Advocate

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Issue 2: June 2024

Positive experiences

NADA
network of alcohol and other drugs agencies

Stock photo posed by model

CEO report

Dr Robert Stirling NADA

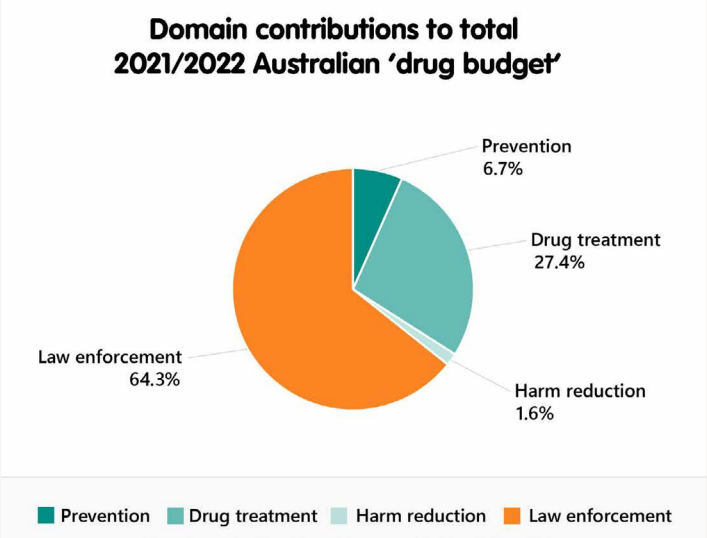
This issue of the Advocate is focused on positive experiences. It highlights the great exemplary work of the NSW NGO AOD sector to create positive experiences for the people who access and work in alcohol and other drug (AOD) services, practical ideas to improve our practices, and updates on key matters of interest.

We continue to work with the NSW Ministry of Health on implementation of Special Commission recommendations. We know that progress takes time, and it won't respond to all the sector's needs, but there is much to celebrate. This includes the creation of new AOD services, an increasing focus on data and workforce development, and infrastructure investment to create more positive environments to deliver care.

NADA recently received additional funds to support member workforce initiatives. This has resulted in further access to the Diploma of Leadership and Management and the AOD Skill Set, the creation of videos to align with the AOD Employee Value Proposition to encourage new people to work in the sector, and a number of member events. We have partnered with NUAA and the Mental Health Coordinating Council (MHCC) on a review of mental health peer worker qualifications for AOD peer workers. We are also recruiting to an identified Aboriginal research officer role to support data for First Nations people within NADAbase.

Member engagement is a top priority for NADA. We have held a number of big member events, including the Cross Sector Forum in Nowra, and Collaborative Connections, a joint symposium with the MHCC. We are participating in all of the Clinical Care Standards roadshow events in each LHD to engage with members in the regions. We've found it really positive to hear from members at these events and increasing collaboration and understanding of the ways we work.

To be on the front foot for the NSW Drug Summit, we have been meeting with NSW Parliamentarians and health and social services peaks to ensure that the structure and framing of the Summit is a positive experience, and that those most impacted have a voice in the discussion and decisions. As yet, no date for the Summit has been set.

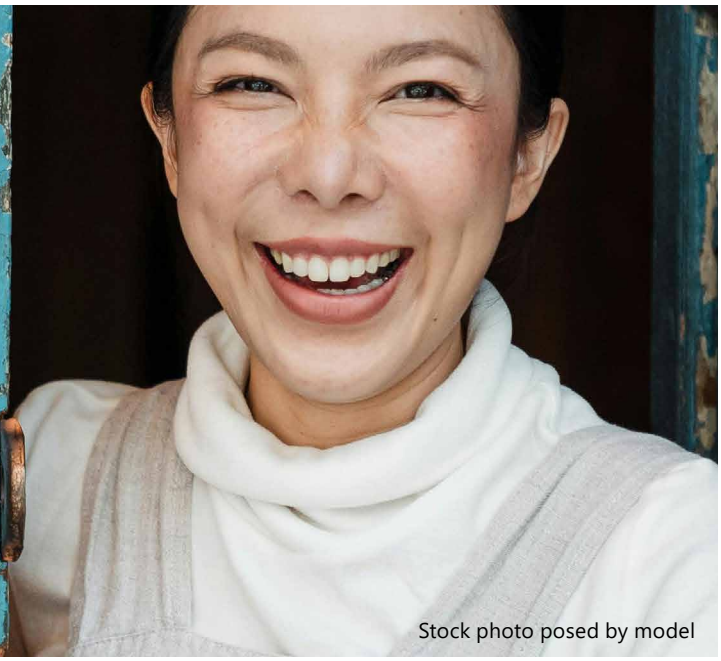


To better inform our advocacy, NADA made a contribution of funds to the Drug Policy Modelling Program to support the updated Australian Drug Budget 2021/2022. The figures related to a health response are unsurprising. In the NGO sector, most funds are provided to treatment services, with little going to specialist prevention and harm reduction services. While the treatment sector does, in many cases, also provide prevention (with community development and education) and harm reduction (as part of pre-and post treatment support), these are mostly unfunded. This is inadequate. We need to increase the number of specialist harm reduction and prevention services, delivered in local communities, and by the communities that they serve.

While it is positive that there has been a 5.4% increase in the percentage of funds to treatment, many members would not see this figure as something to celebrate. There has been increased investment since the last figures 12 years ago, though this varies between AOD health funders, and we are working in conditions of increased costs to deliver services, maintain a healthy workforce and respond to the demand for treatment within the existing AOD budget.

This isn't to say that there hasn't been positive engagement with AOD health funders and there have been some great initiatives, such as the SCI investments and enhancement to National Indigenous Australian Agency funded services. We continue to work closely with AOD policy makers and funders to communicate the needs of members.

Intake is an invitation



Stock photo posed by model

By Antonia Ravesi, NADA

She is sitting in a hotel room, alone and afraid. But she is also exhausted, having endured months of chaos. She takes a breath. Silence. She just wants to sit and be still. It's late. She writes an email to Grow Community; they could support her mental health, which she knew she needed. It wasn't too long before she received an email reply. Encouraging words, with a request to call in the morning.

People seeking AOD support may experience distress; they are also taking a large personal risk. Will they be listened to? Will they be able to access a service that meets their needs?

'I will never forget hearing the staff member's kind, matter-of-fact voice on the phone,' says Lauren Napolitano, who, having completed the Grow Community program six years ago, is now the Senior Residential Program Worker.

To engender a positive experience, consider how to pave the way for a person when they seek AOD support.

Light a beacon to your door

Use your marketing as **pathways to intake**, and promote the range of AOD support options, as well as your service.

Co-design and review marketing materials with people who attend your service and your consumer advisory group. Review language and messages for service access and referrals, harm reduction and overdose prevention. Ensure information is clear and accessible and describe what your service does; avoid medical terminology. For example, the term 'psycho-social support' is regularly used in brochures but will be different depending on the service.

Provide information in response to common queries, such as whether the service can accept people on bail, or from prison, with outstanding court issues or on certain medications such as pharmacotherapies, and what support is provided for trans people, or women with a current Apprehended Domestic Violence Order. Clearly indicate what needs can or cannot be accommodated. If there are exclusion criteria, include a brief explanation such as not being able to accept people with certain medical concerns due to not having 24/7 medical staffing. List alternative services including online support groups and peer lines.

List fee structures (including laundry and holding deposits), identification, and referral documentation required.

Select images to reflect an **inclusive service culture.** Respond to website and administration email enquiries in a timely manner. For services able to provide peer worker supported first contact, make sure this is included in all your service information.

Keep a record of where you advertise your service and ensure you **keep the information up-to-date**. Share this task amongst the team, delegate and rotate a coordinator so that all workers are across key community contacts. Identify local access points such as shopping centres, GP surgeries, dental clinics, school newsletters and sporting venues for the strategic placement of a flyer or information piece.

Engage community

Contact with community and providing education will **foster greater understanding and compassion**.

It is vital when working in Aboriginal and Torres Strait Islander and multicultural communities to view this work

Intake is an invitation

continued

as **part of your intake process**; we can build networks of support that incorporate connections to culture, Country, and faith.

Maintain connections with faith and cultural leaders in your local community by facilitating **regular opportunities for consultation**. In the leadup to the Drug Summit, this will ensure that public conversations are informed, constructive and reflects the diversity in communities.

Power of the peer

Peer workers involved in the intake process reduces anxiety for new arrivals and for people re-engaging. **Peer worker expertise and specific engagement skills** create a warm welcome; they can demystify treatment and correct perceptions that may deter people from engaging.

Balance information and rapport building

A collaborative approach to intake starts to build trust with the service. Trust needs to be earned, and **safety slowly develops** through the way we listen to the person's story and their priorities, how we collect and offer information. Using a person's pronouns and developing an understanding of what informs their identity, centres the person at the heart of the conversation and acknowledges that substance use is just one part of the story.

Right service fit

We can be loyal to our own service and programs, while making room for a conversation to **ensure your service meets the person's needs and circumstance**. There is no need to be an expert of every type of treatment—having a basic understanding of types of peer led support groups and phone lines, the concepts of a day program and how to access primary health harm reduction services and withdrawal options is helpful—as well as drawing on the knowledge in your team and the broader sector.

Not a match; **provide supported referral wherever possible**. The quality of the whole intake process sets the tone for a person's perception of the sector and if people are matched to the right treatment type, they are more likely to maintain engagement and to feel positive about their experience. Alocohol and Drug Foundation provides Path2Help to assist people to identify options for support.

The Stages of Change model is a useful reminder about ensuring that we **work with the person where they are at**. Insight offers an elearning module, particularly helpful if you are working with young people.

Harm reduction and overdose prevention

Conversations about safety and strategies for reducing risks are essential. Adopt an approach of curious enquiry to understand potential risks. Deliver standard overdose prevention messages to all clients such as combining substances and medications, what to do in the event of an overdose, and the latest drug warnings.

Have an agenda item in staff meetings to share drug warnings. Organise regular updates on **harm reduction strategies** for mental health and substance use, including conversations on wound care for self-harm and self-harm alternatives, and harm reduction strategies for specific substances. NUAA has a range of harm reduction videos to promote discussion. Insight has a video on the universal harm reduction approach which is a useful refresher.

Ensure you have multilingual information for the **cultural groups** in your area, including culturally sensitive information for First Nations communities, and material that speaks to the experience of people from LGBTQ+ communities. Identify other NADA member services who have expertise in working with these groups.

Practice tip reminders

- Intake is an invitation to the person to see if the service is the right fit, and if the sector has what they need.
- How you assess and respond to risk can shape the intake experience. Be honest and transparent about our duty of care and reporting responsibilities to communicate respect and recognise people's capacity.
- Listen to the primary concern for the client which may *not* be their use of substances.
- Include connection to community; formal and informal. Recognise kinship ties and connections to culture and country. Conversations about family and connections will reveal information on mental health, key relationships, and significant events such as grief and loss and dislocation.
- Balance collecting information and building rapport. Welcoming gestures like offering a drink of water and asking about people's experience in finding your service communicates the quality of the service.
- Intake opens the door to accessing treatment and support with all options—not just your service—and can be an effective standalone intervention.
- Identify ways to maintain relationships with key services across sectors. Join local interagency networks.
- Leaving a position? Provide a handover and e-introductions of your key community and referral contacts, for the new worker stepping into your role.

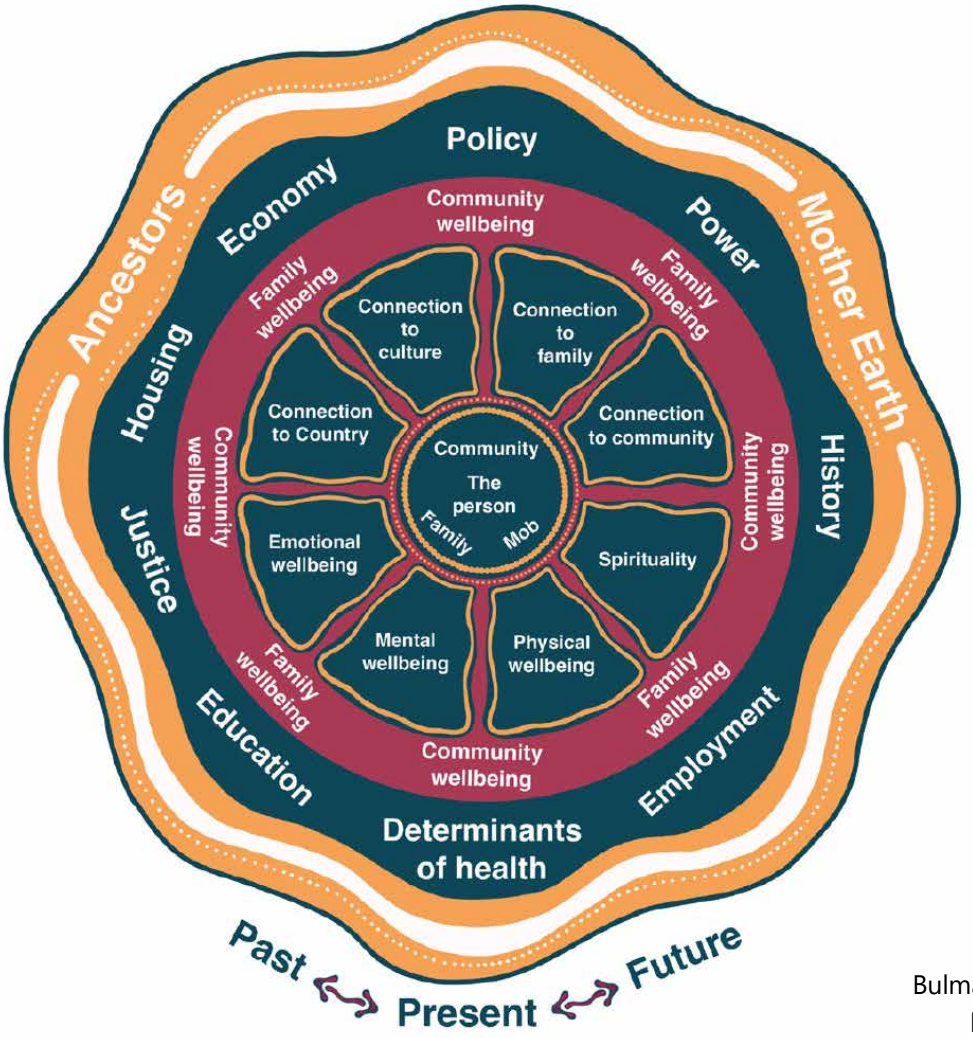
The Aboriginal person's client journey

By Megan Williams PhD and Mark Ragg MBBS BA

When services are being developed, the individual client journey can be overlooked, as can be the role of informal support. Yet, this is the most important part of the picture. Yulang developed this client journey while working on an Aboriginal mental health and wellbeing model of care, but it is applicable to (or adaptable to) any situation where a health service is providing care to Aboriginal and Torres Strait Islander people.

At the centre of the journey, informing every step of the way, is a holistic view of health.[1] *See Figure 1 below.*

Figure 1
Aboriginal people's holistic view of health



In the ideal client journey:

- the person already knows the service, because that service has engaged with community
- the person enters the service with the support of family, community and health services, without needing the emergency department, an ambulance or the police
- an Aboriginal person walks with the person throughout their journey
- the person sees a team involving, and preferably led by, Aboriginal people
- if a formal assessment tool is used, that tool is culturally validated
- the care provided is holistic and meets the worldview of the client
- care takes place in the most culturally appropriate, least restrictive, place
- care links with other services in the community
- if a referral is made, it is a warm referral
- after returning to the community, the client is followed up to ensure they receive the support they need.

See Figure 2 overleaf.

The Aboriginal person's client journey

continued

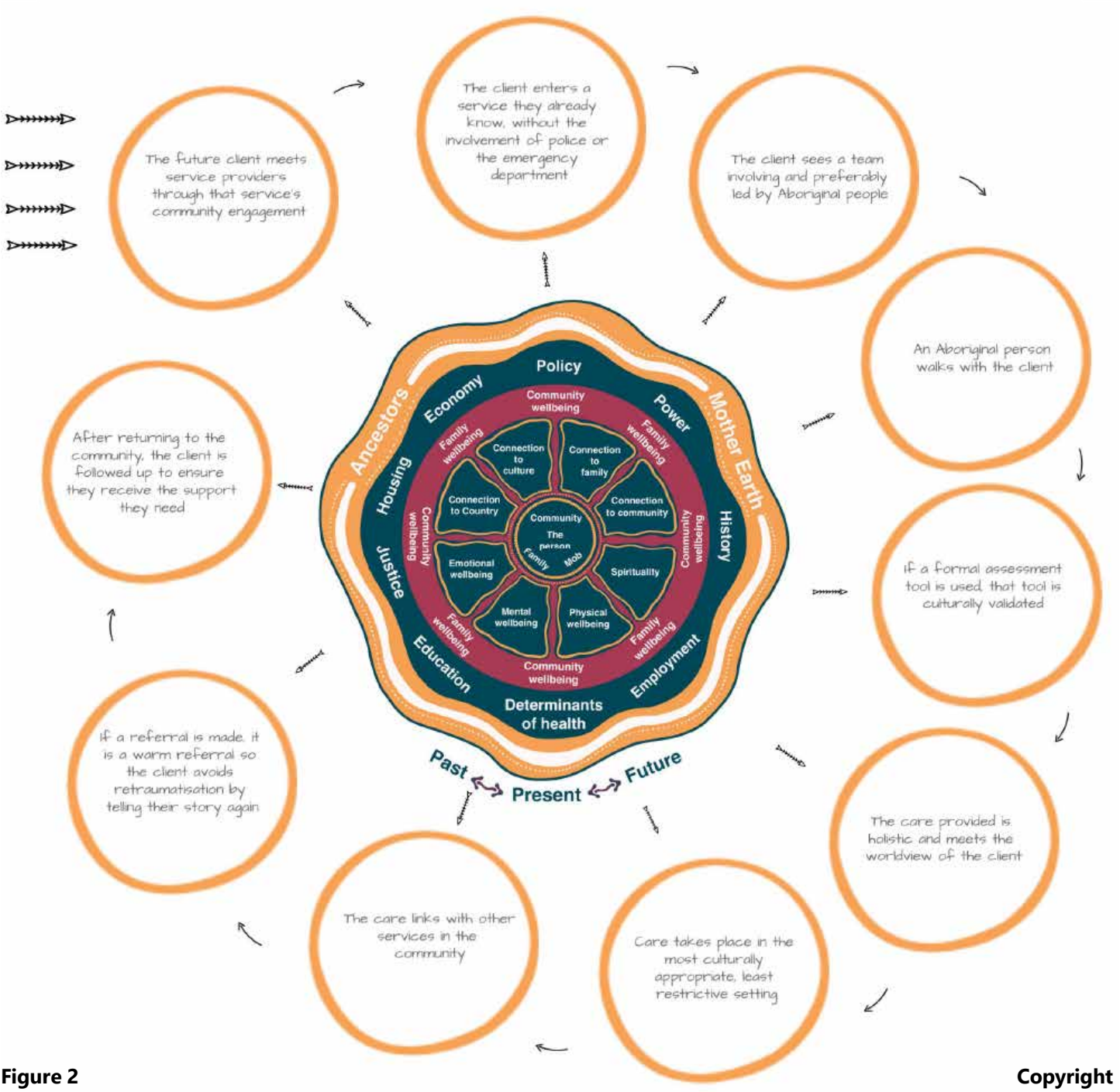


Figure 2
The client journey

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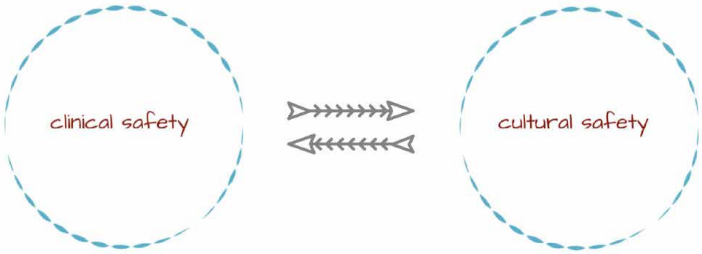
Williams, Ragg & Bulman, 2022

This client journey is best developed by people who are actively developing their cultural responsiveness.

And note the importance of culture throughout. Cultural safety, now a legislated aspect of safety and quality in health care, is as relevant as clinical safety. A health service cannot be clinically safe if it is not culturally safe, and vice versa.



Suggested citation
Williams, M. & Ragg, M. (2023). The Aboriginal person's client journey. Yulang Indigenous Evaluation. https://yulang.com.au/starburst-indigenous-evaluations/client-journey/

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TRANSLATING RESEARCH INTO PRACTICE

Client-centred care in AOD services
Kedesh Rehabilitation Services

Mark Buckingham, Kelly Molloy and Ellen Horspool

What recent feedback have you received from clients about your service?

'I think staff can feel like we're making meaningful change because the change is coming from within, rather than just doing what is told and doing it just to exist and we're getting told in the house—because it's client based therefore a lot of decisions are coming from within us.'[1]

In our most recent Quarterly PREMAT assessment, the clients surveyed agreed with the statement 'staff treat me like a person and not an addict'. In focus groups conducted by a qualitative researcher,[1] clients said they believe that staff showed respect and responsiveness to their boundaries by regularly checking in and emphasising their availability for support while also allowing space for clients to move at their own pace. Also, that inclusivity was reflected in the way staff interacted with them, such as the authenticity and empathic approach to care.

How does the flexibility that you provide allow clients to attain their goals?

Clients can tailor their program according to their needs. They usually apply for residential rehab as that's what they believe they need, yet after consultation with staff, they realise that a few counselling sessions via phone or a day program may be a better fit. This means they can focus on other things that are important to them, like part-time study, casual work, and more integrated community activities to test the skills they are learning with us.

Our support plans are another example; it identifies their preferred responses when distressed. We obtain this from a plan that we develop collaboratively with clients that outlines their specific goals (i.e., housing needs, relapse prevention tools). Allowing room for autonomy in a trauma-informed manner can increase their capacity to engage in treatment longer.

How did you align your processes to become more client-centred?

'When we first started moving towards it, it was a bit like, "Can we do this?" Like, "What are we allowed to do?'[1]

We began the transition to a more enhanced client-centred approach in 2016. This has been an iterative process over the years, which involved generating ideas, implementing changes, and evaluating the changes informally with the team and stakeholders via surveys.

When we initially reflected on the way we delivered services, we realised that we were operating from a one-size-fits-all approach. This was neither therapeutic nor in alignment with our values as an organisation. We wanted to create a service that allowed for mutual collaboration and empowerment.

We started by looking at our intake processes. Traditionally, our service would ask clients to call and get their name marked off on an automated system and we would have little contact with them until intake. We began capping client numbers so that we could work intensively for those waiting for a residential or day program with our service. The same staff member would proactively engage with the client at the same time each week to foster trust and gain a sense of the person's treatment goals and needs. The impact of this is multiple: there has been a decline in no shows, we provide more support for people awaiting

Translating research into practice

continued

inpatient services, and there is reportedly satisfaction with our service overall.

We then incorporated more processes to enable clients to tailor aspects of their treatment. We have assessed our practice proactively against the Clinical Care Standards which have a client centred emphasis.

How do you ensure the client's voice is heard?

We check-in with clients at various stages. During weekly calls before admission, staff ask for the types of support they feel need to facilitate entry. Upon admission, we ask clients to complete a community access centre survey to comment on how they found the assessment and intake process, including things to be improved. When they exit the program, we again ask for clients to complete satisfaction surveys.

We regularly update the client's support plan in consultation with them. We facilitate weekly session rating scales (GSRS) so they can comment on the treatment they are getting, what they like, and what needs to be improved. Focus groups are also held with clients when staff differ on opinions on how to facilitate treatment or when we are looking at changing processes.

Can you tell us about the feedback you have received from staff?

Staff feedback was elicited by the researcher through individual interviews:[1]

'It's never one person making these decisions. It's constant discussion and questioning and you share the load as a team.'

'When you have a team of people that are giving input and saying, "How about we try this or how about we do that?" it actually is for the advantage to the client because you've got all of that different input coming in.'

Client-centred care seemed like an overwhelming shift at first; there was a period of adjustment and staff needed to be adaptable. Now they report that ultimately the approach is more rewarding, and staff have become closer and more respectful as a team. They describe feeling more like critically thinking clinicians and developing greater confidence in their own and others' skills.[1]

All staff are encouraged to have their say and challenge Kedesh processes that may be contradictory to client-centred care. This allows for rich discussion as well as personal and professional growth through critical reflection. There will always be challenges and disagreements on how to deliver care; this is true with any service or treatment modality.

How do you incorporate clients to evaluate your service delivery?

We obtain data in our weekly GSRS groups. The groups also provide a forum for discussion and feedback regarding the client's current experiences within the service. We hand out Quarterly Client Satisfaction Survey and PREMATs to clients; this feedback is presented at staff meetings for further review.

We check in with clients up to a year post-discharge at regular intervals; and call them regardless of their reason for exit. This is how we gain anecdotal evidence on our service; the conversations are often full of gratitude and providing positive feedback. We also hear about how clients are doing which reminds staff of why we do the work we do.

Publications

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Davis, E.L., Ingram, I., Deane, F.P., Buckingham, M., Breeze, D., Degan, T., & Kelly, P.J. (2022). A Qualitative study exploring the benefits and challenges of implementing client centred care (CCC) in an alcohol and other drug treatment service. *Journal of dual diagnosis*, 19(1), 49-59.

2. A systematic review of client centred care in the AOD treatment field
Davis, E.L., Kelly, P.J., Deane, F.P., Baker, A.L., Buckingham, M., Degan, T., & Adams, S. (2019). The relationship between patient-centered care and outcomes in specialist drug and alcohol treatment: A systematic literature review. *Substance abuse*, 41(1):1-16.

How do you welcome people impacted by the criminal justice system

Lucy Cook, Case Manager
Rainbow Lodge

What do people with criminal justice involvement experience as they seek AOD support? People with criminal justice involvement are used to feeling like another number in the system. Some of the men we work with have spent decades incarcerated and so are conditioned to feel labelled, misunderstood and controlled. It is no wonder that when they arrive at our service, they are often extremely guarded and cautious. That said, most clients hope to be met by people who see them for more than their mistakes, substance dependence, or trauma. They want to feel safe, be listened to and understood. They want to know that they will be supported to achieve their goals, big or small. Most of our clients have never had support to access or navigate systems such as health, social services such as Centrelink, banking, gathering basic identification documents and housing. Our clients will say that a lot of their life has been a cycle of trying and failing to navigate these systems before inevitably returning to custody. If they attend our service, there's a good chance they just want someone to help them try something different, so they can hopefully break that cycle.

We have the privilege of stepping into a person's life and walking alongside them for as long as they ask us to.

How do you create a welcoming and safe experience? Each person that we work with has a unique story of how they have come to seek AOD support, and so each client requires a different level and type of support. Our approach has to be client-focused and individualised. Most of our clients are seeking much more than just AOD support because they are *all* more than just their AOD use, so it's important to get to know the client's story and treat them as an individual. The two biggest things I think you can use are humour and a listening ear, especially in the early days of a new client joining our service. Hopefully, this helps to build trust and make the client feel at ease, after months or years of being tense and on edge in custody.

Please share a story of how this has impacted someone's life. One of our clients, who we have worked with for almost 12 months, has recently received a diagnosis of schizophrenia following an involuntary mental health admission. Over the time it took for us to access treatment, this client was experiencing psychosis and so was unable to advocate for himself effectively. He relied on myself and our staff to communicate what he was experiencing, how he was different to his baseline self, and advocate for him to receive the treatment he asked for. In the end, it was me raising something that happened a few months ago that was the catalyst for him receiving treatment; who knows where he would be now if not for that one comment. The journey to reach this diagnosis was incredibly long, but he is now doing extraordinarily well and is stable on his medication. Working with our client base requires much more than sending off referrals, filling in forms and typing case notes. We have the privilege of stepping into a person's life and walking alongside them for as long as they ask us to.

How knowledgeable are you about non-binary and trans communities? What about their needs when they reach out for AOD support? Did you know that by affirming their identities you can improve the effectiveness of your AOD work? By Dr Hannah Gillard, NADA (they/them), Dr Loma Cuevas-Hewitt (she/her) and Ellen Horspool (she/her), Kedesh Rehabilitation Services.

Non-binary and trans women face a myriad of barriers to healthcare. Even in services that specialise in trans health, non-binary people have felt the need to borrow a 'binary transgender label to receive care' or have 'modified the healthcare they were prescribed'.[1] Or they simply went without.[2] Given non-binary and trans women are a priority population for AOD services,[3] we need to cultivate positive experiences for them. Doing so will also improve our clinical work.[4]

Effective and person-led care

'The difference in my recovery was directly related to being respected,' says Naif-Jamie Martin (she/they), a non-binary Wiradjuri woman. 'The difference between recovery sticking and me relapsing, was the clinicians, the team, the doctors, everyone, *acknowledging and respecting my experience*.'

Naif-Jamie's experience tells us that effective AOD support hinges upon services being affirmative of trans identities. This is also supported by best practice guidance: affirming LGBTQ+ people's identities facilitates person-led care that is trauma-informed and effective.[5] Lara Smal (they/them), non-binary case manager at Guthrie House, explains: 'You have to give people the opportunity to exist as their full selves, and *that's when we know recovery happens*.'

The binary illusion

Most people make assumptions of gender based on someone's voice or appearance. There is simply no question; it's taken as a fact. If they look male, they're a 'he'. If they sound female, they're a 'she'. Yet, gender diverse people who defy such assumptions have existed throughout human history. As Naif-Jamie says, 'Indigenous communities have been existing outside these binaries for a long time before colonisation, and it might feel new… but it's always been here.'

Non-binary concepts of gender that existed in precolonial societies include fa'afafine (Samoa), bissu (Bugis society in Sulawesi, Indonesia), hijra (South Asia), and burrnesha (Albania), among others. Many of these identities persist to this day. The male/female gender binary that many accept without question is a construct spread by European colonisation.[6] In Australia, 'Sistergirl and Brotherboy are sovereign terms coined by the First Nations people of this continent,' says Wiradjuri Brotherboy, Hayden Moon.[7]

Nuances of gender diversity

There is nuance and diversity around the terms people adopt to best articulate who they are; not all First Nations trans and gender diverse people would identify with the terms Sistergirl and Brotherboy.[8] It's best to check with Indigenous trans and gender diverse people who access your service to learn about the language they use, suggests Naif-Jamie.

In general, it is good practice to ask people to self-describe their gender, titles and pronouns. For example, Naif-Jamie uses both she/her and they/them pronouns, explaining, 'my "she" is my tribute to the matriarchal ancestors I have. I come from a long line of strong women. My "they" is my commitment to the decolonisation of gender.'

Creating affirmative experiences for non-binary and trans women

continued

Creating inclusive environments

Being aware of the cumulative institutional exclusions facing those who access your service is crucial context for your work. 'Trans women are regularly put into men's prisons, or isolation in men's prisons,' explains Lara. As such, it is important to foster an environment at your service that is welcoming and affirming of their identities. Signal this through imagery on your website, and encourage staff to use their pronouns, if they are comfortable.

Lara emphasises the importance of adapting service documentation, for example, client detail forms and the client database. Ensure there is space for people to self-describe their gender, pronouns and honorifics (e.g. Mx, Ms, Mr). Ellen Horspool, community access coordinator at Kedesh, suggests removing gendered language in policies and procedures. Replace gendered language with terms such as 'they', 'staff' or 'people' where appropriate.

Confidentiality around gender identity is also key. As Ellen explains, 'they may have disclosed their gender identity to me, but they don't want the other residents to know.'

Organisational tips

Addressing the tips below will not only help cultivate an inclusive space for non-binary and trans women accessing your service but may also promote the wellbeing[9] and retention of staff.[10,11]

- Allow people to self-describe their gender, title and pronouns. Don't make assumptions.
- Rollout specialist trans and gender diverse inclusivity training. Organisations such as the Gender Centre, ACON and A Gender Agenda can provide such training.
- Foster a respectful environment with zero tolerance for discrimination. Keep each other accountable by calling out inappropriate discussions and misgendering.
- Partner with specialist services to improve inclusivity in mainstream organisations
- If you are a mixed gender facility, provide non-gendered sleeping facilities and group activity options for gender diverse people who do not want to be assigned to men's and women's spaces or groups.
- Create trans and non-binary inclusive bathrooms.

Across the constellation

- **Gender** is vastly more complex than the male/female gender binary imposed at birth by doctors.
- A **transgender** (or trans) person is someone who does not identify with the gender assigned to them at birth (typically male or female). This contrasts with 'cisgender' people who do. Someone may be a trans man or trans woman. Additionally, some non-binary people may also identify as trans, as it signifies they identify with a gender (non-binary) that is different to what they were assigned at birth (typically male or female).
- **Brotherboys** have a 'masculine spirit', whereas **Sistergirls** have a 'feminine spirit', and perform, 'the cultural roles that align with those spirits'.[12] These identities cannot simply be mapped onto the terms 'man' and 'woman', respectively.[13] Notably, Sistergirls and Brotherboys might identify with binary or non-binary understandings of gender.[14] Wiradjuri academic Sandy O'Sullivan explains that 'Sistergirl' and 'Brotherboy', 'are frequently used by Indigenous people who are trans to self-describe their experience outside the [gender] binary'.[15] TransHub also notes the spelling: in First Nations communities, 'the terms "Sistagirl" and "Brothaboy" are used as terms of endearment, for women and men respectively, with no reference to gender diversity.'[16]
- **Non-binary** people are those who are not exclusively men or women. Similarly to transgender, 'nonbinary' can be an umbrella term comprising identity labels such as androgynous, agender, bigender, pangender, genderqueer, genderfluid, genderflux, transmasculine, transfeminine, and so on. Given 'non-binary' means that someone is not exclusively a man or woman, there is space within this community for non-binary people who may feel some affiliation with womanhood or manhood, or who may simultaneously occupy the identities of man and non-binary, or woman *and* non-binary. Naif-Jamie describes that for her, 'nonbinary woman' means: 'I enjoy playing and experimenting with gender, and honouring my true self. Nonbinary woman means a woman who is queer; it feels political to me. It's a challenge: *I'm a woman, and I can be other things*.'

Bibliography overleaf.

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International non-binary people's day

We invite you to recognise this day by learning more about inclusive language for non-binary communities.

Resources

- LGBTQ+ inclusive and affirming practice guidelines
- Pride in Health and Wellbeing
- TransHub
- Policy and practice recommendations for AOD services
- NADA gender and sexuality diverse AOD network

Creating affirmative experiences for non-binary and trans women

continued

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Positive by design

Navigating complex health and social service systems can be incredibly frustrating. But they need not be that way. How might we remove the friction and optimise the experiences for people seeking support? Uniting Head of Social Innovation, Laura Breslin, shares the practice of service design.

Can you share how you came across service design?

I naturally fell into service design around 10 years ago, when I was consulting with a range of social impact organisations. I noticed patterns in the challenges organisations (mainly not-for-profits) were facing, and in the way they were addressing these problems, which was generally quite 'traditional' and top down, making decisions without real understanding of the people and communities that were affected by these issues. I also noticed how complex and systemic many of these challenges were, and knew that new ways of thinking and operating were needed to address them. In helping these organisations, I started dabbling in design thinking methods, bringing in new methods and tools to help organisations think about their problems in different ways.

I'm a self-taught designer, learning on the job and through the range of resources and short courses that are available. I have a background in community development, and although the language and tools are different, as I started learning design, I was really surprised with how strongly it connected to my community development practice, including the role of lived experience, participatory design methods, systems thinking, and how we aim to shift power through the design process to clients and communities, using co-design.

In my role now at Uniting, I have evolved my service design practice, moving beyond human centred design to incorporate broader social innovation methods. For the systemic problems that we are addressing at Uniting, and particularly in thinking about how we scale solutions beyond our organisation, I've found that service design is not enough! We have to understand the systems surrounding people and communities to be able to disrupt disadvantage and so my toolkit has naturally had to extend, and I am continuously learning and taking inspiration from others, including from different industries.

Can you provide an overview of the process, and the various tools?

I find that I never apply service design in the same way! Each project is different, and I adapt my approach according to the context, starting place, restraints and stakeholders that I am working with. While tools and methods are helpful, I find the mindsets that underpin the process are the most important thing to focus on, and I have a common set of mantras that underpin all my work. These are a few favourites:

Deeply understand the problem Even in service design processes, I too often see an eagerness to design new things. It's really important to dedicate enough time to uncover new problems. This means undertaking research to deeply understand and define the problems that you are trying to solve, and in what conditions or systems these problems exist. Understanding the experiences, motivations and values of people with a lived experience is also critical in this, as this gives you important clues about the right problems to be solving for.

Positive by design

continued

Curiosity Ask 'why' all the time. Don't start from a place of 'knowing' but a place of 'listening and understanding'. This mindset allows you to challenge prevailing assumptions (including your own!) and get below the surface to root causes of issues. Unveiling these can be really critical and provide guidance about where and how to develop new solutions or improvements.

Story telling Don't underestimate the role that design can have in 'sense making'. Story telling is a crucial part of design that can help unify diverse stakeholders around common goals. If you tell a compelling story, generally using real lived experiences, you can engage people quickly in understanding what issues you need to solve for, why and what impact you need to achieve. This can radically fast track workshops and meetings, where traditionally you might have gone round and round with different opinions or viewpoints of the same problem. Journey maps, system maps, empathy maps, and personas can all be helpful here.

Don't aim for perfect In designing solutions, I always look for what's 'minimal viable'. Generally a solution is not going to work first time, so the design method of rapid prototyping, which is essentially creating a minimum viable solution in a low cost way, and then testing and iterating upon that, is critical to an effective design process. Prototyping together with people who will be using a solution can be a really effective way to quickly develop something that you know is going to meet their needs. It can also be a really fun experience for everyone and great way to use participatory and co-design methods.

What would prompt a government department, or philanthropic or large health organisations adopt a service design approach?

Anytime you are trying to solve a complex problem, design thinking can help! It is a really useful and practical methodology for breaking down complex problems into manageable chunks. And because of the focus on testing and iterating, it is also a really effective risk management strategy, as by the time you get to implementation at scale, you have already ironed out problems and issues. I've seen design thinking be used effectively for service and product design, large scale system innovation, business improvement, strategy and more! I'm really pleasantly surprised to see an increase in organisations recognising the value of the methodology. This is evident in the increase in in-house service design / innovation functions popping up across government, health and social services. You do not need to be a trained 'designer' to use this method. I would encourage any organisation to pick a few methods and start using them. You don't need to invest in an end-to-end design process, the tools and methods are a pick and mix of options and you can apply them in so many different ways to nudge projects along.

There are lots of resources out there, including free and low-cost. Check out IDEO short courses, TACSI resources and even YouTube.

Obviously when engaging clients or communities who have experienced trauma in design processes, there are certain ethical practices that need to be followed. This can't be jumped into quickly and needs training, resourcing and preparation. I love the resources from the Mental Health Coordinating Council for guidance on this.

How can organisations improve the experiences of people from navigating to service entry to exit and beyond?

Empathy is key component of design thinking and good service design. Using research methods to shine a light on the lived experience of people navigating services can give incredibly valuable insights into their pain points, motivations and values. There are so many ways to do this ranging from standard feedback and consultation approaches to more participatory approaches such as video diaries, and creating a 'day in the life of' maps. For designers, it is so important to get out from behind a desk and immerse yourself in the field. Observe behaviours and interactions and deeply listen to people's stories.

It's also important not to get overwhelmed and try to fix everything! You can design small incremental improvements that can have a huge impact if executed well. Engaging people who use services in the design process can be a really effective way of prioritising what you focus on and giving them control in directing where resources go. You might uncover radical innovations, but small improvements can be just as impactful.

Psychological safety in the workplace

Michele Campbell NADA

'The belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes, and that the team is safe for interpersonal risk taking.'— Dr Amy Edmondson

Harvard Professor Dr Amy Edmondson coined the term 'psychological safety' in 1991, and later described it as the 'absence of fear'. When members of a team hold a shared belief that it's okay to take risks, speak up and express their concerns without a fear of negative consequences, this is 'team psychological safety'.

As a leader, you need to keep people accountable while maintaining engagement. This is sometimes a delicate balance, as the environment needs to be one of belonging and safety, while ensuring performance is maintained and business needs are being met. People need to feel a sense of safety in the workplace, enough to take risks and admit mistakes. It's okay to not get it right all the time, the environment needs to be right for people to own it and work toward improving.

It's about being real and self-aware. It's about being confident enough in the environment to bring your authentic self to work and challenge the status quo.

It's not about being comfortable; rather knowing you won't be castigated for having an opinion or suggestion. Being uncomfortable in a safe environment is a good foundation for growth and development. Stepping out of your comfort zone is a good way to challenge yourself and it makes you realise you can usually do what you thought you couldn't!

Psychological safety is important not only for team performance, but it also maintains a sense of belonging and fosters a learning environment by allowing for a diverse range of perspectives to be heard.

Ways of creating a psychologically safe workplace include:

- Be present. Engage with your team and show them you are listening to understand and are interested in what they have to say.
- Encourage people to bring their whole selves to work, engage in activities to understand each other and people's preferred ways of communicating. For example, use of a tool for behaviour styles in the workplace such as the DISC.
- Focus on opportunities for improvement rather than blame, nip negativity in the bud.
- Be honest, transparent (as much as possible) and inclusive.
- Highlight contributions of members of the team.
- Be open and responsive to feedback. People who feel safe will be willing to give feedback without fear of retribution.

Different team members may experience different levels of psychological safety and that will impact how the team relates to one another and across hierarchies and sites within the organisation. This can also lead to a decrease in team effectiveness and productivity. It is important to understand people's perceptions and experiences will differ and how that is managed is important for the functioning of the team.

The nuances of this are shown in this paper by Loignon and Wormington$_2$; it may be oversimplifying the situation to unambiguously assume a shared perspective of psychological safety. Their recommendations included considering the pattern of psychological safety in the team, rather than just the level (high to low) and the causes of divergent perceptions of psychological safety.

While there are limitations to the current research, it highlights the importance of providing a workplace where people feel connected, valued and have a sense of belonging. This leads to more cohesive and productive workplaces which is of benefit to all. It also highlights the importance of continual learning and of fostering learning organisations.

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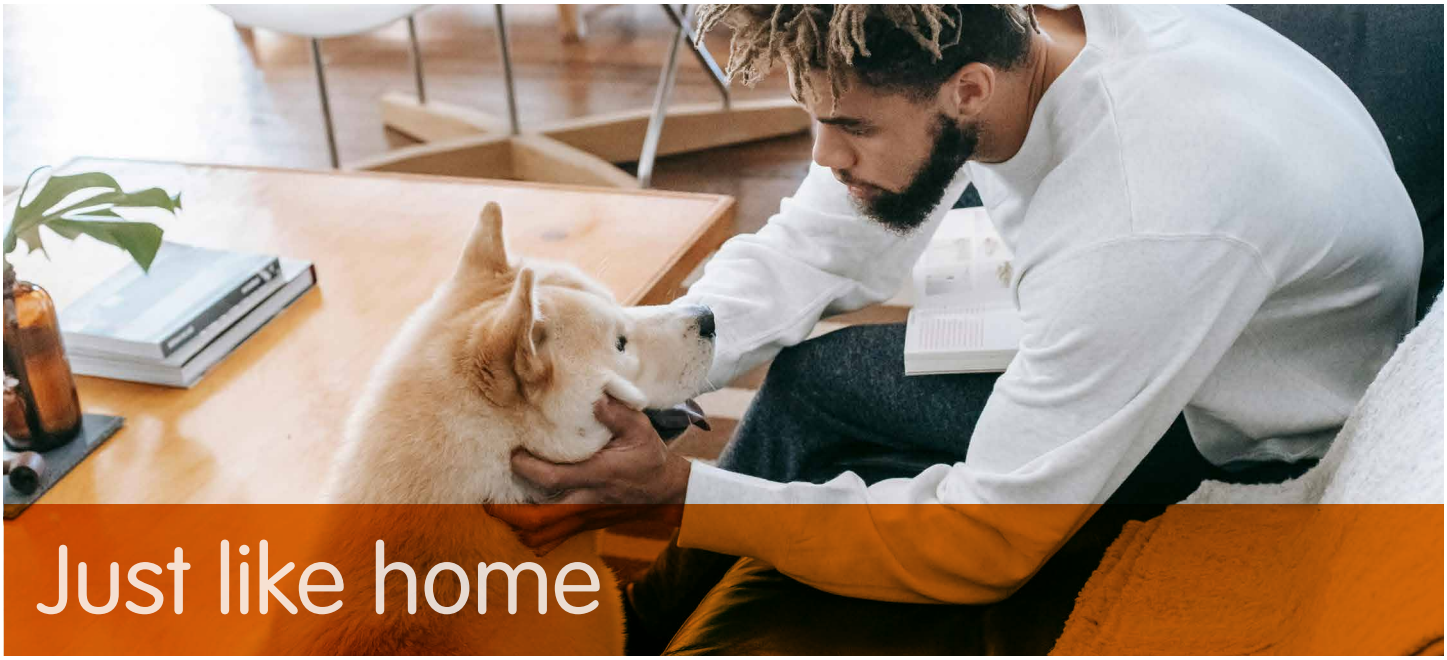

Just like home

By Jo Penhallurick

AOD services operate from a range of spaces. These spaces can be residential, drop-in, in community or outreach amongst others. Each space is unique and tailored to the type of service, location and what is physically possible. However, no matter what type of service or indeed where the service is, what we increasingly know is that spaces impact how people feel, think and their wellbeing.

Although sometimes difficult to measure, there is a small but increasing evidence base to show that the physical spaces people interact with impact on their wellbeing and recovery. There is increasing recognition that that the physical environment may have an impact on feelings of worth and dignity for people who access the service as there is a link between our psychological state and physical environment.

One qualitative study found that people who access the service 'attribute meaning to the physical space in which they receive care, and several themes identified include striving towards normalcy, feeling protected, feeling at-home, and feeling in communion with others and purpose'.[1] Other studies have found that the way in which physical spaces are decorated contributes to their recovery, including soft and neutral colours, plants, natural light and sounds being the most efficacious.[2] Another recent study found that when trauma-informed designed was employed at a homeless shelter, there was a statistically significant improvement in experiences of preparedness, hopefulness and safety.[3]

This evidence base is reflected by the local knowledge of those who access and those who provide services in NSW have been communicating for some time: that improving the physical spaces, from basic maintenance to building with a trauma-informed lens, will improve outcomes for clients. This hope for improved outcomes has been reflected recently in the applications for the NGO Service Development Grants, in that organisations hoped to achieve outcomes such as addressing trauma needs, connecting to culture and building support networks, among other things, by changing the physical spaces within which people interact.

The NGO Service Development Grants were an initiative from the NSW Ministry of Health as a response to the Ice Inquiry. The grants were developed to enable AOD services in NSW to improve their operations and amenities to benefit the people seeking support.

Speaking to both the intent of the grants and the literature, Gowan Vyse from the Haymarket Foundation has said the following about the NGO Service Development Grants:

'...has enabled us to improve our facilities and provide a much more dignified and private space for people experiencing homelessness. We have created an inviting dining room and added some much-needed colour to our garden area with some funky furniture as well as making our flooring safer. We don't own our building and have limited resources so undertaking this work would have been impossible without the grant. Thanks so much from all of us at the Haymarket Foundation.'

While further research in an Australian AOD context would be beneficial, the recent responses to the upgrades funded under the NGO Service Development grants support the evidence base—that improving spaces does improve wellbeing and dignity.

References overleaf.

Eliminating hepC in regional NSW

Despite being a curable condition, hepatitis C remains one of the leading causes of liver cancer in Australia. To meet the World Health Organization's hepatitis C virus (HCV) elimination targets by 2030, we know we need to increase screening and diagnosis, upskill the workforce, and implement innovative models of care.

Reaching people in rural and remote locations remains a key challenge in the HCV response. The **NSW Hepatitis C Remote Prescribing Program** is one way we are tackling this head on – and so far, we are seeing great success.

The program utilises a nurse-led and patient-centred model of care. Nurses perform the initial hepatitis C assessment and patient work-up then refer to prescribers who review the information and initiate direct acting antiviral therapy. Several resources have been developed and/or tailored to facilitate the efficient exchange of clinical information and virtual prescribing. Only patients who meet the Remote Consultation Criteria can be included in the program (i.e., patients must be non-cirrhotic or have compensated cirrhosis and have no significant co-morbidities).

The NSW Hepatitis C Remote Prescribing program was established in November 2020 to facilitate linkages between nurses and prescribers to increase access to treatment in regional areas. Funded by NSW Health and coordinated by ASHM, the program has since been extended to other settings where treatment may otherwise be limited, including mental health services, AOD services, Aboriginal medical services, and homelessness settings.

Over the past 3 years, the program's model of care has demonstrated highly successful outcomes, enabling over 210 patients to be initiated onto treatment. Whilst all medical practitioners and authorised nurse practitioners can prescribe direct acting antiviral therapy for the treatment of hepatitis C, the program can expedite and facilitate increased access to treatment in patients' preferred settings. Nurses participating in the program provide flexible, patient-centred, on-treatment support, harm minimisation education and individualised follow-up to help these patients through treatment and achieve hepatitis C cure.

Learn more

- Visit the program webpage or email NSWLinkages@ashm.org.au if you are interested in joining the program as a prescriber or referrer.
- Learn more about hepatitis C and access an online form for practitioners who are not already experienced in hepatitis C treatment to gain specialist approval within 24 hours to initiate direct acting antiviral therapy.
- Access free online training and on-demand learning in HIV, viral hepatitis, and sexual health medicine.

23 JULY

Tune into a hepatitis C webinar
Stay up-to-date in the latest developments in hepatitis C testing and treatment. Learn about options to facilitate testing and address barriers to treatment. Learn more.

Just like home

continued

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Reconnect with the basics to improve experiences for all

By Dr Suzie Hudson, Clinical Advisor and Maureen Steele, Consumer Engagement Coordinator for the AOD Value Based Health Care Program CAOD

'Let people work at their own pace and just listen to them. Some people feel like they have never really been listened to—so taking the time to listen and believing us, that kind of respect is so important.'
Maureen Steele, Consumer Engagement Coordinator: CAOD

The AOD Clinical Care Standards (CCS) workshops are well underway across NSW. One vital aspect of the workshops is hearing people speak about their experiences of treatment and the elements of care described in the CCS. In a Murrumbidgee region workshop, Maureen spoke about the process of care planning (Standard 3):

'Our goals can change, I mean they can for everyone. And so, you need to look at everybody differently. Take the time to find out what they really want to do.'

Shared decision-making empowers people to actively participate in decisions about their care, considering their values, preferences and applying the available evidence of what works. This helps to create positive experiences for people accessing AOD treatment, as well as those providing it, and is at the heart of value-based healthcare.

In NSW, value-based healthcare means continually striving to deliver care that improves health outcomes that matter to people, experiences of receiving care, experiences of providing care and effectiveness and efficiency of care. In this journey of continuous improvement, implementation of the CCS is enhanced through a culture of feedback; that is, routinely asking people about their experience in treatment, and being open to modifying your approach, for example:

'I am wondering whether this care plan we worked on together is supporting you in the way you would like—would it be helpful to take another look and see whether we might shape it to better to respond to what you have raised today?'

Routinely inviting feedback, monitoring outcomes from person-centred validated tools, and adapting practices to better meet a person's evolving needs helps us to provide treatment in a respectful and planned way. We invite you to conduct a Comprehensive Assessment (Standard 2) or collaborate on a Care Plan (Standard 3) and receive feedback from colleagues and consumers as a way of enhancing your own practice.

Creating positive experiences is both personal and in partnership.

'Life is complex and if we can try and address some of those other social determinants of health, working together to try and address other goals (than specifically AOD goals), often I think that the alcohol and drug problem can take care of itself.'

Value-based healthcare extends beyond clinical settings and seeks to respond to social determinants of health—recognising that health outcomes are influenced by social, economic and environmental factors. This involves partnerships with external organisations, advocacy for policy changes and other initiatives.

Stigma surrounding substance use profoundly impacts a person's treatment-seeking behaviour. To improve their experience, efforts must be made to combat stigma and discrimination at both the societal and institutional levels. We should strive to create welcoming and non-judgmental environments where people feel safe and supported as part of the basics of care.

'It's hard to talk about your drug and alcohol stuff, and we have already beaten ourselves up enough. So having someone nurturing, to listen, we are not used to that, and it is wonderful. A lot of us are looking for that, so if you could provide that … it would be fantastic.'

Through collaboration and a shared commitment to high-quality care we can realise the full potential of the NSW AOD CCS. We invite you to reconnect with the basics and contribute to a positive experience for all.

Feel free to reach out: Suzie.Hudson@health.nsw.gov.au

Member profile

St Vincent de Paul Society NSW

Service overview

The St Vincent de Paul Society NSW (the Society) is a member and volunteer-based organisation that has been assisting people experiencing disadvantage and hardship in NSW for over 140 years. The Society currently has close to 11,500 members and volunteers across the state.

In 2022/23:

- we supported 28,250 people by our Vinnies Services across homelessness and housing, health, and disability and inclusion
- our members supported more than 87,000 people with food, clothing, household items, cost of living expenses and emotional support
- our members distributed $13.7 million in financial and material aid.

Our clients

Our clients often experience homelessness or are at risk of homelessness, as well as other social issues such as domestic violence, unemployment and involvement in the justice system, as well as mental health concerns and complex health conditions.

Our health services operate across most of NSW, and we are able to provide a service wherever our clients are.

Service highlights

Our health services provide a holistic approach to addressing the needs of vulnerable communities, as well as a continuum of AOD support which provides our clients the opportunity to transfer between our services depending on their needs.

- **Detoxification and rehabilitation service** supporting single men and women, as well as people with children, with a medically supervised detoxification unit and medium to long term residential rehabilitation and case management to address substance use issues.
- **Complex support AOD services** providing case management to people with AOD concerns as well as other social/mental health issues, ensuring they receive intensive support to address their specific needs.
- **AOD day rehabilitation programs** offering a structured and supportive program for people wanting to address their substance use issues without having to live in a residential facility.
- **AOD outreach programs** providing case management to coordinate care for people experiencing AOD and other significant health and social issues that cannot be addressed by their AOD treatment alone.
- **Clinic services** offering on-site healthcare, including primary care, chronic disease management, optometry, podiatry, psychiatry, and medication management, to people who are homelessness or at risk of homelessness at no cost.
- **Aged care services** provide a home with healthcare to single men with direct experience of homelessness, mental health needs or substance use issues while following the harm minimisation principles with a focus on dignity of risk.

Our staff

Within health services we employ AOD case workers (with community related tertiary qualifications), registered nurses, and care service employees (aged care only). Our staff are a dedicated and diverse team who strive to support our clients in achieving their goals.

Case study

Cleo referred herself to the Continuing Coordinated Care Program (CCCP) after meeting CCCP staff at the local NGO hub. Cleo engaged with CCCP on two occasions' previously after witnessing their support of her friend who also self-referred from the same hub.

Cleo was on a relatively high dose of methadone and was using heroin and benzodiazepines. Cleo was diagnosed 15 years ago with bipolar disorder and anxiety and prescribed medication which worked for a period of time, but Cleo had stopped taking 12 months ago. She stated that she felt the need to address her mental health and was using to deal with her mental health. Cleo has been supported to continue to engage with her OTP prescriber through the local LHD drug health service. Cleo was referred to a mental health NGO for psychological counselling and a psychiatric evaluation to diagnose her mental health. Cleo has been engaging in weekly case management with CCCP and SMART recovery meetings (CCCP facilitated); she has ceased using benzodiazepine and made attempts to reduce her heroin use. Cleo is now in the process of making admission to attend a residential service to stabilize her OTP and abstain from other substances.

Contacts

Phone 13 18 12
Email vinnies@vinnies.org.au
Street address 2C West St Lewisham NSW 2049
Website https://www.vinnies.org.au/nsw/find-help

Profile

NADA staff member

Michele Campbell
Clinical Director

How long have you been associated with NADA?

I first encountered NADA 18 years ago when I moved from working at an inner-city withdrawal unit to outreach in regional NSW. I joined the NADA Practice Leadership Group in 2015, and have been on numerous working groups over the years.

What experience do you bring to NADA?

I am an experienced clinician, having been a counsellor for many years prior to moving into management. I have worked in most AOD settings including withdrawal management, residential rehabilitation, outreach, day programs, community education and training. I have participated in many research projects across settings, and developed programs and services from the ground up. I am also a qualified leadership coach.

What activities are you working on at the moment?

Clinical Care Standards Roadshows are happening around the state which is a good opportunity to talk to member services and gain a better understanding of sector needs. We are working on improving access to youth withdrawal with some LHDs and the CICADA unit. The new guidelines for depot buprenorphine will be out soon and we are producing a webinar on this topic. We are working on a training package with MHCC for cross sector training and working with The Matilda Centre on building mental health capacity in AOD services.

What is the most interesting part of your role?

Connecting with members and being energised by their enthusiasm and dedication. Advocacy for the sector and cross sector collaboration.

What else are you currently involved in?

I am involved in local clubs, bushwalking, yoga, playing with the dogs and miniature ponies, and spending time with my partner. Can't forget watching Moto GP!

A day in the life of...

Sector worker profile

Colin Marsh
Team Leader, Namatjira Haven

How long have you been working with your organisation?

I started with Namatjira Haven in 2015, then transitioned into a community position. I returned in 2020, so a total of 6 years.

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

I flew in and out of 12 different communities as Relief Manager for a supermarket in the Northern Territory. This experience inspired me to get in touch with my previous interests, working with young people. A career change in Adelaide saw me working for a housing/ homelessness service, which lead me to work in AOD.

What does an average work day involve for you?

Working with the support and case work team, I manage daily activities, group work, resident medication and wellbeing, staff supervision and conflict management.

What is the best thing about your job?

Flexibility! I work four days a week. But mostly I am grateful that the men that come into the service allow me to walk alongside them when they are vulnerable, and that I can support them in this journey.

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

Increased services within the community, for the sector to establish improved methods and access to detox centres and or community-based detox in an outreach capacity, continued AOD staff development/training, and AOD sector development to ensure access to suitable/ qualified people.

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

Talking out any concerns or internal conflict I have. And looking after my wellbeing by eating well, getting sleep, exercise, and being grounded through my connection to country, culture, listening well and being mindful.

News and events

Telling stories with data

Have you ever pondered over the wealth of data you gather, envisioning the stories it could tell? Are you intrigued by research but find yourself constrained by time or lack of support?

The concept of 'research' transcends mere statistics and data; it's a gateway to uncovering captivating, enriching, and meaningful insights into our services, our clients, and their interactions with our treatment protocols, both during and post-care.

Also, the concept of 'research' encompasses various engaging designs including evaluation, participatory action research and data analytics.

The **NGO Research Capacity Building** project is an exciting initiative being led by NADA. The project entails building the research skills and knowledge of NGO staff working in the AOD sector to enable organisations to develop a sustainable research culture.

NADA is actively seeking members to join the project. As a participant, you'll become part of a vibrant community of practice, alongside other members conducting research in the sector. Moreover, you'll gain access to research initiatives including eLearning modules on developing evaluation topics and doing evaluations to enrich service delivery. Additionally, you'll have the opportunity to receive guidance from seasoned researchers on planning and executing research projects.

We encourage all NADA members, regardless of agency size or scope, to consider joining the project. Participation incurs no cost, and there's absolutely no obligation to engage in any of the research capacity building initiatives.

Would you like to take part? Email Michelle Black.

Collaborative connections

On 10 April 2024, MHCC and NADA held a cross-sector symposium for community-managed mental health and AOD services in NSW to hear from sector leaders about what is working well in collaborative care, innovative models of care, and what is being done to help bridge the gap in service delivery and design between the two sectors.

Attendees viewed presentations, panel discussion and question-and-answer opportunities with speaker representatives from the NSW Parliament, Uniting NSW.ACT, The Buttery, Odyssey House, Kedesh Rehabilitation Services, Sydney Drug Education Counselling Centre, The Matilda Centre, Independent Community Living Australia, Weave, MHCC and NADA. Watch the videos.

Attendees engaged in a workshopping activity to share about current challenges and barriers to integrated practice. The findings have been documented in a report, with key recommendations including the need for cross-sector training, peer worker integration and training, stronger partnerships and co-location of services. To learn more, contact chris@nada.org,au

Implementing the NADA RAP

NADA has revised its human resource and anti-discrimination policies to address barriers to workforce participation for First Nations communities. It has also organised internal events for National Reconciliation Week and NAIDOC Week and encouraged staff to attend external events for these dates.

NADA staff are consultating with First Nations community members and/or networks to develop an engagement plan, a strategy to educate staff on the effects of racism, and a cultural protocol document.

The NADA Reconciliation Action Plan working group support the implementation of NADA's second Innovate RAP. Thank you to members of the group for your collaboration! Please fill out the EOI form to join us.

Australian drug budget report 2021/22

As part of the Drug Policy Modelling Program's commitment to generating applied evidence to help inform decision-makers, we estimated Australian government expenditure on direct measures to counter the drug problem. The report details government investment across drug prevention, treatment, harm reduction and law enforcement.

We found that Australian governments spent $5.45 billion in total on drug countermeasures in 2021/22. Most of the spending was in law enforcement (64%) followed by drug treatment (27%) then prevention (6.7%) and harm reduction (1.6%).

A panel of speakers shared their responses to these findings and unpacked what this report means for drug policy: Dr Annie Madden from Harm Reduction Australia, Dr Robert Stirling from NADA, Dr Erin Lalor from ADF, and Emma Maiden from Uniting NSW.ACT (chaired by Dr Paul Kelaita from DPMP). Panellists noted that the spending did not reflect effectiveness, with grave concerns about the tiny spending on harm reduction, and the lower spending on prevention. All panellists felt that a better balance of spending would be a more equal split between the domains, consistent with public opinion (NDSHS 2022/23 data revealed that the public would like to see one third on prevention, one third on treatment/harm reduction, and one third on policing measures). It was also noted that rather than each domain arguing for more of the pie, we should advocate to grow the total pie. This was especially noted given the high unmet demand for drug treatment, an average of five fatal overdoses per day in the 2022, and continued significant harms experienced by people who use drugs.

A video of the drug budget session is available here.

Learn online with NADA






NADA has moved its learning content to Insight QLD's platform. Insight are specialist providers of training, education, clinical resources and practice advice for AOD workers and service.

The NADA learning portal is only available to learners in New South Wales so make sure to update your profile to capture this information.

Learn online

Modules include:

- Core AOD knowledge and skills
- Comprehensive treatment and standards of care
- Engaging with families and significant others
- Asking questions on gender and sexuality

NADA network updates

NADA practice leadership group

Members met in May to share happenings in the sector and their organisation. They received the updated withdrawal management in the AOD NGO sector paper to provide feedback, with new recommendations to be finalised. NADA had been in discussions with AOD and training providers to extend both the AOD Skill Set and Leadership and Management Diploma. The Ministry of Health was locking down a suite of workforce training and development opportunities, which will be available to sector workers. Dr Suzie Hudson delivered two workshops in Wagga and Narandera with NADA, with over 10 different types of NGOs attending. Next is Southwestern Sydney, followed by Bega and Queanbeyan and members are encouraged to get involved!

Network member services had been busy. Weave Youth & Community Services held the Southeast Block Party, with Mad Pride coming up in October! Lives Lived Well closed their watershed site for renovations. WHOs were also upgrading their infrastructure; the team had been in contact with architects to build a facility for a residential and day program, closer to the local hospital.

The dates have been set! The NADA Conference will take place on 5–6 June 2025 at the International Convention Centre (ICC) Sydney.

Nurses network

The Nurses Network continues to be a space for AOD nurses working in the sector to share their experiences and seek feedback and knowledge from their peers in the network. If you are a registered nurse working in a NADA member service and would like to be a part of the network, please contact Jo Murphy.

Youth AOD services network

At the April meeting, members discussed their plans for NSW Youth Week, and shared events their services were running. Representatives from the Centre for Alcohol and Other Drugs, NSW Ministry of Health also engaged network members around a government roundtable into volatile substance use by young people. This roundtable follows an inquest into the death of teenager Bradley Hope, who died as a result of chroming. Training will be run for the network on substances commonly used by young people and support approaches in July.

If you support young people and you would like to learn more about the network, see the network webpage.

The network is a space for workers who support young people to connect, share resources and problem-solve issues. The network also provides training to members and space for workers to discuss AOD education work they are performing in schools.

Women's clinical care network

At the May meeting, the Prisoners Legal Service, a pilot project by Legal AID NSW, presented their work regarding connecting people who are experiencing incarceration with AOD treatment. Network members also discussed work they are doing to support women experiencing domestic and family violence in their AOD service provision.

The International Women's Day Forum, an event held for the network, received excellent feedback. 93% of attendees found the event worthwhile. They particularly liked the session on supporting First Nations data sovereignty for First Nations women accessing health services, LGBTQ+ inclusivity education and the networking opportunities.

The network meets online 4-5 times per year, and provides networking, resource sharing, professional development, and collaborative problem-solving opportunities. Learn more about this network.

NADA network updates
continued

Gender and sexuality diverse AOD network

The last meeting was held in February, where network members discussed work to promote inclusivity for trans and non-binary women in AOD spaces, in addition to remote and regional awareness in LGBTQ+ inclusivity work.

Network co-chair Sasha Bailey, in consultation with LGBTQ+ organisations and trans community members, is continuing work on a Trans Youth AOD Project. The project, supported by a Pride Foundation Grant, seeks to understand and improve trans youth experiences of accessing and engaging support for their AOD concerns.

If you are a gender and/or sexuality diverse person who works in the AOD space, and is interested in learning more about the network, please check out the webpage.

NADA data and research advisory group

NDRAG hosted the NADA Data Forum in March, where members came together to share best practice in collecting and analysing data for people accessing non-government AOD services. With over 120 people registered, this hybrid event allowed for both members and funders of services to collaborate on the development of a data strategy to underpin NADA and the sectors' commitment to timely service delivery and evidence-based care in the AOD sector. The NDRAG will be taking the ideas and feedback from this event to work on during the next meeting.

The group also welcomes new co-chair Yalchin Oytam, NADA's Research and Data Manager and looks forward to his support in developing research and data capabilities in the sector.

The group is always looking for new members who have an interest and experience in the data and research space. Then, if you are interested, please contact Jo Murphy jo@nada.org.au Jo Murphy.

CMHDARN

The Community Mental Health Drug and Alcohol Research Network (CMHDARN) has so many exciting projects in the pipeline. You can expect some helpful resources to keep your research trauma-informed, and also some new helpful guides to help you answer the questions 'what even is research and how do I do it?'

If you're wanting to do participatory research with people with lived experience, but you're feeling lost in the sea of different terms used to describe participatory research, this video will help you to understand the different levels of research participation, including consultation, co-design, and lived experience led research. Watch it here.

NADA members will also find our webinar recording on Unpacking the Annual Overdose Report with the Penington Institute helpful to inform your practice. The webinar features CMHDARN and the Penington Institute discussing the findings of the Penington Institute's Annual Overdose Report and why the data is important for community-managed/non-government mental health and drug and alcohol service providers. Watch it here.

CMHDARN encourages all NADA members who have an interest in research practice, and keeping up to date with new evidence-based resources and tools to support your work to sign up to the network—it's free! We also are eager to remind you to check out all of CMHDARN's existing resources to help improve your capacity to undertake research, and if you're already starting a research or evaluation venture be sure to use the CMHDARN Research Ethics Consultation Committee who help provide ethical advice and guidance for your project.

If you have any questions about the CMHDARN, please don't hesitate to email the project coordinator.

CMHDARN
Community Mental Health, Drug & Alcohol
RESEARCH NETWORK

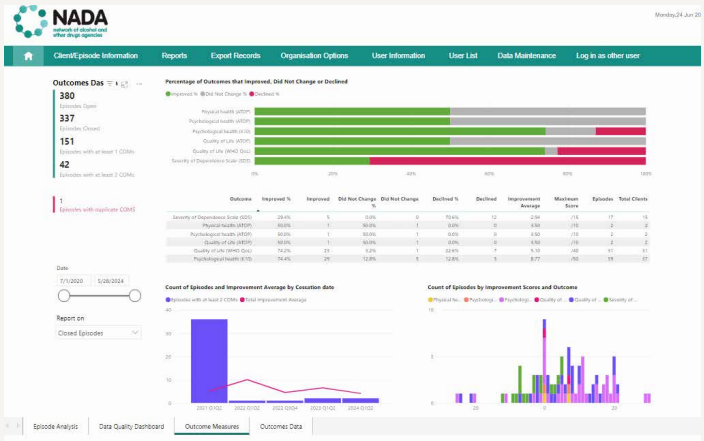
NADAbase update

Mei Lin Lee PhD NADA

What's new

Outcomes dashboard is now live

NADA built the outcomes dashboard to provide high-level insights into outcome measures to inform care, and aid in reporting to funders. NADAbase users will see this interactive dashboard located within the Homepage screen in NADAbase, next to Data Quality tab.



NADAbase data collection forms – ready for download

We have created new data collection tools and updated the FAQs to assist members with their data collection and quality. Available from the NADAbase webpage:

- NADAbase FAQs [PDF]
- NADAbase episodes data collection form [PDF]
- NADAbase outcomes data collection form [PDF]

Reporting

NADA reported member data to the following people:

- Monthly minimum dataset to InforMH for members who receive Ministry of Health funding
- 3nd Quarter for FY23/234 (Jan-Mar 2024) data report (including outcomes data) for members who receive Primary Health Network funding

Behind the scenes: NADA has been working with members who receive funding to set up the AOD Hub programs and report their MDS data through NADAbase. To date, we have set up 25 programs. Welcome to the world of wonderful data, NADAbase users!

What are we working on? Watch this space.

- **Refreshing NADAbase tutorials** including reviewing and updating the NADAbase tutorials.
- **For importers, we are working to phase out old specifications that do not align with the latest release of the data dictionary, Feb 2024.** Gentle reminders have been sent to NADAbase users since July 1, 2023.

Current opportunities

>> Apply now NADA training grant for the July to December 2024 round. Closes **30 June.**

>> Apply now Attorney-General's Department: Crime prevention and drug diversion for people under 25. Closes **11 July**.

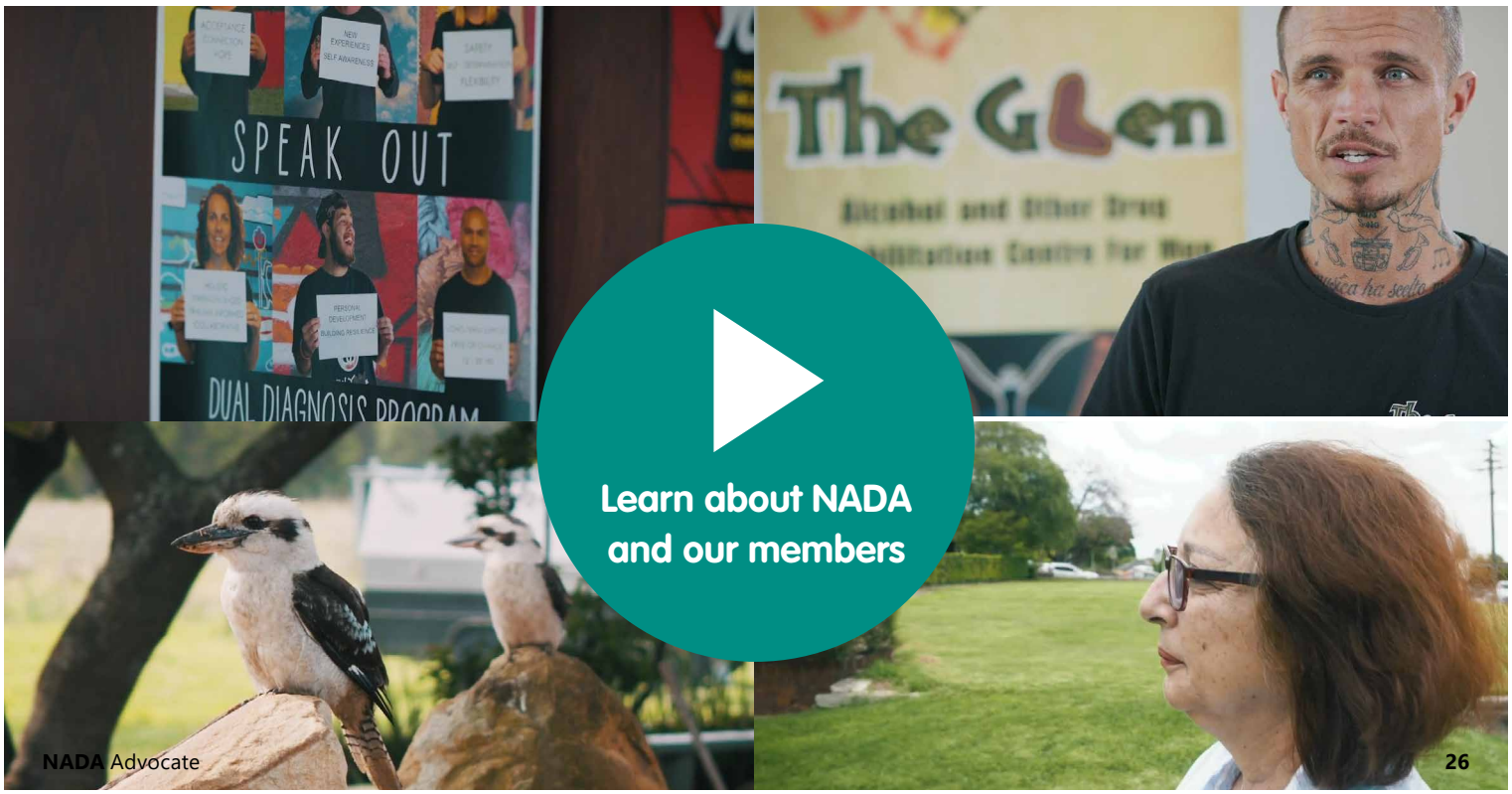
>> Submit an abstract Centre for Social Research in Health, UNSW Sydney: Tackling Stigma Conference. Closes **31 July**.

>> Apply now Attorney-General's Department: National Justice Reinvestment Program – Round 2. Closes **10 September**.

NADA
network of alcohol and other drugs agencies

Enhance the quality of your service, the experiences of people accessing support, and worker wellbeing.

View resources



Advocacy highlights

Policy and submissions

- National advocacy through Australian Alcohol and other Drugs Council (AADC) has focussed on pre-budget submission and request to meet with Minister Butler regarding prioritisation of AOD policy and funding, particularly via PHNs. NADA received a positive response from Minister Park about advocating for national governance arrangements and is working with the CAOD and the Minister's Office on a letter to focus on the negative impact of Commonwealth investment on NSW Government investment.
- NADA provided input to a number of submissions coordinated by AADC: Submission to the Senate Standing Committee on Community Affairs Inquiry into Excess Mortality, Submission to the National Autism Strategy, Submission to the Community Affairs Legislation Committee Inquiry into the Therapeutic Goods and Other Legislation Amendment (Vaping Reforms) Bill 2024, Submission to the Select Committee on Cost of Living.
- NADA made a submission to the NSW Department of Customer
- NADA contributed funds to support the updated Australian Drug Budget 2021/2022.

Advocacy and representation

- NADA continues to meet with NSW parliamentarians to discuss the NGO sectors position on the Summit: Minister Kate Washington, Jeremy Buckingham, The Western Sydney MPs via Greg Warren-Campbelltown.
- Secure Jobs and Funding Certainty NSW Election Commitment: The Secure Jobs and Funding Certainty Roadmap is being finalised to be presented to all NSW Ministers involved.
- Representing the sector with key stakeholders: NSW Ministry of Health; Department of Health and Aged Care; DSS Community Grants Hub; NIAA; PHNs; ACDAN; ADARRN; AADC; AOD Peaks Network; ATCA, NUAA, ACI; DPMP; MHCC; NCOSS; FONGA; NCETA; USyd Matilda Centre, UQ, UoW, UNSW, TAFENSW, HumanAbility Jobs and Skills Council.
- Ongoing meeting representation: NSW Ministry of Health AOD NGO Reference Group; DAPC, QIT Sub Committee, CAOD Values Based Health Care Advisory Group, Living and Lived Experience Workforce Steering Committee and Expert Advisory Committee, ACI D&A Executive Committee; AADC Members Council; AADC Policy Officers Network, NCOSS; FONGA; NCOSS Health Equity Alliance, HumanAbility Community Services Industry Advisory Committee, CMHDARN Operations Meeting, CHMDARN Reference Group, MOH Clinical Care Standards Community of Practice, First Nations Strategic Partnerships Group, MoH Strategic Research and Evaluation Advisory Group, Secure Jobs and Funding Certainty Leadership Group, VBHC Benchmarking Group & Clinical Care Standards Working Group, NSW Education in Addiction Advisory Committee, Naloxone State-wide Advisory Group, HMHA State Steering Committee, National Practice Standards Steering Committee, The Matilda Centre NSW Strategy for Young People's Health & Wellbeing 2025, Stigma & Discrimination Working Group, AODTS NMDS Working Group.

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

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Photo by Kris Ashpole