trusted relationship between the staff of an AOD and a legal service; or providing training to build the capability of health staff to recognise likely areas of legal need among their clients and vice versa.

In the same way that continuing care support reflects an understanding that '…severe and chronic addiction is generally a long-term adaptation to trauma that must be treated with compassion and dignity,' health justice partnership can provide a holistic approach to address co-occurring legal issues in the context of substance use.

Sounds great! Who can provide this support?

Health Justice Australia actively support services to build and strengthen collaboration and achieve better health and justice outcomes for people with multiple, intersecting health and legal needs, who can be poorly served by a fragmented service system. Watch a recorded webinar to learn more, then read resources and download tools on establishing a health justice partnership.

Engage me from the get-go

The chronic underfunding of the AOD sector cascades a host of logistical challenges for residential treatment services, including long waiting lists, lack of appropriately qualified and trained staff, and the use of non–purpose-built facilities for accommodating and treating clients. As such, services often need to devise creative strategies to support people on their waiting lists. Triple Care Farm's Lauren Mullaney (Program Manager—Psychological Services) and Matthew Short (Intake and Outreach Worker) share their supportive waiting list management with NADA's Tata de Jesus.

Can you tell us how your service manages and supports people on your waitlist? Last year we were fortunate to secure some funding from our local PHN to hire an intake outreach worker. Their role is to work with young people through the intake phase of treatment until they can enter residential or withdrawal treatment. The intake outreach worker's scope is varied, and can include practical case management support, like getting paperwork together and sent, to community visits, brokerage support and liaising with external stakeholders and young people's identified support networks.

What have been the outcomes for you, your organisation and client experiences resulting from this waitlist service? There have been many things that have really improved young people's experience of intake, as well contributing positively to their general wellbeing. For instance, we have been able to:

- support people that we may have ordinarily lost contact with, while building rapport so by the time they are ready to come through the door they already feel comfortable with the service and staff
- be timelier with our referrals. For instance, referring people more quickly to the 'right service' (if it isn't us) and link in with emergency care if required
- work with 'high risk' circumstances to support vulnerable young people effectively, with opportunities to provide harm reduction strategies.

Overall, this role has helped us to better meet the needs of our young people in the community, in a more realistic way. In addition, we have been able to provide support to their external stakeholders/supports navigating the process with them.

What are some practical strategies for other services who want to start providing support for people on their waitlist? We recognise that as soon as someone picks up the phone that there is an opportunity and potential motivation for change. If we can harness that and support people through their wait time, we may see less 'drop out' because there is perceived momentum with their identified goals.

We recognise that often it can come down to funding, which can limit the things we are available to provide. However, starting small, and embedding whatever resources are available into this type of intake service can be really beneficial. From a staffing and risk perspective, it can also ensure we are managing issues before they arise. Long term, this has the potential to positively influence other workflows down the line, and more importantly, support clients more effectively.


Stock image posed by models

Collaborating across cultures

Cultural inclusiveness in health service provision means that there is awareness of, and respect for people from different cultural backgrounds. Cultural inclusion in the context of AOD treatment service provision also recognises the importance of responding to cultural needs to ensure that care is safe, equitable and of high standard. Mohamad Fenj, founder and program manager of The Rehabilitation Project, shares his thoughts on issues that culturally and linguistically diverse (CALD) clients and communities face, and the importance of weaving culture into everyday discussions with clients.

What are some of the issues that people from CALD communities face when trying to access AOD treatment?
AOD use within CALD communities is often connected with stigma, denial and shame to self, family and community. In some communities, there is a negative attitude surrounding accessing mainstream services. CALD communities may feel tentative to seek assistance outside of the immediate family due to culturally sensitive issues exposing personal matters to outsiders.

Language and communication barriers are other key factors hindering CALD individuals accessing services. Many individuals and families do not know how to access AOD treatment or what to expect at the treatment facility. Some services do not cater for the requirements of CALD communities including faith practice, dietary needs, bilingual and bi-cultural staff.

How can building and strengthening relationships with CALD community organisations benefit 'mainstream' AOD services and their clients? The CALD community forms around half of the Australian population made up of those born overseas or with a parent born overseas. Strengthening relationships with CALD community organisations allows for greater collaboration, reach and client support. This can create a platform for 'mainstream' services to be more CALD inclusive in their assessment, intake approach as well as service delivery and aftercare.

Strengthening relationships with CALD community organisations will result in more successful referrals, engagements, and outcomes. Learning about the different CALD values and principles in diverse groups and faiths will strengthen the 'mainstream' workforce and inclusiveness.

Can you share your top 3 tips for how AOD services can engage with CALD community organisations?

1. AOD treatment services to invite CALD community organisations for an in-service walkthrough of their residential facilities and introductions to their community based treatment.
2. Develop relationships with CALD community organisations to increase referral pathways, continuing care referrals and linking back to the community.
3. Integrate cultural awareness training and practice within your workforce.

NADA, in partnership with the Drug and Alcohol Multicultural Education Centre (DAMEC), is working on a project to increase the capacity of AOD treatment services to support CALD people and their communities. The project will devise, implement and evaluate an auditing process to enhance the cultural inclusion of mainstream AOD treatment services in supporting people from CALD communities. The auditing process will optimise service experiences by identifying organisational factors that support best practice cultural inclusion. Email Tata de Jesus to learn more.

The power of peers

Introducing M3THOD, an innovative response to sexualised drug use

By Jack Freestone, ACON

Introduction

Peer interventions have been delivered across settings, populations, and domains of health and wellbeing for decades. Broadly they involve non-clinically trained staff providing health education, services, care, support, or assistance to someone with a similar lived experience, or identity characteristics as they relate to age, gender, ethnicity, disability, sexuality, or other characteristics.[1,2] Peers are often valued for their ability to engage with populations 'hardly reached' by health services in settings that traditional health care workers find difficult to access or navigate[2], as such peer work is of particular significance to sexuality and gender diverse populations who often experience barriers to accessing mainstream healthcare.[3,4] Owing to their likeness, peers not only reduce barriers to care but also exercise understanding, empathy and influence to positively change health-related behaviours.[5] Ideally peer work is founded on lived experience, is shaped by consumer voices and prioritises principles of reciprocity, autonomy, and empowerment.[6]

There is a long history of and large evidence base around peer work in both the mental health[7] and HIV sectors.[8] Comparatively, peer work in the AOD sector has historically prioritised mutual support groups, with roles for named peer workers across a range of AOD service types (community support, harm reduction, and treatment) developing in recent years.[9] Peer work in AOD is an area of increasing attention and systematic reviews of AOD peer work preliminarily indicate positive effects and recommend the ongoing delivery and evaluation of a range of AOD peer support models among diverse populations.[10, 11]

The defining principles of peer work, the salience of peer support for sexuality and gender diverse communities and the increasing focus on peer work within the AOD sector, has informed ACON's initiative to develop a program of peer-based support around sexualised drug use, M3THOD.

What is sexualised drug use?

Sexualised drug use (SDU) commonly termed 'chemsex' or 'party and play' is the practice of combining drugs such as GHB and crystal methamphetamine with sex. SDU has been characterised as an experience of intense connection, disinhibition, and euphoria, where sex is adventurous, prolonged, and involves many partners.[12] A prevalent practise of sexualised drug use has been observed among trans and gender diverse populations[13] and among gay and bisexual men.[14] Not all who practice SDU experience harms, however a range of harms relating to sexual health, mental health, accidents, and emergencies, overdose, and challenges negotiating sex and consent have been documented in the SDU literature.[12,15]

Although some engaged in SDU experience significant harms evidence suggest that few access services. Some feel that AOD services do not have appropriate expertise or cultural understanding to adequately respond to SDU.[16] In response, peer led supports and approaches that may bridge sexual health and AOD services have been suggested.[17,18]

Introducing M3THOD

This service is led by peers and was developed in consultation with 16 sexuality and gender diverse community members (cis and trans)) with lived expertise around SDU. M3THOD is founded on principles of motivational interviewing and the stages of change model. M3THOD is for gay and bisexual men, trans women, and non-binary people, living in NSW who use GHB or crystal methamphetamine for sex. All peers are ACON staff with SDU lived expertise, they receive extensive intervention

training and ongoing coaching from ACON counsellors and external clinical supervision.

M3THOD is delivered in alignment with the principles of harm reduction and person-centred care, METHOD peers work with flexibly to meet the individual needs of a diverse clients. Peers are directed by their clients to either provide:

1. harm reduction education
2. a self-reflection exercise to help people to identify if and how SDU is affecting their lives
3. a goal setting exercise focused on cutting down or reducing SDU
4. support to access and navigate other health and wellbeing services.

Formally, M3THOD aims to help people better manage SDU, support those who want to reduce their and assist people to access ongoing AOD, mental health, and sexual health services. M3THOD can offer invaluable support by holding a non-judgemental, confidential, and safe space for people to talk through their experiences of SDU (a stigmatised topic).

How to book at M3THOD peer appointment

Appointments can be delivered to clients via telehealth or in person at Surry Hills in Sydney, clients are invited to book themselves in to chat with a peer via ACON's M3THOD page on the Ending HIV website. To date, M3THOD peers have worked approximately 30 clients and is accepting referrals from service providers across NSW.

Accompanying M3THOD is a multi-year multiphase research project that will explore the process implementing M3THOD and examine the intervention's effectiveness on outcomes relating to substance use, readiness to change and service access.

ACON would like to thank the 16 community members who generously offered their lived expertise to develop M3THOD and all the partners who have helped build M3THOD. Partners include The Kirby Institute UNSW, St Vincent's Hospital Sydney, Sydney Sexual Health Centre, Positive Life NSW and NADA.

Key links resources and referrals information

M3THOD booking page
M3THOD study website
Pivot Point Party and Play resource hub

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Continuing coordinated care

The Continuing Coordinated Care (CCC) program helps people to access or maintain engagement with AOD support. This program does not provide AOD treatment, but assists with coordinating care, for example, helping with a referral to a residential rehab program, or access housing. St Vincent de Paul Society, Mission Australia, and The Buttery delivered the program across NSW.

Clients in the program experience a high level of disadvantage. Upon completion, they experienced improvement in quality of life, reduced severity of dependence, reduced rates of homelessness and reduced rates of domestic violence. NADA's Michelle Ridley asked program staff from The Buttery (Jenny Masters and Pauline Nolan), St Vincent De Paul (Helen Williams) and Mission Australia (Cameron Leiter) to reflect on providing this service.

How does the CCC program provide support in ways that may be different to other AOD programs?

The Buttery: AOD concerns are often complex and attributed to many factors such as homelessness, childhood and/or adult abuse, domestic violence, financial stress, mental and physical health, legal issues, and grief and loss. The program works with the participant to monitor and unpack the reasons that could be contributing to their AOD management, and supports them to prioritising the most prevalent issue and referring them to that specialised service.

St Vincent De Paul: CCC helps people to navigate a complex service system, develop a holistic plan for AOD treatment and address individual needs—to reduce barriers to treatment and support treatment outcomes. The service has the capacity to support a person through all stages of treatment. In some circumstances there are no treatment options, within the service system, available to a person due to criteria limitations and the CCC program has been their primary support, linking people with other psychosocial and health services for the person to address their AOD use.

Mission Australia: Working in the community to create a collaborative service that brings all stakeholders together including family and supports. I have seen many consumers of the program assisted in being able to navigate services available to them and maintain their personal recovery, in a time when often they can be forgotten, as they are no longer acute.

Why is it helpful to have a service like the CCC program for people experiencing AOD issues?

The Buttery: CCC provides an alternative for people seeking AOD management support. Some people do not like groups, or self-help meetings, or counselling, or rehabs; the alternatives can be discussed and worked out over time. Some people also need help with forms and applications, and networking with other services, and this is where CCC can help. It is difficult for people who have AOD concerns to stop or decrease their dependency when they have other overwhelming issues facing them, that cause them depression and anxiety day-to-day. The program will look at these issues, and work with the participant, providing a good wellbeing plan, and ways to alleviate the stress.

Continuing coordinated care
continued

St Vincent De Paul: Many people fall through the gaps in the service system due to not having knowledge of the service system or the capacity to meet the requirements to access services. Treatment frequently requires a person to move between multiple services, often with waiting lists, and access a range of services to meet complex needs. The CCC program helps with coordinating this process and provides support for the person while they are going through it.

Mission Australia: Once there has been an intervention of one kind or other, consumers are often left to go back to their previous environment and patterns of living. Having a CCC support worker can assist in creating a continued change and follow on in the consumers' recovery journey.

What issues do you see most impacting clients accessing the CCC?

The Buttery: Housing, especially in the Northern Rivers after the floods. Participants are also wanting support with physical health, mental health (especially trauma), financial hardship and legal (including family reunification).

St Vincent De Paul: They often have multiple issues, such as homelessness, mental health conditions, chronic health issues, long history of involvement with the criminal justice system, long term AOD use, children in care, mobility issues and cognitive impairment.

What aspects of continuing care do you think are particularly important for best supporting people with AOD issues and other co-occurring problems?

The Buttery: Engagement, building a therapeutic rapport; psycho-education, staff being knowledgeable in the AOD sector and delivering information to the participants about recovery options/supports; networking, understanding the stakeholders; advocacy, breaking down barriers and facilitating access and equity; support, providing care to those in need; and teamwork, having a great team culture.

St Vincent De Paul: Accessibility and flexibility and being able to work with people holistically. A person centred approach and flexibility of the program to adjust to meet individual needs and the capacity to stay with the client through all the stages of AOD treatment.

Mission Australia: Collaboration with all services available, especially in remote areas as there are limited services in these areas. Another thing that is important is understanding from the major capitals of the barriers faced by people accessing services in remote areas.

Stay tuned for a webinar on continuing care, featuring staff from the CCC program and other NADA members to be held during July.

Case study

Jim is a 61-year-old returned serviceman, who took part in Mission Australia's CCC program.

Despite fathering children, Jim lived alone with no family connections. His acquired brain injury impacts his ability to understand the world around him and capacity to control his emotions. He was seeing an AOD counsellor for his alcohol use issues but was finding it difficult to put into place strategies that he was learning, so his counsellor referred him to the CCC program.

Safety was Jim's priority. He didn't have a back door, and strangers would often enter his home and ransack his belongings, triggering his post-traumatic stress disorder.

Jim's CCC worker helped him to repair his door, organised a skip bin and helped him to remove the broken furniture that was causing him to fall. Jim had given people access to his banking details, and they were taking money from his account and leaving him with large debts. The CCC worker assisted Jim to access new banking details and identity documents, and formed a plan to pay off his debts.

The CCC worker also supported Jim to access a neuropsychologist assessment for a NDIS package. Jim and his CCC worker shared many conversations and laughs. Jim is on his way to getting his life back in order and achieve his main goal in life, 'to live my days in peace and just relax'.

Revising the guidelines for substance use in pregnancy

The NSW Ministry of Health's Centre for Alcohol and Other Drugs (CAOD) is revising the Clinical Guidelines for the Management of Substance Use during Pregnancy, Birth and the Postnatal Period (often referred to as the SUPPS guidelines), which were last updated in 2014.

The Ministry is undertaking this work with the help of Dr Julee Oei—senior neonatologist from the Royal Hospital for Women in Randwick—and an interdisciplinary expert reference group. This expert group includes LHD representatives from AOD, maternity, neonatology, paediatrics and psychiatry, as well as representatives from the Department of Communities and Justice, the Aboriginal Health and Medical Research Council, and a women's residential rehabilitation centre. Following further consultation, the Ministry is planning to publish the revised guidelines and a companion handbook later in 2022.

The revised guidelines will consider the changing scope of substance use by pregnant women in NSW, such as the increased use of methamphetamines. In addition, it incorporates emerging evidence for treatments such as depot buprenorphine for opioid dependence as well as new treatment models such as Eat, Sleep, Console for neonatal opioid withdrawal.

The Ministry of Health would like to acknowledge the participation of NADA members in the expert reference group and looks forward to working with NADA and non government partners to implement these guidelines when they become available.

NSW GOVERNMENT Health

NADA events

7 July

Webinar: Improving service provision for gender and sexuality diverse populations

11:00am – 12:00pm: Keen to enhance your service provision for gender and sexuality diverse individuals? This webinar will dive into the importance of discussing clients' gender identity, sexual orientation or intersex status.

13 July

Working with women in AOD treatment and responding to domestic and family violence

9:30am – 4:30pm: Explore best practice responses to survivors/victims of domestic and family violence within the context of AOD treatment. This workshop brings to life the *NADA Practice Guide: Working with women engaged in AOD treatment*.

20 July

Creating inclusive AOD services for gender and sexuality diverse people

9:30am – 1:45pm: Come along to learn how to strengthen inclusivity in your AOD work for gender and sexuality diverse people, and particularly women with trans experiences.

2 August

Understanding the NSW child protection system

9:30am – 4:30pm: *For Women's Network members.* This workshop outlines the legal journey for children and families in the child protection system.

Register at www.nada.org.au/events

NADAbase update

Tata de Jesus NADA

Reporting

On behalf of the NADA membership, we sent the following reports to funding bodies in early February:

- Monthly data reports to InforMH for members who receive Ministry of Health funding
- Quarter 3 January–March data report for members who receive Primary Health Network funding.

If you are a member who has recently made changes regarding funding and would like NADA to report on your behalf, please contact NADAbasesupport@nada.org.au.

Expanding the gender and sexuality diverse questions

As you may be aware, the Australian Bureau of Statistics updated the standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation in 2020. These standard updates the sex and gender questions (revised), as well as introduces questions on sex characteristics and sexual orientation (new). In the 2020 standard, the Sex/Gender question has been expanded to acknowledge gender identity. The additional question relating to sexual orientation provides further information on clients who identify as LGBTIQ.

As such, we are pleased to inform that these data items will be collected after 1 July 2022. NADA is working towards supporting members to collect this data as part of therapeutic practice. Responses to both questions are found in the client information section of NADAbase. After 1 July 2022, the responses are incorporated into the NADAbase reports and will be mapped to the current NSW MDS and Commonwealth (NMDS) data items for reporting purposes. All those importing data to NADAbase are advised to consider adding these items in their bespoke client management systems.

NADAbase team

Due to recent staff changes at NADA, we have new additions to the NADAbase team!

- **Mei Lin Lee,** Senior Research Officer, is responsible for data reporting, data analysis, research and member support.
- **Tata de Jesus,** Program Manager, is responsible for data reporting, importer management, learning and development, and member support.
- **Sarah Etter,** Clinical Director, is responsible for advocacy/policy changes; the key NADAbase contact for AIHW, DoH, MoH and PHNs; and member support.

Please send queries, requests and/or feedback to nadabasesupport@nada.org.au.

NADA network updates

NADA practice leadership group

Convening face-to-face in March, the network farewelled Suzie Hudson, who has moved on to a new role, and welcomed Sarah Etter, NADA's new clinical director, as the new chair.

Following the conclusion of the Workforce Managers and Leaders Study (led by Dr Ramon Wenzel), the NPLG continues to support exciting new workforce development and research projects. They held the 'Enhancing knowledge and skills to support best practice' forum which acknowledged the incredible work done by the sector during COVID. Presentations and panel topics included worker resilience and wellbeing, consumer participation, how the AOD sector has recently evolved, and future predictions.

Youth AOD services network

Early in June, the Youth Network held a virtual meeting. Recently, the network has been a space where members have been supported with their provision of AOD education in schools. Additionally, the network is currently working on an update of its publicly available profile—a guide that collates important, current referral and service information about youth AOD services.

Youth Solutions and D.A.Y.S Youth Team facilitated training about common substances used by young people; and this was a raging success. 100% of survey respondents who attended reported the training helped them to feel more effective in their role. Read more about the network here.

Consumer representative and peer worker network

Open to consumer representatives and peer workers of NADA member services, this network is a supportive space where people can share their experiences, share learning opportunities and find out what is happening in the consumer representative and peer workspace. The network meets online every two months with occasional face-to-face meetings. For more information, or to join, please email Michelle Ridley.

Gender and sexuality diverse AOD worker network

The network is organising a forum on 20 July to promote inclusivity for gender and/or sexuality diverse people, and specifically women with trans experiences, in AOD services. Some network members have also worked on a resource to help people who are gender and/or sexuality diverse find an inclusive AOD service suitable for them. If you are a gender and/or sexuality diverse AOD worker and would like to join the network, email Hannah Gillard. Read more about the network here.

Women's clinical care network

The Women's Network will be attending a workshop in August to understand the legal journey for children and families in the child protection system. The network held its last meeting in April 2022, and continues to be an important space for services supporting women to provide updates on their current work, information-share, discuss best practice service provision, and network with other women's AOD services.

Community mental health, drug and alcohol research network

CMHDARN has launched *Co-production Kickstarter: A guide to get started, and become more familiar with co-production research* to promote greater participation of lived experience in research practice. And also, *Using program logic in evaluation and translational research* to assist in planning and evaluating programs and interventions, as well as support your research projects.

Profile

NADA staff member

Alice Guirguis
Project Support Officer

How long have you been associated with NADA?

I have been with NADA since February—it has been such an exciting introduction to the sector, and I have been thoroughly enjoying the work.

What experienced do you bring to NADA?

I have worked in administration and have volunteer experience in advocacy groups around women's rights and refugee rights. I recently attained a qualification in security studies and have just commenced postgraduate study in social work.

What activities are you working on at the moment?

I am supporting the team in planning several exciting workshops and forums. In addition to that, I am organising the upcoming round of training grants and contributing to the work of the policy toolkit working group.

What is the most interesting part of your role?

Not only do I love everything that I'm learning about the sector, I am particularly enjoying the birds-eye view of the sector that my role gives me—I get to learn about the policy and advocacy side of the work while also hearing incredible stories from members working on the frontline.

What else are you currently involved in?

My social work degree takes up quite a bit of my time. Apart from that, I waitress two nights a week, and enjoy training my one-year-old dog. In my spare time, I love reading, yoga, and visiting new restaurants.

A day in the life of...

Sector worker profile

Andrew McCrudden Western Sydney and NBM CCC, St. Vincent de Paul NSW

How long have you been working with your organisation?

I have been with Vinnies as the team leader of the Western Sydney and Nepean Blue Mountains (NBM) Continuing Coordinated Care (CCC) program for just over three years.

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

In 2004, I started working in an intoxicated persons/complex needs unit in Surry Hills, which led me to working across the homelessness sector for 10 years. My passion was always the AOD sector and having juggled a few casual positions, including working in a detox, I stepped into an AOD case worker role in Morisset. This led into a more senior role in Western Sydney and then my current one.

What does an average work day involve for you?

Screening referrals, allocating referrals to care coordinators, supporting workers with supervision and team meetings, training staff, lots of meetings, reports, managing incidents and child safety notifications. Oh, and coffee, I love coffee.

What is the best thing about your job?

Supporting staff, training staff and coffee.

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

Stigma around drug use and stigma for people with lived AOD experience. Policies and more training for all levels of organisations.

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

I keep and breed snakes! They are my passion and help me unwind. I also have a very supportive girlfriend and some good and supportive friends. When I worked in Western Sydney, I used to drive home, and the on ramp to the M4 was my reminder to drop whatever I was still thinking about from work. Being able to switch off is vital.

Member profile

St Vincent De Paul Continuing Coordinated Care Program

The Continuing Coordinated Care Program (CCCP) provides case management to coordinate care for people experiencing AOD other significant health and social issues. The program does not provide direct counselling or other therapeutic AOD treatment interventions, but links people into these types of services. It supports people to access and maintain engagement in AOD treatment, improve access to and coordination of health and psychosocial services, reduce AOD use and related harm, and provides individual and systemic advocacy to obtain access to AOD, health and psychosocial services.

St Vincent De Paul CCCP supports people across Sydney, Nepean Blue Mountains, Southern NSW, Murrumbidgee, the Central Coast and Hunter districts.

The program is available to people who are over 18 years of age with complex psychosocial support needs that require intensive case management to support achievement and/or maintenance of AOD treatment goals.

Client journey

James*, aged 47, had participated in 5 weeks of residential rehab before being supported to move into shared community accommodation. However, the people he was living with were using drugs and James soon relapsed returning to regular methamphetamine use. Following this, James moved from crisis-to-crisis accommodation and was then referred to the SVDP Central and Eastern Sydney CCCP. James presented with a long history of substance use, highly isolated without connection to family or friends, long-term unemployment and homelessness, mental health issues, and experiencing intense self-stigma and shame. James knew he wanted his life to be different but had not had the ongoing support to identify his strengths to enable him to achieve his goals.

James worked with his CCCP care coordinator for 9 months and during this time he was connected with an AOD community based counsellor and he completed a community-based AOD treatment program and other short recovery-oriented courses. James' CCCP worker supported him to move into a boarding house and submit an application for priority housing and he was allocated permanent social housing.

James gained the confidence to participate in volunteer work where he felt he was able to give back to the community and develop his cooking skills and gain work experience. From this opportunity, James was recommended for casual employment and is reducing his debt through a Work and Development Order that was facilitated by the CCCP.

James was connected with health professionals to address his physical health concerns and he now attends a community gym and is regularly active and enjoying cooking healthy meals now that he has his own kitchen. James has achieved his goal of abstinence for several months now and acknowledges that he still experiences triggers and cravings but is now confident in identifying and managing them when they arise. James recently exited the CCCP as he no longer required intensive support.

Contact us

To make a referral or contact one of our teams you can email:

- Western Sydney
- Nepean Blue Mountains
- South Western Sydney
- Central and Eastern Sydney
- Hunter New England and Central Coast
- South Eastern NSW
- Murrumbidgee

*name changed for privacy

St Vincent de Paul Society
good works

News

AOD sector wins NSW Health award

Above (L to R): Antoinette Sedwell (ACI Drug and Alcohol Network Manager, ACI), Sarah Etter (Clinical Director, NADA), Suzie Hudson (Clinical Advisor, Ministry of Health), Pooria Sarrami (Research Advisor, ACI), Skye Russell (Implementation Officer, ACI).

On 19 May 2022, the Alcohol and Drug Cognitive (ACE) Enhancement Program won the Keeping People Healthy category at the 23rd Annual NSW Health Awards.

ACE provides clinicians with simple, strongly validated tools to screen for, assess and confidently respond to cognitive impairment in their clients. Treatment is targeted to a client's capacity, to ensure they can be retained in treatment.

The program was a collaborative effort between the Agency for Clinical Innovation, Illawarra Shoalhaven LHD and 11 specialist residential rehabilitation services: Adele House, Calvary Riverina Centre, Jarrah House, Kedesh, One80TC, Salvation Army—Dooralong, Salvation Army—William Booth, St Vincent de Paul - Freeman House, The Glen Centre, WHOS Hunter and WHOS New Beginnings. Clinicians, consumers and researchers worked in partnership to develop and test the resources.

'Congratulations to the NADA members involved! What an amazing acknowledgement of the contribution of the AOD sector at the NSW Health Awards, and the important role that the non government sector plays,' said the NADA Chief Executive Officer, Robert Stirling.

'Everyone involved was motivated by the strong desire to develop high quality tools to meet an identified need and demonstrate effectiveness through robust peer reviewed research,' said the Agency for Clinical Innovation's Antoinette Sedwell, who led the project

'We were able to demonstrate significant improvement in retention and cognitive functioning and built research capacity across our sector.'

Learn more about the resource on the ACE website.

Award winning medical practice

Practice Manager Adelaide Waller accepts the award.

The Haymarket Foundation is proud to serve people at-risk or experiencing homelessness in Sydney—and to win an award is an added bonus.

The team behind the Haymarket Foundation's medical practice has won a national award for its work.

During an online gala presentation for the HESTA Impact Awards, the staff took out the team innovation category.

The practice provides accessible health care and chronic care management to people at-risk of or experiencing homelessness in Sydney.

Another difference is that health and housing are considered together: helping patients to set health goals and assess what kinds of housing support will matter most to them.

The service is currently operating out of a practice in Chippendale, with a purpose-designed drop-in GP practice to open opposite Central Station.

The award came with $10,000 prize money which will be put towards fitting out two GP consultation rooms in the new premises.

Read the story in the South Sydney Herald

Find out more about the service

News

Out and about: Business Women's Lunch

Above (L to R): Chris Keyes (NADA Deputy CEO), Doug Sneddon (Odyssey House Chairman) and Sarah Etter (NADA Clinical Director)

Presented by Odyssey House NSW, the Business Women's Lunch brings together a panel of highly accomplished business women to share their personal journey of success, leadership and resilience. Dr Kerry Chant, Sam Mostyn and Josephine Sukkar AM inspired the attendees. A graduate also spoke of how he turned his life around as a result of Odyssey programs. Funds raised from the day will support building of the facility for Odyssey's new Family Recovery Centre.

Does your organisation need a governance health check?

NADA has partnered with Justice Connect's Not-for-profit law program to offer free governance health checks to members. If eligible, you will receive one-on-one support from a lawyer to help your board and organisation: stay on top of legal and governance obligations; manage risk and embed good governance practices; improve skills, knowledge and confidence to identify and deal with legal issues; and avoid penalties. 'The work involved was not too onerous and the outcome was incredibly helpful. We are very grateful to have been involved,' said a NADA member. Apply now

A video tool for clients to manage their growth

Developed by former Glebe House case manager Danny Shannon, Encapsulator.io is a video journaling tool developed for people addressing their AOD issues. Inviting self-reflection, the Encapsulator guides people through a series of questions. The person records their answers, journaling their goals and milestones. People are given the opportunity to express themselves without any fear of judgement in a safe, confidential space. The tool helps people to identify potential barriers to achieving their goals, which helps them plan to overcome them. Video can capture a person's present state, to revisit, or send a hopeful message to the future. To learn more, please email Danny or call 0466210651.

Hellos and goodbyes

As with many places near and afar, there has been much change at NADA over the past few months. We have reinstated the deputy CEO position, to play a key role in organisational development and lead on AOD sector policy and advocacy. We welcomed **Chris Keyes** to fill the role.

We bid farewell to longstanding clinical director **Suzie Hudson**. Suzie was NADA's first clinical director and cemented the position as critical in supporting the needs of members. We witnessed her passion for clients and thank her for her work. **Sarah Etter** has stepped into the role. Sarah will continue to provide clinical leadership for the non government AOD sector in line with NADA's strategic direction, and also inform workforce strategies, policies and evidence based practice.

We also welcomed senior research officer, **Mei Lin Lee**. Mei Lin provides NADA and its members with research and ethics support. She also supports best practice governance of NADAbase data, in coordination with the NADA Data and Research Advisory Group.

A message from Chris Keyes

As Deputy CEO, I will play a key role in ensuring that NADA continues to deliver on our strategic directions and meet member needs. I will lead on AOD sector policy and advocacy, as Chair of the NADA Advocacy Sub Committee. I look forward to pursuing advocacy priorities such as a NSW Government response to the Special Commission of Inquiry into the Drug 'Ice' and addressing the non government AOD workforce crisis.

I have worked across government and non government healthcare settings in Australia and the UK, including occupational therapy, mental health and peak body positions. My background is predominantly in the community managed mental health sector and I've a keen interest in approaches that build service integration and workforce capability to identify and respond effectively to people who experience co-occurring mental health and AOD use.

I'm thrilled to be joining the NADA team at what I see as a critical time for the sector. Please reach out if I can support you in the areas of advocacy, planning and performance, research and evaluation, sector and workforce development. I look forward to working with you.

NADA practice leadership group

Meet a member

Sarah Etter Clinical director NADA

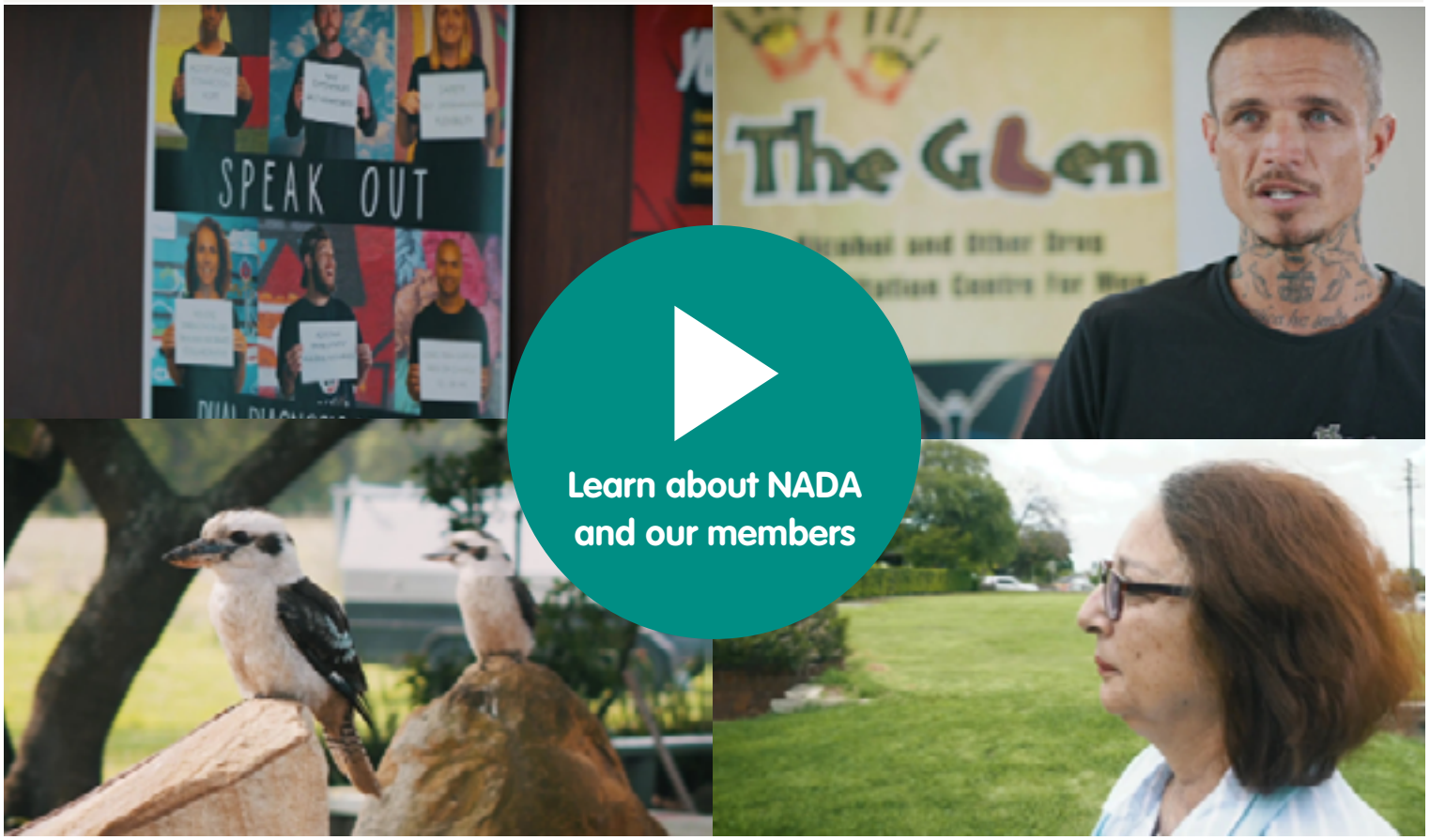
How long have you been working with your organisation? How long have you been a part of the NPLG?
I am the new clinical director at NADA and joined the team at the end of March. I went to my first NPLG meeting on that day!

What has the NPLG been working on lately?
The network held the NPLG forum in June which focused on the resilience and creativity of the AOD sector and challenges faced by managers and leaders. The network is also continuing to support research and sector development efforts. The NPLG would like to acknowledge the incredible and challenging work that has been done by those in the sector, particularly over the extremely challenging past few years. The recruitment and staffing difficulties have been a significant obstacle, and the NPLG forum and ongoing research allows improvements to occur in that area.

What are your areas of interest/experience—in terms of practice, clinical approaches and research?
I started my AOD journey in New York and have a background in both residential and community services. I am passionate about evidence informed practice, data collection, research, and the ways these processes can inform and influence the sector. I also have a strong belief in the importance of trauma informed care in all areas of our work.

What do you find works for you in terms of self care?
Spending time with my children and connecting with good friends.

What support can you offer to NADA members in terms of advice?
Please contact me with any issue, big or small, around workforce strategies, policies, and evidence based practice. I'm here to help however I can, be it with research queries to clinical assessment questions, and all in between.



Advocacy highlights

Policy and submissions

- NADA sent a letter to the NSW Premier advising that the sector is expecting a response to the Special Commission of Inquiry into the Drug 'Ice' as part of the NSW Budget in June.
- NADA CEO provided Croakey Health Media with the sector's Federal election priorities.

Advocacy and representation

- NADA continues to apply pressure to the NSW Government to respond to the Special Commission of Inquiry into the Drug 'Ice' and call for a plan to incrementally increase treatment funding over the next 10 years.
- NADA raised workforce challenges and opportunities with both levels of government via our issues paper [PDF].
- The NADA CEO provided a keynote address at the Addictions Conference in May on workforce challenges and opportunities.
- NADA presented to the Australian Institute of Health and Welfare NMDS Working Group showcase our inclusion of gender and sexuality diversity in the NMDS, as well as non government representation on AOD data governance structures.
- NADA continues to represent the sector on the Dubbo Residential Rehabilitation and Withdrawal Centre Project Team.
- Ongoing meeting representation: NSW Ministry of Health COVID-19 Clinical Council, NGO CoP and AOD CoP, NCOSS Health Equity Alliance.
- Key meetings: Department of Health, Department of Social Services – Community Grants Hub, NSW Ministry of Health, NSW Department of Communities and Justice (DCJ), Australian Alcohol and other Drugs Council, AOD Peaks Network, DACRIN, FAMS, LGBTIQ Health Alliance, NUAA, NCOSS, MHCC and NCETA.

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