NADA Practice Resource

WORKING WITH WOMEN ENGAGED IN ALCOHOL AND OTHER DRUG TREATMENT

THIRD EDITION

A resource developed by the Network of Alcohol and other Drugs Agencies, which aims to support the provision of best practice interventions for women accessing alcohol and other drug treatment.

NADA
network of alcohol and other drugs agencies

Australian Government
Department of Health

NADA is supported by funding from the Australian Government Department of Health.

Acknowledgement of country

NADA proudly acknowledges Aboriginal and Torres Strait Islander people as the Traditional Custodians of the lands and waters throughout Australia. Our office stands on the land of the Gadigal people of the Eora Nation.

We recognise, respect and value the deep and continuing connection of Aboriginal and Torres Strait Islander people to land, water, community and culture.

We look to and celebrate Aboriginal and Torres Strait Islander people for their cultural guidance, leadership and expertise.

We pay our respects to Elders past, present and future.

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THIRD EDITION

The NADA Practice Resource: Working with Women Engaged in Alcohol and Other Drug Treatment, was developed as part of the Network of Alcohol and other Drugs Agencies (NADA) Women's AOD Services Development Program.

ABOUT THIS RESOURCE

This resource aims to support the provision of best practice interventions for women accessing Alcohol and Other Drug (AOD) treatment and to effect organisational change around becoming gender responsive, family inclusive and trauma informed. While this resource was developed for use by the non government AOD sector in NSW, the information in it is relevant for, and could be used by, organisations that work with women who present with a range of complex needs.

The Women's AOD Services Development Program was funded by the Department of Health (formerly the Department of Health and Ageing) under the Substance Misuse Services Delivery Grant Fund in July 2013 to improve the capacity of NSW non government alcohol and other drug services to meet the needs of substance using women, with and without children who have mental health and other complex health and social issues.

ABOUT NADA

The Network of Alcohol and other Drugs Agencies (NADA) is the peak organisation for non government alcohol and other drugs services in NSW. We advocate for, strengthen and support the sector. As a member driven peak body, NADA's decisions and actions are informed by the experiences, knowledge and concerns of its membership.

We represent close to 100 organisational members that provide a broad range of alcohol and other drugs services including health promotion and harm reduction, early intervention, treatment and continuing care programs. Our members are diverse in their structure, philosophy and approach to alcohol and other drugs service delivery.

We provide a range of programs and services that focus on sector and workforce development, data management, governance and management support, research and evaluation, sector representation and advocacy, as well as actively contributing to public health policy.

Together, we work to reduce the harms related to alcohol and other drugs use across the NSW community.

NADA has award level accreditation under the Australian Services Excellence Standards (ASES), a quality framework certified by Quality Innovation and Performance (QIP).

Further information about NADA and our programs and services is available on the NADA website at **www.nada.org.au**.

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The NADA Women's AOD Services Development Program Expert Advisory Group

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Resource Development

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GLOSSARY OF TERMS

ASSERTIVE FOLLOW UP	Is a process of checking in with clients via SMS, phone call, email or letter as a means of providing support or following up missed appointments.
CISGENDER	A term used to describe people who identify their gender as the same as what was presumed for them at birth (male or female). 'Cis' is a Latin term meaning 'on the same side as.
COMPLEX NEEDS	Refers to the interaction of the multiple areas of need that people accessing AOD treatment may experience, including mental health issues, experiences of trauma, family and domestic violence, experiences with the criminal justice system, physical and cognitive health needs and factors associated with marginalisation.
CONTINUING CARE	Is the provision of support and/or services that occur after or at the conclusion of a specific AOD treatment program. It may take the form of a support group, leisure activity, supported accommodation or case management.
FAMILY AND DOMESTIC VIOLENCE	A term that incorporates a wide range of abusive behaviours that occur in the context of intimate and family relationships, involving spouses/de-facto partners, ex-partners, children, siblings, parents and/or caregivers.
FAMILY SENSITIVE OR FAMILY INCLUSIVE PRACTICE	An approach that recognises that interventions are more effective when they include family members, where the term family refers to all supports or significant others. It supports the view that individuals influence other members in their environment – especially family – and that family members, in turn, have an impact on these individuals.
GENDER RESPONSIVE	Gender responsiveness, in an AOD context, can be defined as aiming to understand and address issues experienced by women and creating an environment that reflects these understandings through approach and treatment options.
HOLISTIC PRACTICE	Is an approach to providing care in a way that considers all aspects of a clients life, including their physical and mental health, living situation and social networks.
POST TRAUMATIC STRESS DISORDER	Post-traumatic stress disorder is a specific set of responses that can develop in people who have been through a traumatic event. The traumatic event(s) experienced or witnessed by an individual may have threatened their life or safety, or that of others around them, and led to feelings of intense fear, helplessness or horror. This can be a serious accident, physical or sexual assault, war or torture, or disasters such as bushfires or floods.
STRENGTHS BASED APPROACH	Recognises the resilience of individuals and focuses on their strengths and potential rather than their deficits.
TRAUMA INFORMED CARE/PRACTICE	Term used to describe a way of working with people that acknowledges the lasting impact of trauma. Trauma informed care also emphasises physical, psychological and emotional safety for both clients and providers, and helps survivors regain a sense of control and empowerment over their lives.

ACRONYMS

AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and Other Drug(s)
BBV	Blood Borne Virus
CALD	Culturally and Linguistically Diverse
CBT	Cognitive Behavioural Therapy
CRA(FT)	Community Reinforcement Approaches (and Family Training)
CTO	Community Treatment Order
DAMEC	Drug and Alcohol Multicultural Education Centre
DCJ	Department of Communities and Justice
FASD	Fetal Alcohol Spectrum Disorders
FDV	Family and Domestic Violence
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer and any other people who identify with the label
NADA	Network of Alcohol and other Drugs Agencies
NCETA	National Centre for Education and Training on Addiction
NDARC	National Drug and Alcohol Research Centre
NDSHS	National Drug Strategy Household Survey
NGO	Non government organisation
NIDAC	National Indigenous Drug and Alcohol Committee *Defunded in 2014
OOHC	Out of Home Care
PTSD	Post Traumatic Stress Disorder
STI	Sexually Transmitted Infections

CONTENTS

Do you work in the AOD sector?

Chances are you bring some essential qualities to your work, including:

- a non-judgemental attitude
- empathy and compassion
- a willingness to work with clients 'where they are at'
- the ability to listen and support clients and their loved ones
- a commitment to challenge discrimination and stigmatising language and behaviour
- skills and professionalism
- an optimistic approach that gives your clients hope
- a holistic practice that considers all of the factors that contribute to improved wellbeing
- a passion for social justice and equality
- a curiosity that drives you to engage with innovative, best practice interventions.

The great news is that these are exactly the kinds of qualities that are essential when working with women who experience alcohol and other drug use issues.

We know that by the time women access (AOD) treatment they have faced multiple challenges in their lives. However, the multitude of complex needs with which women may present must never overshadow the strength it has taken to make that first step, and the resilience they have demonstrated in getting this far.

If you do nothing else in the course of your important work alongside these courageous women, simply acknowledge the achievement they have made in finding their way to you.

This resource is intended to support you in the work that you and your organisation engage in every day. In this resource you will find:

- snapshots of specific challenges that women face in the context of treatment
- frontline worker experiences from organisations that provide specialist AOD services for women
- case studies and best practice approaches that you and your organisation can implement.

While this resource covers a wide range of topic areas, it is by no means an exhaustive guide – important original documents have been consulted and made reference to within the resource and you are encouraged to seek them out for more comprehensive information.

HOW TO NAVIGATE THIS RESOURCE

This resource is designed to be a quick reference guide. It is separated into eight sections that cover a range of specific topic areas. The concluding section provides important additional guidelines and recommendations for further reading, and is grouped according to the topic areas they relate to.

Sections have been structured in order to promote thought, reflection and discussion around practice approaches to working with women in the AOD treatment sector. Each section addresses a key area of knowledge that contributes to improved ways of working. Concise summaries of research and practice literature relevant to each topic area are presented throughout the resource and in addition, a number of regular features are used including:

Key points and principles – appear at the beginning of each section for quick reference.

From the frontline – provides a snapshot of real-life experiences of women in specialist women's services and shares and practice wisdom sourced from workers based in either women-specific AOD services or mixed gender services who were consulted as part of the development of this resource.

Case studies – present lived experiences of women accessing AOD treatment and provides examples of the complex array of issues and challenges faced by women within the context of a treatment journey.

Find out more – provides references and links to original source literature, published research, guidelines and clinical guides that have been reviewed in the development of this resource. Recommended resources can be used as a catalyst for further reading and exploration into material that will support improved treatment provision and outcomes for women and their loved ones. In **Section 7** and **8** of this resource are specific toolkits, guidelines and references for finding out more about all the material that has informed the resource.

PURPOSE OF THE RESOURCE

The purpose of the resource is to raise the profile of women in AOD treatment. Improving service provision to women means acknowledging their unique experiences and perspectives, enhancing the best practice approaches AOD treatment services already have in place and/or adopting philosophical perspectives that give a greater voice to the needs of women. Organisation level engagement with interventions that serve the needs of women have far-reaching benefits. These include improving gender responsiveness, addressing issues related to domestic and family violence for both victims and perpetrators, interaction of gender affirmation and AOD treatment, raising awareness regarding the needs of children and introducing concepts around positive parenting and family inclusive practice.

This resource provides structural solutions, such as building sustainable community partnerships, professional development and worker self-care that are essential in supporting improved work practices with women. Developed from evidence-based practice and research, this resource has brought together relevant findings from the literature and practice experience as a starting point for deeper consideration and discussion into the needs of women accessing AOD treatment.

TRANS AND GENDER-DIVERSE WOMEN

Unless otherwise noted, this resource is primarily referring to cisgender women in AOD treatment. Women of all gender histories have experiences of substance use and interact with AOD treatment services, and you can visit section 3.3 for more information about trans and gender diverse women's experiences and support.

This resource highlights skills, knowledge and attributes outlined in the NADA Workforce Capability Framework and we encourage you to explore them together as part of your Professional Development planning.

Website: **www.nada.org.au/resources/workforce-capability-framework**

1 WOMEN IN ALCOHOL AND OTHER DRUG TREATMENT

1.1 Women and their experience of alcohol and other drug use

KEY POINTS AND PRINCIPLES

- Gender shapes substance use in relation to initiation, access, consumption, experiences of dependence, AOD-related risk behaviours and AOD treatment outcomes.
- Women access AOD treatment at lower rates than men and are under-represented in the drug and alcohol treatment system (according to Australian and international data). This is the case for both trans and cis women.
- A range of issues create barriers for women's access to AOD services, including social stigma, discrimination, experiences of trauma, childcare and child custody concerns, and financial issues.
- On entering AOD treatment, women present with higher rates of: mental health issues; experience of complex trauma as a result of childhood physical and sexual abuse and/or family and domestic violence; AOD-related risk taking; pregnancy and childcare issues; and greater social and economic disadvantage.
- Pregnancy and parenting are specific areas of need that require effective support and intervention for women engaged in problematic substance use. The key to engaging women is to reassure them that there is 'no wrong door'.
- Pharmacotherapy for women works best when implemented with other supportive interventions such as coordinated case management, counselling, group therapy and practical support.
- A high proportion of women who access AOD treatment are seeking assistance for the problematic substance use by a loved one – principles of family inclusive practice are best practice in this context.

WOMEN'S AOD USE AND ENGAGEMENT WITH TREATMENT IN AUSTRALIA

Women's substance use and their experience of problematic use and dependence are shaped by gender. Australian social and environmental influences also have a significant role to play in terms of accessibility, consumption norms and the social perceptions that are attached to different drug types. However gender is the dominant lens through which substance use is judged. Building recognition of the ways in which gender shapes women's experiences of substance use and treatment for problematic use has the potential to improve ways of working in the AOD sector, and the treatment outcome of improved general wellbeing for women in Australian society.

AOD use is generally more prevalent among men than women, and in Australia overall, women are far less likely than men to use either licit or illicit substances (AIHW 2020). Gender differences are evident in most patterns of substance use and women in the National Drug Strategy Household Survey (NDSHS) 2019 were found to be around half as likely as men to meet the criteria for alcohol dependence (using the ASSIST-Lite), or to have injected any drug in the past year. The main exception to this pattern is the use of pharmaceuticals and prescription drugs for non-medical purposes. An equal number of men and women reported having used pharmaceuticals such as analgesics, sedatives, steroids or opiates in a non-prescribed way in the past 12 months (AIHW 2014).

WOMEN'S AOD USE AND ENGAGEMENT WITH TREATMENT IN AUSTRALIA

continued

In Australia, the estimated prevalence of harmful substance use or dependence disorders among women is around half that of men. However, in 2018/19, monitoring of AOD treatment utilisation showed that approximately one third of treatment episodes were for female clients seeking help for their own substance use (AIHW 2020). Alcohol is the most common principal drug of concern for both women and men seeking treatment, and male clients made up the majority of treatment episodes in 2018/19 where alcohol, cannabis, heroin and amphetamine were identified as the primary drug.

Consistent with national rates that suggest women are unrepresented in treatment, a third of NSW treatment episodes at over 250 AOD services were for female clients, whose median age was 40 years (AIHW 2019). Women appear to be seeking and entering treatment for their substance use at lower rates than men, when they are older and at rates that are disproportionate to their likely level of need. Subsequently, identifying and responding to women's treatment needs and women-specific barriers to accessing services may increase rates of treatment utilisation.

Women with problematic substance use and those who enter treatment have been found to differ from male substance users in a range of ways. A number of factors and characteristics have been found to be associated with their increased risk of initiation to substance use, increased risk of transition to problematic substance use and dependence, as well as their outcomes once engaged in treatment. Risk factors that are highly prevalent and, in some cases, unique to women substance users need to be taken into account in order to deliver best practice treatment. The literature also indicates that women accessing AOD treatment are more commonly poorly educated and have low levels of income, have a financial dependence on partners or others and have lower rates of employment than their male counterparts (McCabe et al. 2013, Yeom 2011).

Gender differences are evident among injecting drug users, where women who inject drugs are more likely than men to inject with multiple partners, share paraphernalia after an injection partner, exchange sex for money or drugs, and have difficulty negotiating condom use with their sex partners (Strathdee et al. 2001; Ashley et al. 2003) resulting in vulnerability to HIV infection.

An awareness of the challenges that women face in engaging in treatment for their problematic use of alcohol and other drugs provides the foundation from which to develop appropriate interventions and make improvements to service provision. Explored in the next section are some of the areas of complexity that women may experience on their journey into treatment.

1.2 Unpacking issues and identifying needs of women in AOD treatment

Improving the access and retention of women in AOD treatment can be facilitated by an awareness of the factors that may have contributed to their problematic alcohol and other drug use, and those that perpetuate it. Women generally present with a more severe clinical profile than men when entering treatment, with more problems related to mental health, family and interpersonal relationships, employment, and physical health (Green 2006), including involvement with child protective services and partners who are also substance users (Brady & Ashley 2005). In spite of the fact that women who enter treatment generally have fewer years of substance use and have used smaller quantities than men, they present with an equivalent severity of substance use problems and symptoms (Covington et al. 2008, Yeom 2011).

From the frontline

Many of the issues and needs of women accessing AOD treatment identified through research are echoed by the AOD sector. According to NSW non government AOD treatment services who were consulted in the development of this resource, areas of specific need include:

- pharmacotherapy – the lack of places for women on pharmacotherapy programs and inconsistent collaborative care planning with prescribers and pharmacotherapy case managers
- parenting issues – a lack of treatment places for women with children in their care; increasing numbers of women presenting for treatment with children in out-of-home care (OOHC); inconsistent collaborative case planning with case workers from the Department of Communities and Justice (DCJ)
- increasing complexity of presentations – trauma and its enduring effects on AOD use and women's quality of life, mental health issues, cognitive impairment that complicates AOD treatment, physical health issues particular to women
- housing issues – particularly the lack of affordable and appropriate housing available to women
- changing cohorts of women seeking treatment, such as greater numbers of first-time treatment seekers and well-resourced older women.

STIGMA AND DISCRIMINATION

Several theories relate to the stigma and discrimination experienced by women who use alcohol and other drugs, and they usually align with traditional views of women's roles in society. According to Shimmin "stigma for women who use any licit or illicit drugs is more severe than for men because of women's "place" in society, as those who bear and rear children and who are seen to uphold the moral and spiritual values of society. There is also the negative stereotype that women users are sexually promiscuous because of their drug or alcohol use. This association is not seen in men." (Medina-Perucha et al. 2019).

> "Stigma for women who use any licit or illicit drugs is more severe than for men because of women's 'place' in society…" Shimmin, 2009

Women often face social barriers as they are more likely than men to encounter disapproval for their substance use and their participation in treatment. This may include the loss of family support due to substance use or associated criminal behaviours (Fonti et al. 2016, Matsumoto et al. 2020).

While stigma is potentially of concern for all people who use drugs, women with drug and alcohol use issues face a significant social stigma and discrimination in relation to pregnancy and parenting. Along with the barriers posed by family responsibilities or lack of childcare options if they were to seek treatment, the stigma of being a substance-using mother and the fear of losing custody of children are significant barriers to treatment entry and engagement (Greenfield et al. 2007).

Find out more...*about tackling stigma and discrimination.*

NADA Language Matters Resource

The resource provides workers with best-practice guidelines on how to use language to empower clients and reinforce a person-centred approach.

Website: **www.nada.org.au/resources/language-matters/**

NUAA's Stigma and Discrimination Campaign

In order to address issues and challenge issues of stigma and discrimination, NUAA has been implementing training based on resources developed by the Australian Injecting & Illicit Drug Users League (AIVL). NUAA targets health care professionals and those working in the drug and alcohol area as well as the broader community and people who inject drugs themselves to tackle stigma and discrimination in a thought-provoking and innovative manner.

Websites: **www.nuaa.org.au / www.aivl.org.au**

AOD Media Watch

The media plays an important role in the public debate regarding Alcohol and Other Drugs (AOD). AOD Media Watch aims to improve the reporting of AOD issues through putting the spotlight on stories that contain misinformation, perpetuate unnecessary moral panic and stigma.

Website: **www.aodmediawatch.com.au/**

Stigma Watch SANE Australia

SANE StigmaWatch reflects and acts on community concern about media stories, advertisements and representations that stigmatise people with mental illness or inadvertently promote self-harm or suicide.

Website: **www.sane.org/get-involved/stigmawatch**

CO-OCCURRING MENTAL HEALTH AND AOD ISSUES

In Australia, 20-30% of women who have alcohol use issues meet diagnostic criteria for a mental health disorder (ABS 2008). Women who use alcohol and other drugs have a higher prevalence of co-occurring mental health issues such as mood, anxiety, post-traumatic stress disorders (PTSD) and eating disorders than men (Covington et al. 2008). Affective disorders, such as major depression, are associated with poorer treatment outcomes and higher rates of relapse. In a review of the evidence for women in drug and alcohol treatment, Greenfield et al. (2007) suggest that higher rates of co-occurring disorders among women, such as depression, anxiety, eating disorders and PTSD, may make it difficult for women to gain appropriate treatment for both mental health and substance use problems. Additionally, the experience of multiple disorders may increase the likelihood that women perceive their issues as specific to their mental illness with the result that they focus on seeking psychiatric help, rather than AOD treatment.

In a study of over 300 women experiencing co-occurring substance use and PTSD, those who perceived their need for psychological and emotional treatment as highly important were found to be significantly more likely to not attend, or drop out early from, AOD-related treatment (Resko & Mendosa 2013). Among women substance users, common co-occurring issues such as depression may go undetected, and women may also choose to self-medicate rather than seek professional assistance.

The complexities of some highly prevalent mental health issues present serious additional risks. Alcohol and other drug use is strongly associated with eating disorders for women, and substance use and eating disorders are both associated with the highest mortality risks of all psychological disorders. Women who are nutritionally deprived when they present to AOD treatment are best supported with medical intervention and advice because individuals with substance dependence and an eating disorder face increased problems with withdrawal and dependency (Harrop & Marlatt 2010).

From the frontline

AOD treatment services who were consulted in the development of this resource reported that they were witness to an increasing complexity of mental health problems experienced by the women who presented to their services. When asked to nominate the main mental health issues that affect female clients of their service, the following issues were nominated: depression; anxiety; trauma; personality spectrum disorders; psychotic disorders and eating disorders.

All of our women have mental health issues – a lot are on antidepressants. All of them are depressed and anxious. Some have PTSD and the majority of women have had a major trauma in their lives. Recently, we had a woman referred who had just come out of hospital for drug-induced psychosis.

We ask for a mental health report before the client comes in but we sometimes find in the withdrawal period that the alcohol and other drug use has been protective of the mental health problem so we will see psychosis emerging.

We have a lot of women on mood stabilisers and we have had a couple of women who've come to us on CTOs (Community Treatment Orders)… and went very well actually. We had one young woman who stayed… for five months... but we've had other women admitted with psychosis and they struggled to live in that sort of [residential treatment] community setting.

Due to the high risks and complex needs of women experiencing substance use disorders and co-occurring mental health issues, integrated and holistic treatment approaches are recommended. There's also a need for a longer-term approach to recovery and sensitive outreach, engagement and support interventions (Brown & Melchior 2008, Chen & Biswas 2012, Matsumoto et al. 2020). See **Section 2.7** for more information on outreach as an intervention.

Find out more...*about working with co-existing mental health and alcohol and other drug issues.*

Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings. NDARC 2016 (Mills et al.)

The purpose of these guidelines is to provide AOD workers with up-to-date, evidence-based information on the management of comorbid mental health conditions in AOD treatment settings. They are based on the best available evidence and draw upon the experience and knowledge of clinicians, researchers, consumers and carers.

Website: **www.comorbidityguidelines.org.au/**

Complex Needs Capable: A Practice Resource for Drug and Alcohol Services NADA 2013

Complex Needs Capable and the accompanying website was developed to build capacity within the non government drug and alcohol sector by supporting the development of staff skills, knowledge and confidence, and of organisational capacity in responding to the needs of people with drug and alcohol issues and complex needs such as cognitive impairment and criminal justice system contact.

Website: **www.complexneedscapable.org.au**

eLearning or Complex Needs can be found at: **www.nada.org.au**

NSW Clinical Guidelines: For the care of persons with comorbid Mental Illness and Substance Use Disorders in Acute Care Settings NSW. NSW Health 2009

These guidelines have been written for those working in the AOD and/or mental health sectors who provide care for people with comorbid mental health and substance use disorders.

RELATIONSHIP ISSUES

Personal relationships can affect women's AOD treatment entry and success, representing treatment seeking barriers (Greenfield et al. 2007, Grella 2009, Tuchman 2010). Problematic intimate relationships have the potential to increase the risk and harms women experience as a result of their substance use. On the other hand, more stable or supportive relationships can reduce these risks and harms. Substance misuse by significant others, and living with a substance user, have been found to be risk factors associated with poorer outcomes and higher likelihood of relapse for women in treatment, but this relationship has not been demonstrated as significant for men (Grella et al. 2008).

Personal relationships and family history appear to be a more significant influence on women's initiation, pattern of use, and continuation of problematic alcohol and other drug use than for men. For example, women with alcohol and other drug problems appear more likely than men to have been raised in a family environment of heavy drinking or problematic drug use (Ashley et al. 2003, CSAT 2009). Furthermore, women who identify as substance users are more likely to have intimate partners who are substance users (Brady & Ashley 2005) and appear more likely to report that they had family, friends or partners who used drugs or who supported their continued substance use (Greenfield et al. 2007).

Some women perceive their entry into drug use, or their continued use with their partner as a way to maintain or develop more intimate relationships (Kay et al. 2010). Furthermore, situations and conditions such as having a stressful marriage and being pressured to use drugs by sexual partners have been found to significantly affect women's post-treatment relapse to alcohol use (Grella 2008).

The principles of family inclusive practice (explored in more detail in **Section 2.4**) are applicable when considering engaging partners of women who experience substance use issues. While in some cases it may not be appropriate to involve partners directly, referrals to alternative supports such as family groups or counselling is recommended. Education and information about the process of dependent substance use, the related issues and what is involved in treatment can assist those supporting women accessing AOD treatment. Confidentiality is key in working with significant others. However, clear explanations about what confidentiality means in a treatment context at the first point of contact is best practice, while being empathetic to the reasons for requesting information.

Find out more...*about strengthening supportive intimate relationships.*

Relationships Australia

Relationships Australia is a leading provider of relationship support services for individuals, families and communities. Services are for all members of the community, regardless of religious belief, age, gender, sexual orientation, lifestyle choice, cultural background or economic circumstances.

Website: **www.relationships.org.au**

Family Drug Support (FDS)

Family Drug Support (FDS) provides support and assistance to families throughout Australia who are experiencing difficulty with a family member using alcohol or other drugs. FDS provide a 24 hour, 7 days a week support line for families, support groups and meetings, the 'Stepping Stones' and 'Stepping Forward' courses, events and resources.

24 hour support line: 1300 368 186.

Website: **www.fds.org.au**

Your Room: Families

Information to support families in NSW to reduce the harms caused by alcohol and other drugs, find support services and understand treatment options.

Website: **www.yourroom.health.nsw.gov.au/Pages/home.aspx**

FAMILY AND DOMESTIC VIOLENCE (FDV)

Women are more likely than men to identify relationship issues as a cause for their problematic substance use. In addition, women in treatment have much higher rates of family violence experience than women in the general community (Greenfield 2010). A high prevalence of intimate partner violence among substance using couples suggests that where drug use is central to a couple's relationship, women's ability to enter treatment may also be limited by the threat of violence. Family and domestic violence encapsulates a wide range of abusive behaviours, occurring within intimate and familial contexts. While FDV predominantly involves men's violence against their female partners, other relationship violence is included in this definition such as that existing in same-sex relationships, non-spousal relationships and carer relationships – parent to child and vice versa (White et al. 2013).

"Families would benefit from AOD services making the links between AOD and FDV explicit. This has the potential to increase the client's capacity and motivation to change AOD use, with improved outcomes for their children." (White et al. 2013).

Given that a considerable proportion of people accessing alcohol and other drug treatment are men, there is potential for some of them to have been perpetrators of FDV. This presents an opportunity in the context of AOD treatment to explore FDV as standard practice, and an issue that is not just targeting women who have been victims. One of the key recommendations from Australia's national research centre on AOD workforce development (National Centre for Education and Training on Addiction), resource "Can I Ask? – An alcohol and other drug clinician's guide to addressing family and domestic violence" (White et al. 2013) is to include training that builds capacity in the area of FDV so that AOD workers feel confident to raise FDV issues, to provide screening and assessment and explore risk assessments and safety planning.

Find out more...*about addressing FDV in AOD settings.*

Domestic and Family Violence Tools for Alcohol and Other Drug Settings

These tools aim to provide more effective responses for people who use AOD in harmful ways and either experience domestic and family violence (DFV) and/or are at risk of using DFV.

Domestic and Family Violence Capability Assessment Tool: for Alcohol and Other Drug Settings

Website: **www.atoda.org.au**

Scope of Practice: for Working with Service Consumers in Alcohol and Other Drug Settings who Experience or Use Domestic and Family Violence

Website: **www.atoda.org.au**

Practice Guide: for Responding to Domestic and Family Violence in Alcohol and Other Drug Settings

Website: **www.atoda.org.au**

1800 RESPECT National Sexual Assault, Domestic Family Violence Counselling Service

A 24-hour confidential information, counselling and support service for people who have experienced sexual, domestic and/or family violence.

Can I Ask? An alcohol and other drug clinician's guide to addressing family and domestic violence. NCETA 2013 (White et al.)

This resource explores the relationship between AOD and FDV, with a focus on identifying how the AOD sector can better support clients who have co-occurring AOD and FDV issues, and minimise associated harms experienced by their children.

Breaking the silence: Addressing family and domestic violence problems in alcohol and other drug treatment practice in Australia. NCETA 2012 (Nicholas et al.)

This review explores the relationship between AOD and FDV services, with a focus on identifying how the AOD sector can better support their clients who have co-occurring family and domestic violence issues and minimising the harm experienced by children.

The Domestic Violence Line provides telephone counselling, information and referrals for women and same-sex partners who are experiencing or have experienced domestic violence. The service has an extensive list of contacts, people and services across NSW who can help.

Phone: 1800 656 463

Website: **www.domesticviolence.nsw.gov.au**

FINANCIAL DISADVANTAGE AND HOMELESSNESS

Women entering treatment commonly experience lower levels of education and income, and have lower rates of employment. Women have more problems related to lack of employment and vocational skills (Grella 2008) and report financial dependence on partners or others (Engstram et al. 2012). Furthermore, low socio-economic status and income inequality are often linked with poor health and wellbeing and have been associated with serious drug-related harms including fetal alcohol syndrome, alcohol-related deaths and drug overdoses (Spooner & Hetherington 2004).

Homeless women who use alcohol and other drugs have a higher risk of mental health issues, experience of trauma and potential involvement in the sex industry (Brown et al.

From the frontline

Homelessness or the risk of homelessness is of great concern to women accessing AOD treatment, particularly given that prolonged problematic substance use is a significant contributing factor to financial difficulties and accommodation instability. Many AOD services have identified inconsistent or poor access to support services needed by women such as safe and stable housing.

Homelessness is on the top of the list [of concerns]. When women lose their accommodation – they end up with someone just to get a roof over their head. They sleep on couches and they trade the need for safety.

Housing is a massive gap. It's difficult for women with more than one child, single women… if they are on pensions their ability to pay commercial rent is difficult.

There is a population of women who want to get out of the criminal justice system and they are stuck and unable to get out. The women have been travelling […] from the city to get away from their old networks but there's few supports here, there's no housing.

2012, Hopper et al. 2010). They are vulnerable to further poverty, family breakdown and violence (Dawson et al. 2013). Addressing these issues, in addition to providing material support, is therefore highly important for this group.

Positive socio-economic factors, such as being gainfully employed, having a higher income and higher level of education generally mean better rates of treatment retention (Greenfield et al. 2007). Engagement in AOD treatment is an opportunity to explore further education and vocational training options with women and reaffirms the benefit of partnership building with organisations that specialise in this area. See **Section 5** in this resource for more information.

Providing assertive community outreach has helped identify people who are homeless and educate them about available services and AOD treatment (CSAT 2013). The literature suggests that targeted informal day programs and drop-in programs for homeless women with substance use issues are effective. Particularly where they are successfully integrated components of harm reduction, trauma informed services and social support to homeless and marginally housed. Studies indicate that low-threshold and tailored environments for care can engage highly vulnerable and intervention resistant clients into regular service contact, with benefits for health and wellbeing (Hopper et al. 2010, Magee & Huriaux 2008). Read more about the effectiveness of outreach in **Section 2.7** of this resource.

Find out more...*about responding to homelessness in AOD settings.*

Refer to the Department of Communities and Justice (DCJ) website for information about services and supports to assist people with housing.

Website: **www.facs.nsw.gov.au/housing**

Trauma-Informed Organizational Toolkit for Homelessness Services (Guarino et al. 2009)

This Toolkit offers homeless service providers with concrete guidelines for how to modify their practices and policies to ensure that they are responding appropriately to the needs of families who have experienced traumatic stress.

CRIMINAL JUSTICE ISSUES

Women involved in the criminal justice system are understood to generally experience high levels of social disadvantage. Among police detainees in Australia, female offenders were found to be substantially more socially and occupationally disadvantaged than women in the general community, and more disadvantaged than male detainees (Loxley & Adams 2009). Male detainees were more than twice as likely as women to report having recent income from paid employment, while females were significantly more likely to be receiving government welfare and to have dependent children in their home (Loxley & Adams 2009). Women involved in the criminal justice system experience high rates of victimisation and mental health issues (Tripodi et al. 2011).

Hall et al. (2013) recommended that interventions should comprehensively address the psychological and social needs of women involved in the criminal justice system, because addressing victimisation, drug and alcohol use, and other mental health disorders is more effective than programs that focus on criminal recidivism alone. Best practice interventions for women who have had experience with the criminal justice system should include components that address women's immediate needs, such as assistance in accessing safe and affordable housing and providing job training, education and employment assistance.

Providing an environment that is sensitive to the experiences of institutionalisation by providing space, time and emotional safety will facilitate engagement in AOD-specific treatment interventions (NADA 2013). For drug and alcohol treatment among women in residential correctional facilities, the therapeutic effects of treatment programs appear to be enhanced when trust-based relationships are established, care is individualised and the treatment facilities are separate from the general prison environment (Fingeld-Connett & Johnson 2011).

Women leaving prison face particular challenges and it is understood that on release, women with substance use issues need both practical and emotional support to re-enter the community. This population have significant and complex health care needs, but this time of transition is indicated to be an effective opportunity to offer support, services, and other health-promoting interventions (Colbert et al. 2013).

For transgender women, this can be compounded by being incarcerated in facilities that do not affirm their gender, or by having their gender not taken seriously by institutions. Special care and support, particularly through the use of peers, can be helpful to support these women. It is useful to note that many of the factors associated with relapse into alcohol and other drug use mirror those associated with re-offending.

Find out more...*about responding to women who have experience with the criminal justice system.*

Complex Needs Capable: A Practice Resource for Drug and Alcohol Services NADA 2013

Complex Needs Capable and the accompanying website was developed to build capacity within the non-government drug and alcohol sector by supporting the development of staff skills, knowledge and confidence, and of organisational capacity in responding to the needs of people with drug and alcohol issues and complex needs such as cognitive impairment and criminal justice system contact.

Website: **www.complexneedscapable.org.au**

Your Guide to Surviving on the Outside Community Restorative Centre NSW 2007

This booklet is a guide for ex-prisoners and prisoners who are about to be released.

Website: **www.crcnsw.org.au**

WIPAN (Women In Prison Advocacy Network)

WIPAN helps women who have left prison or are close to being released adjust back into the community.

Website: **www.wipan.net.au**

Sisters Inside

An independent community organisation that exists to advocate for the human rights of women in the criminal justice system, and to address gaps in the services available to them.

Website: **www.sistersinside.com.au**

COGNITIVE IMPAIRMENT

The term cognitive impairment is used to describe deficits in cognitive skills or functioning, and refers to symptoms present at birth and or acquired later. Deficits related to Fetal Alcohol Spectrum Disorders (FASD), acquired brain injury, and genetic abnormalities are often grouped under this term. The Complex Needs Capable resource developed by NADA explores in detail issues related to cognitive impairment (specifically, intellectual disability, acquired brain injury and FASD), and, more importantly, the strategies and interventions required for services to become more 'capable' in responding to these needs.

The AOD treatment services consulted in the development of this resource highlighted cognitive impairment as a significant issue that affected women clients accessing their service. They suggested that cognitive impairment, though common, is often missed in assessment prior to accessing AOD treatment.

There is a big issue with cognitive impairment in drug treatment settings and people are discharged for non-compliance when in fact they may not be able to understand [what has been asked of them].

Having a cognitive impairment can result in a person not being able to access or maintain the drug and alcohol treatment they require. People with a cognitive impairment often:

- don't receive the services they need
- are unable to maintain waiting list protocols
- fall through services gaps and experience a 'referral merry-go-round'
- are screened out of entry to services
- are perceived to have no or low motivation
- are put in the 'too hard basket'
- are said to have 'challenging/problem behaviours' when they, in fact, have a cognitive impairment
- are exited from services early
- are unable to access services because they don't have a diagnosis
- are told that disability services should address their drug and alcohol issues.

When armed with knowledge about how cognitive impairment can affect a person and the practical strategies and adjustments in service provision, AOD treatment services can successfully support people with intellectual disability, acquired brain injury and FASD to receive the expert drug and alcohol treatment they need (NADA 2013).

Find out more...*about working with women who have cognitive impairment.*

Alcohol and Drug Cognitive Enhancement (ACE) Program

The ACE program is a suite of tools and resources produced by the Agency for Clinical Innovation (ACI) Drug and Alcohol Network, to assist drug and alcohol clinicians to screen for, identify and respond to cognitive impairment in clients seeking treatment for substance use.

Website: **www.aci.health.nsw.gov.au/projects/ace-program**

Complex Needs Capable: A Practice Resource for Drug and Alcohol Services NADA 2013

Complex Needs Capable and the accompanying website was developed to build capacity within the non-government drug and alcohol sector by supporting the development of staff skills, knowledge and confidence, and of organisational capacity in responding to the needs of people with drug and alcohol issues and complex needs such as cognitive impairment and criminal justice system contact.

Website: **www.complexneedscapable.org.au**

Looking Forward: Acquired Brain Injury. arbias 2011

Looking forward is a handbook for supporting people with acquired brain injury. It gives a basic introduction to brain injury and the challenges involved for people living with acquired brain injury. It offers practical advice and strategies to enable practitioners to empower people to achieve their full potential.

Website: **www.arbias.org.au**

PREGNANCY AND PARENTING

Women accessing treatment may be pregnant or become pregnant, presenting unique perinatal risks that are associated with a higher rate of obstetric complications and poor outcomes, including miscarriage, birth defects, decreased birth weight, cognitive deficits, growth restriction, increased neonatal mortality and maternal health problems (Keegan et al. 2010). The negative impacts of substance use on the development of a child in utero and growing up in households where problematic alcohol and other drug use are commonplace, are well documented.

However, the key message should be 'no wrong door'. If a woman presents to an AOD treatment service that may not have the capacity to respond to all the issues relating to pregnancy and parenting, then all effort should be made to engage with her while additional or specialist services can be sought. Access to childcare, prenatal care, mental health services, women-only programs, psycho-education sessions focused on women-specific topics and comprehensive services that offer multiple components have all been associated with improved outcomes for women. Pregnancy and care of children can be a significant motivating factor for AOD treatment engagement and retention. However, child safety should always be paramount. Pregnancy and parenting including child safety concerns are explored in more detail in **Section 4** of this resource.

Find out more…*about working with women who become/are pregnant.*

Clinical Guidelines for the Management of Substance Use During Pregnancy, Birth and the Postnatal Period NSW Ministry of Health 2014

These guidelines support and provide best practice advice to health professionals in the management of drug use during pregnancy, birth and early development years of the newborn.

"It's time to have the conversation": Understanding the Treatment Needs of Women Who Are Pregnant and Alcohol Dependent FARE 2013 (Burns & Breen)

This report puts forward the gold standard for the treatment of alcohol dependence in pregnancy. This research reports on information gathered from 11 semi-structured qualitative interviews with clinicians that treat pregnant women with problematic alcohol use provided expert clinical advice on current treatment practices and the gold standard for treatment and factors that impinge on this approach.

Responding to the Needs of Children and Parents in Families Experiencing Alcohol and Other Drug Problems ADF 2012 (Gruenert & Tsantefski)

This issues paper provides a summary of current research as well as professional opinion relevant to working with families, especially when a parent presents for treatment or support. The paper aims to be a useful resource for both service providers and practitioners, providing tips and advice on family sensitive and family inclusive practice, with a specific focus on supporting children.

1.3 Considerations for women on pharmacotherapy

Women in pharmacotherapy treatment have the same needs as women in drug and alcohol treatment more generally, including a strengths-based approach that is trauma informed, access to childcare and greater focus on engagement and retention in treatment. Opioid dependence is associated with a range of physical health problems and frequent incidence of comorbid mental health issues, and these issues commonly appear to be more prevalent and/or more severe for women (Kay et al. 2010). Compared to male opioid users, female users and women in treatment are significantly more likely to have a mood or anxiety disorder (Grella et al. 2009) and have been found to have more extreme problems related to recent employment, medical, psychiatric, and family social matters (Kelly et el. 2009).

Women participating in methadone programs often have experience of childhood sexual abuse, childhood physical abuse, lifetime experience of intimate partner violence and low levels of financial independence (Engstrom et al. 2012). Opioid users engaged in treatment have demonstrated large improvements in their health and social functioning, but these improvements have been shown to be moderated by the experience of co-existing psychiatric disorders (Grella 2009), highlighting the need for treatment to identify and address women's highly prevalent mental health issues in conjunction with pharmacotherapy.

In situations where women accessing treatment are pregnant, induction to methadone maintenance as part of comprehensive treatment programs is considered best practice (Keegan 2010, Minozzi et al. 2008). Commencement of methadone should ideally take place in an outpatient setting, with maternal and obstetric supervision - as is common practice in Australia, and supported by the American College of Obstetricians and Gynaecologists (ACOG). Continued buprenorphine treatment is safe for women who become pregnant while already in this type of treatment. It achieves similar outcomes to methadone in reducing maternal drug use and promotes positive neonatal outcomes, and appears to result in a less severe neonatal abstinence syndrome (Young & Martin, Jones et al. 2012). However as buprenorphine induction may place the foetus at risk from precipitated maternal withdrawal and potentially trigger relapse in mothers, methadone is recommended for active opioid users who need to be inducted to pharmacotherapy during pregnancy (Young & Martin 2012).

From the frontline

Women's AOD Services Network members, who were consulted in the development of this resource, reported incidents involving case workers from the Department of Communities and Justice (DCJ) who had stipulated a reduction in, or cessation of, pharmacotherapy as a condition for either retaining a child in the mother's care or for restoration of the child to her care.

We have had a few women who have been on prescribed Valium [in conjunction with pharmacotherapy] for however long and it's like "bang, you need to be off it"… and we've had a couple of hairy [challenging] situations where that's been the expectation and we've had to try to explain again [to the DCJ worker] the slow [withdrawal] process that needs to occur.

1.4 Women accessing treatment for a significant other's drug use

When it comes to accessing AOD treatment for someone else's substance use, women in Australia are twice as likely as men to have sought assistance (AIHW 2014). Women may access AOD treatment to assist them to find answers as to why a loved one is using alcohol and other drugs and how they can receive support. An empathetic and non-judgemental approach is essential in order to engage women who may feel isolated from the AOD treatment sector because their partners are the focus of care and treatment.

"Blame, guilt, grief, shame and frustration are natural companions of the trauma of AOD problems and other major family difficulties in our culture–families have needs in their own right and have a right to have their needs acknowledged" (Marsh et al. 2013)."

Support and a sense of being heard can help significant others to manage their concerns and reduce levels of anxiety. Copello and colleagues (2005) recommend the following five steps when working with a family member or partner who is living with someone with AOD-related problems. These steps aim to reduce the level of strain (physical and psychological) experienced by the family member or partner, and enhance their coping mechanisms:

- Give the family member or partner the opportunity to talk about the problem and be heard.
- Provide relevant information in accordance with the needs of the client.
- Explore how the family member or partner responds to the person's substance use.
- Explore ways of enhancing social support.
- Discuss the possibility of onward referral for further specialist help.

"Practice that is family inclusive does not require specialist family therapy training and can result in family members receiving the support they need in their own right and can also be beneficial to treatment outcomes for the drug user. However, if counsellors wish to engage in family therapy, specific skills and specialist training is required" (Marsh et al. 2013).

Find out more…*about supports for women who attend AOD treatment for another person's problematic substance use.*

NADA Working with Families resources

Family Drug NADA in partnership with Family Drug Support and the Ministry of Health NSW Government, developed training and resources for the AOD sector and other primary health contacts to build the capacity of workers to better support families who are impacted by someone else's substance use. You can use these resources to increase your capacity to support families and significant others impacted by substance use by:

- completing the eLearning modules to increase your knowledge and ability to apply evidence based practice approaches that support families and significant others
- using the facilitator guide [PDF] and slides [PPTX] to run your own in-service that specialises in supporting families and significant others impacted by the AOD.

Website: **www.nada.org.au/resources/working-with-families**

Family Drug Support (FDS)

Family Drug Support (FDS) provides support and assistance to families throughout Australia who are experiencing difficulty with a family member using alcohol or other drugs. FDS provide a 24 hour, 7 days a week support line for families, support groups and meetings, the 'Stepping Stones' and 'Stepping Forward' courses, events and resources.

24 hour support line: 1300 368 186.

Website: **www.fds.org.au**

A Checklist for Family Sensitive Practice for the Alcohol and Other Drug Field. NCETA 2010

This checklist comes as part of the Family Sensitive Policy and Practice Toolkit, and provides a comprehensive checklist for reviewing how oriented to family inclusive practice an AOD service is.

Website: **www.nceta.flinders.edu.au**

2 CREATING AN ENABLING ENVIRONMENT FOR WOMEN: BEST PRACTICE APPROACHES FOR AOD TREATMENT

KEY POINTS AND PRINCIPLES

- **An enabling environment for women requires a gender-responsive approach** where AOD treatment is shaped by, and is responsive to, women and their experiences.
- **A strengths-based approach** to AOD treatment with women focuses on their strengths and resilience, contributing to capacity building and client self-determination.
- **Trauma informed service provision** acknowledges the lived experience of trauma common to women and is sensitive to avoiding perpetuating traumatic events.
- **Family inclusive practice** responds to the significance of familial relationships for women. Strengths can be harnessed among families or within communities to support positive and sustained treatment outcomes.
- **Evidence-based interventions for AOD treatment** such as behaviour therapies, cognitive behaviour therapies, motivational interviewing and 12-step groups are suitable for women. Good practice insists on comprehensive assessment and individualised treatment planning.
- **Coordinated case management and integrated programs** benefit women and overcomes fragmented service systems.
- **Sexual safety and sexual health** are part of a comprehensive AOD treatment plan for women accessing AOD treatment.
- **Assertive follow up, outreach and aftercare** are interventions applied in the AOD treatment sector that assist in engaging and retaining women in treatment long enough to establish effective and sustained improvements to their lives.

All the treatment approaches explored in this resource have consistent and complementary messages. They are easily adaptable to the AOD treatment sector, and have been implemented in Australia and overseas contributing to a solid evidence base.

The following six components of women's treatment have been identified as promoting positive treatment outcomes: access to childcare; access to prenatal care; access to women-only programs; psychoeducational sessions focused on women-specific topics; mental health interventions and comprehensive services that offer multiple components.

Positive treatment outcomes from the components described above are longer retention in treatment; decreased substance use; decreased mental health symptoms; improved birth outcomes; greater employment; HIV risk reduction and improved self-reported health status (Ashley et al. 2003).

The best practice interventions identified in this resource have relevance to, and are able to be adapted in, mixed-gender services and specialist women's AOD services. In this section various approaches and interventions are presented, with reference to comprehensive practice guideline documents for a more expansive description and implementation strategies.

IMPROVING ACCESS

Improving access for women into AOD treatment by being responsive to the needs and issues they present with requires some flexibility and planning – facilitated by engagement skills and comprehensive assessment. Even if the result is to provide support and referral onto a specialist service, it is essential that workers and treatment services enlist the skills they have to engage women and encourage them to take the first step into treatment.

From the frontline

Most women indicated that gaining access to treatment without waiting made it easier to receive help. Other treatment enablers were:

- low or free cost of treatment
- a suitable location
- access to childcare
- access to transport
- a women-only service

When I went to [service] they got me in straight away. There were [also] local aftercare groups- very helpful.

I only waited two weeks. It was really easy to get into and the price is really good, I think a lot cheaper than the last rehab I was at.

EFFECTIVE INTERVENTIONS WHEN WORKING WITH WOMEN

The literature tells us that effective women specific interventions include:

- family-inclusive practices that focus on repairing relationships with children and family members and enhancing the quality of the family/domestic environment
- addressing trauma
- developing support systems to prevent relapse
- comprehensive service models for pregnant women
- parenting skills for mothers on methadone [and other pharmacotherapy] maintenance
- relapse prevention for women with PTSD, marital distress and alcohol dependence
- dialectical behaviour therapy for patients with co-occurring drug dependence and borderline personality disorder. (Greenfield et al. 2007).

In a longitudinal study of recovery and relapse cycles, self-help participation was more strongly associated with moving from substance use to recovery for women than for men in substance use treatment, and women were more likely than men to participate in self-help (Grella et al. 2008).

This section provides an overview of a number of the approaches and interventions outlined above with reference to source documents that provide more comprehensive articulation of each topic. The case study over the page also provides an example of how a number of these interventions can work together.

Find out more...*about engagement and assessment processes.*

NSW Health Drug and Alcohol Psychosocial Interventions: Professional Practice Guidelines NSW Health 2008

These guidelines aim to provide a benchmark for the delivery of quality psychosocial interventions within AOD treatment services. They recognise the value of such interventions within the AOD field, and support professional implementation of them. They emphasise the need for better understanding about the purpose and benefits of the interventions.

Case study

Kylie is a 22 year old Aboriginal woman referred to our service by Aboriginal Legal Aid (ALS) for detox and rehab for poly drug dependence. She first used illicit substances at age 13 and disclosed daily methamphetamine and cannabis use, and regular heroin use. Prior to referral, Kylie had presented to the local antenatal service at 27 weeks pregnant and had not previously attended antenatal appointments. She was engaged by the Chemical Use in Pregnancy Service (CUPS) team at the local hospital and allocated a Department of Communities and Justice (DCJ) caseworker. Kylie was involved with the criminal justice system and had current charges for which the diversion of incarceration was a motivating factor to seek treatment. She reported a previous suicide attempt and a history of depression.

Kylie is exposed to domestic violence in her current relationship, and while in treatment sought an Apprehended Violence Order (AVO) to protect herself and her unborn child. Kylie's parents have a history of alcohol dependence and while she had resided in her parents' home prior to admission, DCJ deemed it unsuitable for her to return there with her newborn child. Despite these stressors, Kylie was willing to engage in treatment and demonstrated insight into the need to provide a safe environment for herself and her unborn child. She worked openly with staff and external formal supports such as DCJ, CUPS and the ALS to improve her circumstances.

The goal of treatment was for Kylie to detox from illicit substances prior to the birth of her child. Treatment also provided the opportunity for her to stabilise socially and develop a safe and supportive long-term plan. By remaining with us and participating in our short term rehabilitation program following the birth, staff were able to assist Kylie in her transition to motherhood and provide coaching on parenting skills. DCJ recommended that she attend a longer-term rehabilitation program; however, Kylie was able to negotiate an outpatient support program so that she could settle back into the community with her baby. On completion of the program she returned to the community, where she was supported by numerous services to secure appropriate accommodation and engage in key AOD aftercare and parenting supports. Being flexible and extending the service to accommodate the unique needs of Kylie in this circumstance was of great benefit to the client and her family.

Kylie's case study outlines not only the concurrent issues that required attention alongside her substance use, but the benefits of applying a number of best practice approaches for women, including: coordinated case management; harnessing of specialist services not able to be provided by the AOD treatment service; attending to issues related to FDV and mental health issues; being trauma informed; and allowing for client self-determination.

Counselling guidelines: Alcohol and other drug issues 3rd Edition WA Drug and Alcohol Authority (Marsh et al. 2013)

These guidelines includes over 50 chapters exploring some of the key skills needed to work at an individual level with people who have AOD problems including a case management, group work, referral, working with intoxicated and incarcerated clients, clinical supervision and stress and burnout.

Talking therapies for people with problematic substance use Te Pou o Te Whakaaro Nui 2010

This guide provides useful background information on problematic substance use, suggestions for interventions during the various stages of treatment, and information on the range of talking therapies currently utilised by practitioners in New Zealand. Also includes sections on Maori, other Pacific Islander cultures and working with refugees.

2.1 Establishing a gender-responsive service

A gender-responsive approach attends to the experiences of women and, in the context of AOD treatment, focuses on how substance use and dependence is shaped by gender. It also explores how the socialisation process can impact treatment experiences. Being gender-responsive means that the planning of AOD interventions, the language used, how it is delivered and by who, is explored and developed according to the experiences of women. In this context, gender is understood to be "what a society believes about the appropriate roles, duties, rights, responsibilities, accepted behaviours, opportunities and status of women and men in relation to one another. In simple words, people are born female or male but learn to be girls and boys who grow into women and men. This learnt behaviour makes up gender identity and determines gender roles." (WHO 2009).

"Being gender-responsive means that the planning of AOD interventions, the language used, how it is delivered and by who, is explored and developed according to the experiences of women"

Gender-responsive services are those that aim to understand and address issues experienced by women. Gender-responsive approaches may include women-only programs and groups; services with only female staff; provision of on-site childcare; pre-natal, parenting, or other child-related and gender-sensitive program content; and, therapies that focus on issues prevalent among women such as trauma from physical, emotional, and sexual abuse (Covington 2008; Greenfield 2009, Prendergast et al. 2011). While all of these interventions may not be possible in a mixed-gender service at all times, there are areas that might be adapted – such as women-only groups and mixed-gender groups that have very specific guidelines around sensitivity to gender issues.

There is an opportunity to apply a gender-responsive approach in a mixed-gender service that leads to positive outcomes for men such as improved awareness of negative attitudes towards women and their effects. More specifically, through male staff involvement in some aspects of gender-responsive approaches, there can be transfer of learning and role modelling. This approach can have the dual effect of educating male clients in improved behaviours regarding women and reinforcing supportive, non-abusive relationships between men and women. It is important to remember that describing an AOD treatment service as being gender-responsive means that there is more within programs and interventions than simply raising awareness it means that there is a commitment to actually doing something about gender inequality.

Research findings are inconsistent as to whether women-only AOD treatment is more effective for women compared to mixed-gender services. However, incorporating gender-responsive practices within a mixed-gender service could enhance access and retention for women. **Section 6.1** explores specific ways of reviewing practices at a mixed-gender service in order to make it more gender-responsive.

Find out more...*about gender-responsive programming.*

Integrating Gender into HIV/AIDS Programmes in the Health Sector: Tool to Improve Responsiveness to Women's Needs. WHO 2009

This tool helps health-care providers integrate gender into HIV/AIDS programmes they wish to set up, implement and evaluate so they are more responsive to women's needs. It suggests practical actions to address key gender issues. Although related to HIV services the key messages regarding gender responsiveness are easily translated into the AOD sector.

Gender-Responsive Treatment for Women with Substance Use Disorders WATCH (Women and Their Children Heal) 2007 (Bastek-Karasaw & Davis)

The purpose of this document is to offer agencies and programs that serve women with substance use disorders across the continuum of care, a set of sample standards and recommendations for treating problematic drug use in women throughout their lifespan. These recommendations serve as a guide for creating quality gender-responsive treatment and support services for women within a biopsychosocial context, ultimately enhancing their outcomes. The information and recommendations presented here are based on research, reflect best practices in the treatment of addiction in women, and are grounded in women's experiences.

2.2 Adopting a strengths-based approach to treatment provision

A strengths-based approach focuses on finding strengths within the individual, their networks and community. Examples of strengths might be personal competencies, resources, motivations, personal characteristics and positive relationships (McCashen, 2005; Saleeby, 1996). Working from a strengths perspective means identifying positives within individuals and building their network/environment strengths as opposed to the traditional deficits and/or pathology perspective. The strengths-based approach is compatible with resilience theory where the central principle is that in spite of facing adversity people often do well and thrive (Masten 2001) and also encompasses other theories and broader ideas such as empowerment and wellness (Saleeby, 1996).

A strengths-based approach seeks to reveal and reinforce the strengths women bring with them to AOD treatment. Simple ways of including this approach to working with women in AOD services can be through strengths-based questioning. Here are some examples:

- What did it take for you to be here today?
- What is working well for you?
- What have you tried, and what has been helpful in making changes?
- You are resilient, what do you think helps you bounce back?
- What would things look like if they were working better for you?

(Adapted from Change Lives, New Journeys 2013).

A strengths-based approach places women at the centre of AOD treatment provision as the experts on their lives. With this core value underpinning AOD interventions, treatment occurs in a manner that values the experiences of women and seeks to gather the support of willing collaborators that could include other support services, families and community groups. As with a gender-responsive approach, a strengths-based approach to AOD treatment underpins and informs all proposed interventions in ways such as thinking about how language is used, how programs are run and ensuring client consultation. It is embedded in the way organisation themselves are managed.

Find out more...*about a strengths-based approach.*

Strengths-Based Practice: The Evidence UnitingCare (Scerra 2011)

This discussion paper explores the evidence of strengths-based practice, and reports how strengths-based principles can be enacted in different ways in a range of contexts to achieve positive outcomes and to empower the children, young people and families.

Change Lives, New Journeys

A website that relates to living with and supporting those with a lived experience of brain injury – adopting a strengths-based approach.

Website: **www.changedlivesnewjourneys.com**

2.3 Trauma informed care and trauma specific approaches

Trauma is often characterised as resulting from a one-off event. Yet repeated extreme interpersonal trauma resulting from adverse childhood events (`complex' trauma) is not only more common, but far more prevalent than currently acknowledged, even within the mental health sector. The effects of complex (cumulative, underlying) trauma are pervasive and, if left unresolved, can negatively impact the mental and physical health across a person's lifespan. Research shows that the impacts of even severe early trauma can be resolved, and its negative intergenerational effects can be intercepted. People can and do recover and their children can do well. For this to occur, mental health and human service delivery needs to reflect current research insights (Kezelman & Stavropoulos 2012).

AOD treatment services and workers wanting to become trauma informed and engage in trauma-informed care need first connect with these five core principles (adapted from Complex Needs Capable, NADA 2013, based on ASCA practice guidelines for trauma informed care):

- **Safety** – How can workers/AOD services be changed to ensure physical and emotional safety more effectively and consistently?
- **Trustworthiness** – How might a service modify practices so as to engender trustworthiness through task clarity, consistency, transparency and interpersonal boundaries?
- **Choice** – How can services be modified to ensure consumer experiences of choice and control are maximised?
- **Collaboration** – How can services be modified to ensure that collaboration and power-sharing are maximised?
- **Empowerment** – How can services be modified to ensure that experiences of empowerment and the development or enhancement of client skills are maximised?

Women with substance use disorders, and especially those with co-occurring mental health disorders, have a higher likelihood of past experience of traumatic events, including sexual assault and domestic violence.

Drug and alcohol use disorders, mental health and trauma are now recognised as critical and interrelated issues, requiring comprehensive treatment responses (NIDA 2009). Factors associated with early attrition among women with co-occurring PTSD and substance use disorders in treatment include experience of partner violence during adolescence (McCrady et al. 2009). The addition of trauma-focused group behavioural treatments to existing substance abuse treatment has been found to reduce PTSD symptoms in women with co-occurring substance disorders (Resko & Mendoza 2012).

Study findings indicate that despite concerns about potential negative impact of addressing trauma in an AOD context, positive outcomes have been achieved and the interventions have been successfully delivered by a range of clinicians, not necessarily just those with higher degrees or advanced expertise in the area of trauma (Bates et al. 2002).

Trauma informed practice is highly congruent with evidence-based AOD intervention, as outlined in the following table adapted from Trauma Matters: Informed Practices in Women's Substance Use Services (The Jean Tweed Centre 2013).

Examples of Congruence Between Trauma-Informed Practices and Evidence-Based Substance Use Approaches

TRAUMA INFORMED PRACTICE	EVIDENCE-BASED SUBSTANCE USE APPROACHES
Pacing – avoiding the rush to disclosure (the 'action stage' of the trauma recovery experience) and accepting that a woman need not necessarily disclose her experience of trauma	Stages of Change – recognising that different strategies are necessary based on the woman's stage of change regarding her substance use and that action strategies are only appropriate in the action stage of change
Relationship building – accepting the challenge to construct a therapeutic connection over time, recognising that trustworthiness is built slowly and respectfully by honouring the woman's background and experiences	Harm reduction principles – finding goals that are consistent with the woman's current abilities and situation, not necessarily requiring abstinence as a goal
Ensuring safety in the counselling relationship – avoiding aggressively confrontational approaches that can re-traumatise and obstruct safety	Motivational Interviewing – avoiding shame, blame and guilt and focusing instead on learning from setbacks
Providing choice and control	Motivational Interviewing – internalising the focus of control and highlighting self-efficacy
Building empowerment skills	Motivational Interviewing – building on the woman's strengths; asking questions that elicit information, rather than telling in an instructional way
Using a collaborative approach with women instead of a top-down hierarchical model	Harm reduction principles – taking small steps approach Relationship building – the quality of interpersonal relationship may determine whether or not women remain engaged in the process of change; the quality of the interpersonal relationships may be more important that the concrete services received
Strengths and skills based	Motivational Interviewing – providing a menu of options that respond to concurrent life circumstances; recognising the need for support that address a range of areas, such as food security, child care, adequate housing and poverty

The key message is that trauma informed care can be implemented in any service setting and is consistent with strengths-based approaches and family inclusive practices, both of which place the client and worker in a collaborative partnership.

Comprehensive services integrating mental health, substance use and trauma-informed services may provide more effective treatment for women than non-integrated service settings. Provision of more integrated counselling (addressing trauma, mental health and substance use issues) is associated with better outcomes for women (Greenfield 2009).

While the nature of trauma is complex and challenging, the variety of supportive resources and toolkits is vast. A commitment to learn, train and educate around trauma-informed practice is a demonstration of support from AOD workers to women who experience trauma, serving to enhance engagement and retention in AOD treatment.

From the frontline

The impact of enduring symptoms of trauma on AOD treatment and women's quality of life were highlighted during consultations held with AOD treatment services who informed this resource. Some of the issues thought to be a consequence of past trauma that were raised included self-harming behaviours, emotion dysregulation, difficulties with interpersonal relationships, recognising and/or maintaining healthy boundaries, and vulnerability to future trauma. As examples, several informants highlighted the difficulties faced by women who begin emotionally charged romantic relationships during residential treatment, and the negative effect the relationships had on their treatment outcomes when the relationships failed.

"the message from the frontline is that a good understanding of trauma and its ongoing effects on women and their children is essential for all workers in AOD treatment settings."

The increased risk of trauma among Aboriginal women, including intergenerational trauma, was also noted by some informants. AOD workers also raised the issue of the trauma experienced by children following separation from their mothers as a result of Care and Protection Orders, and the long-term implications of such trauma on children's mental health. Network members suggested that opportunities be explored for providing mental health care for children in the context of drug and alcohol treatment for mothers. Overall, the message from the frontline is that a good understanding of trauma and its ongoing effects on women and their children is essential for all workers in AOD treatment settings.

Child sexual abuse, adult sexual assault, high levels of domestic violence and children being removed… we have significant issues with women relating to others and lacking emotion regulation.

In my experience [the issue of trauma] has been substantial. I can't really think of a woman in drug treatment who doesn't have a complex trauma history.

I'd say 90% of the young women we see have a history of some type of abuse, or they've witnessed traumatic events. Many of them come to us with self-harming behaviours, personality disorders, PTSD… It can be difficult because we're a mixed gender service and they're vulnerable to forming a volatile relationship while they're with us.

We help women focus on what is a healthy relationship... If domestic violence isn't addressed women will continue to make unhealthy relationship choices.

Find out more...*about trauma informed treatment.*

Trauma Matters: Guidelines for Trauma-Informed Practices in Women's Substance Use Services Canadian Women's Health Network 2013

The guidelines set out in this document focus specifically on the intersections of trauma and substance use issues among adult women.

Trauma-Informed Treatment Guide for Working with Women with Alcohol and Other Drug Issues 2nd Edition (Marsh et al. 2012)

This manual is for service providers working with women experiencing alcohol and other drug and mental health issues. The manual covers a wide range of topics, such as: assessment and screening; case formulation and the neurobiology of trauma.

Information is also included on working with different populations, such as Aboriginal women and culturally and linguistically diverse women. The manual takes a practical approach with a 'tip sheet' at the end of each chapter and a number of useful appendices, including: information sheets for clients on a range of topics; information for workers to consider when confronting a number of issues, such as domestic violence and assessment tools.

Trauma-Informed Organizational Toolkit for homelessness services (Guarino et al. 2009)

This toolkit offers homeless service providers with concrete guidelines for how to modify their practices and policies to ensure that they are responding appropriately to the needs of families who have experienced traumatic stress. AOD services can also use this resource to assist them in becoming trauma informed.

2.4 Family-inclusive practice

A family inclusive or family sensitive approach, recognises the possibility of harnessing constructive support from family members. It's worth noting that the approach acknowledges that the meaning of 'family' is defined by the client and can include significant others and carers. As already outlined in the previous section of this resource, family and family life for women can be particularly significant and it is therefore a useful target for intervention.

AOD workers have an important role to play in harnessing family inclusivity as a support for treatment with women. According to the Bouverie Centre, "All workers are capable of generating practical ideas for the way your service operates that will improve the quality of life for family, carers, clients and other workers."(1998).

A family inclusive practice approach recognises that interventions are more effective when they include family members. It supports the view that individuals influence other members in their environment, especially family, and that family members, in turn, have an impact on these individuals (Kina Family and Addictions Trust 2005, in NADA 2009). The Tools for Change toolkit was specifically designed to inform AOD workers about working better with family members and carers of problematic substance users was produced by NADA (2009), and provides practical tips, interventions, resources and examples of AOD organisations that have implemented a family inclusive practice approach. In 2018 this toolkit was expanded and NADA in partnership with Family Drug Support and the Ministry of Health NSW Government developed training and additional resources. You can use these resources to increase your capacity to support families and significant others impacted by substance use by:

- completing the eLearning modules to increase your knowledge and ability to apply evidence based practice approaches that support families and significant others
- using the facilitator guide [PDF] and slides [PPTX] to run your own in-service that specialises in supporting families and significant others impacted by the AOD.

The family inclusive practice approach also attends specifically to parenting. While parenting is not the exclusive preserve of women, support for improved parenting has benefits for both mother and child(ren). "Women are typically primary carers, especially in single parent families," (Marsh et al. 2012) and while being a parent can be a potential barrier to women accessing AOD treatment, it can be a motivating factor for reaching out and getting support. Family inclusive practices seek to build on the strengths of the parent-child relationship while working with areas of difficulty. Specific parenting related interventions are explored in **Section 4.**

I heard [service] has a good reputation, it is a long-term rehab which I need. I liked the sound of the program and that my son could visit and stay. It's also very family orientated and [caters to] a smaller number of women.

I picked this service because it deals with the issues that I need to deal with, such as parenting issues.

While many services may not have the option for children to stay or be able to run dedicated parenting programs, there are alternative strategies they can utilise for being more family inclusive, as outlined below:

- Setting up specific times and appropriate spaces for family/children to visit.
- Having particular environments that are welcoming to children; eg, waiting areas or gardens.
- Involving specialist parenting services to provide workshops to clients as part of their regular program.
- Using parenting examples in the context of therapeutic groups as appropriate – many of the skills are relevant to 'coping skills rehearsals' and identifying the stressors that might be a precursor to relapse.
- Engaging clients in developing information brochures that target family members, providing details about the experience of AOD treatment as a way of demystifying the process.
- Having open days, art exhibitions, picnics and other activities so that family members can attend.
- Single session therapy, an effective and efficient therapeutic approach that addresses family needs without requiring a long-term commitment to therapy.

Family inclusive approaches start with conversations about families and significant others. Within the context of an assessment, questions related to family, children and parenting can be asked that provide some acknowledgment of the impact families and significant others may be having and furthermore, what plans might be made to put in place to be inclusive of them. For more concrete examples of incorporating family inclusive practice in your workplace refer to **Section 6** of this resource.

Find out more...*about Family Inclusive and Family Sensitive Practice.*

NADA Working with Families resources

NADA in partnership with Family Drug Support and the Ministry of Health NSW Government, developed training and resources for the AOD sector and other primary health contacts to build the capacity of workers to better support families who are impacted by someone else's substance use. You can use these resources to increase your capacity to support families and significant others impacted by substance use by:

- completing the eLearning modules to increase your knowledge and ability to apply evidence based practice approaches that support families and significant others
- using the facilitator guide [PDF] and slides [PPTX] to run your own in-service that specialises in supporting families and significant others impacted by the AOD.

Website: **www.nada.org.au/resources/working-with-families/**

Tools for Change: A new way of working with families and carers NADA 2009

This toolkit seeks to improve the support offered to the families and carers of clients who access AOD services in NSW, moving towards a more family inclusive model where all parties are considered engaged, supported and involved.

A Checklist for Family Sensitive Practice for the Alcohol and Other Drug Field NCETA 2010

This checklist comes as part of the Family Sensitive Policy and Practice Toolkit, and provides a comprehensive checklist for reviewing how oriented to family inclusive practice an AOD service is.

2.5 Evidence based interventions and coordinated case management

The approaches outlined above (gender-responsive, strengths-based, trauma informed and family inclusive) provide best practice frameworks to AOD treatment for women. These frameworks guide and shape the way a range of therapeutic modalities, accepted as effective for use with general AOD treatment populations, can be applied when working with women. In short, many of these generalist interventions are aligned with the needs of female substance users or are capable of being adapted to gender-specific treatment needs, including:

- **Behavioural therapies:** Dialectical Behaviour Therapy (DBT), Acceptance and Commitment Therapy (ACT), Community Reinforcement Approach (CRA)

  These therapies focus on improving interpersonal, self-regulation and distress tolerance skills by integrating behaviour strategies and mindfulness practices. CRA for example seeks to reinforce positive or non-substance using behaviours as opposed to ongoing substance use behaviours.

- **Cognitive Behavioural Therapy (CBT)**

  CBT is a structured therapy that aims at adjusting thoughts and behaviours that control problematic behaviours. CBT focuses on the cognitions, or interpretations of events that lead to actions and emotions incorporating strategies such as skills rehearsals and relapse prevention.

- **Motivational Interviewing (MI)**

  Motivational Interviewing is based on the Stages of Change (Prochaska & DiClemente 1982), and incorporates a specific set of interviewing strategies designed to guide an individual through different stages in the process of changing behaviour. The core goals of MI are to generate behaviour change by assisting the individual to resolve ambivalence about treatment and reduce their substance use.

- **Narrative Therapy and Mindfulness**

  Narrative Therapy is a collaborative and non-pathologising approach to counselling and community work which centres people as the experts of their own lives. A narrative approach views problems as separate from people and assumes people as having many skills, abilities, values, commitments, beliefs and competencies that will assist them to change their relationship with the problems influencing their lives. It is a way of working that considers the broader context of people's lives particularly in the various dimensions of diversity including class, race, gender, sexual orientation and ability.

  Mindfulness is a modern reworking of ancient meditation traditions, principally Buddhist. It is designed to help people deal with day to day difficulties by putting the individual in control of their own mind. The aim of mindfulness therapy is to help the individual learn to be aware of their thoughts and bodily sensations and in so doing be able to better cope with day to day emotions and problems.

  While these approaches are less researched as those described above, they may be just as effective and are in keeping with the themes of trauma-informed practice, a strength-based approach, a gender-responsive approach and family inclusive practice.

- **Self-help groups**
  Self-help groups are groups of people with common experiences related to their substance use that meet together in order to support each other, share practical help and obtain goals of either abstinence or reduced harm associated with ongoing substance use.

- **Peer support work**
  Peer support work is undertaken by those who have a lived experience of substance use and/or have other common experiences such as their age or social connections. Peer support involves a range of activities designed to support, in a non-professional way, others who may be distressed or isolated.

When adapting these treatment modalities to match with the frameworks already explored as best practice in the AOD treatment of women, the following questions can be asked:

1. How might these therapeutic modalities be shaped by gender?
2. What modifications in language, approach or delivery might make them more gender sensitive?
3. How might the intervention be tailored for specific client needs?

For interventions to be most effective, they need to be tailored to clients' needs and address specific risk factors. The evidence indicates that the overarching principles of what works in women's treatment for drug and alcohol issues are targeted and gender responsive services. Furthermore, AOD treatment service workers are often well placed to coordinate or be part of a coordinated case management approach that ensures services 'wrap around' the women they are trying to support. Exploration of coordinated case management, as adapted from the Complex Needs Capable resource (NADA 2013), is presented in the next section.

Find out more...*about different therapeutic modalities outlined above.*

NSW Health Drug and Alcohol Psychosocial Interventions: Professional Practice Guidelines NSW Health 2008

These guidelines aim to provide a benchmark for the delivery of quality psychosocial interventions within AOD treatment services. They recognise the value of such interventions within the AOD field, and support professional implementation of them. They emphasise the need for better understanding about the purpose and benefits of the interventions.

Counselling guidelines: Alcohol and other drug issues 3rd Edition WA Drug and Alcohol Authority (Marsh et al. 2013)

These guidelines includes over 50 chapters exploring some of the key skills needed to work at an individual level with people who have AOD problems including a case management, group work, referral, working with intoxicated and incarcerated clients, clinical supervision and stress and burnout.

Talking Therapies for people with Problematic Substance Use Te Pou o Te Whakaaro Nui 2010

This guide provides very useful background information on problematic substance use, suggestions for interventions during the various stages of treatment, and information on the range of talking therapies currently utilised by practitioners in New Zealand. Also includes sections on Maori, other Pacific Islander cultures and working with refugees.

COORDINATED CASE MANAGEMENT

Case management is a process designed to coordinate supports, interventions and other services in response to the needs identified by clients through assessment. One of the important features of the coordinated case management of women engaged in AOD treatment is a collaborative approach that places the client at the centre of the planning. In this approach, the AOD worker acts very much like a coordinator of both the

therapeutic interventions they can provide given their skill base, as well as the sourcing and implementation of external specialist services. It is useful to seek clarity within your organisation about identifying a particular approach to coordinated case management given that different approaches have different levels of intensity (NSW Dept. of Health 2008).

As outlined in the NADA Complex Needs Capable resource, there are two preferred case management approaches when working alongside clients with complex needs: Proactive and Assertive case management (2013), and these are in keeping with the needs of women in AOD treatment. The following elements are essential whichever case management approach is implemented:

- Establishing a trusting relationship with clients
- Establish close and frequent communication with them (eg, check-ins and regularly scheduled meetings)
- Develop a care plan based on their goals, strengths and needs
- Facilitate transportation for important appointments
- Liaise with other service providers with consent
- Assist the development of life skills and/or the person's participation in healthy, safe activities
- Establish close communication with supportive significant others in the person's life
- Advocate for improved communication among service providers, continuity of care and access to care/services.

(Complex Needs Capable, NADA 2013:35)

Find out more...*about various types of case management.*

Complex Needs Capable: A Practice Resource for Drug and Alcohol Services NADA 2013

Complex Needs Capable and the accompanying website was developed to build capacity within the non-government drug and alcohol sector by supporting the development of staff skills, knowledge and confidence, and of organisational capacity in responding to the needs of people with drug and alcohol issues and complex needs such as cognitive impairment and criminal justice system contact.

Website: **www.complexneedscapable.org.au**

Case management in the substance abuse field: insights from the research literature 2005 (McDonald)

Prepared as a contribution to the process of establishing new policies and activities in case management, this paper presents insights from the published research literature, identifying and assessing how case management is used in the AOD sector and its results.

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Pathways of recovery 2005 (Rickwood)

The paper considers definitions of the terms 'relapse' and 'relapse prevention' and discusses the place of relapse prevention within the spectrum of interventions for mental health. Relapse prevention and the related concept of rehabilitation are placed under the umbrella of recovery, which comprises treatment and continuing care.

2.6 Women's sexual health and safety in AOD treatment

Substance use is frequently a gendered experience for women, where initial substance use experimentation can be associated with intimate relationships and sexual experiences. While the exploration of links between substance use and sexual experiences is the domain of therapeutic work in AOD treatment, there are opportunities to provide information and education specifically around sexual and reproductive health, and contraception in particular.

"Negotiating safe sex and contraceptive use can be difficult for young women (WHO, 2006) even when they can access contraception. Power differentials in relationships mean they are not always in a position to insist on condom use, and young women with poor body image or those in violent relationships are more at risk. These types of findings reinforce the importance of exploring sexual behaviour and safety whenever women present for assistance in an AOD treatment setting. Furthermore, there are strong associations between women's problematic substance use and traumatic sexual events, such as childhood sexual abuse and sexual assault as an adult (Willis & Rushforth 2003). Substance use is a common coping mechanism for dealing with sexual trauma.

There can be additional layers of substance use and sexual interaction between transgender women and their partners, as a way of being able to interact with their body in ways that feel more comfortable, or more distanced. Drug use in the context of sex was reported among 15% of trans people in the past year (Callendar & Cook 2019)

Women who have lengthy histories of problematic substance use may be less likely to have engaged with routine sexual and reproductive health check-ups; these areas of need may be addressed in the context of AOD treatment via referral to a specialist clinic. Furthermore, AOD treatment provides an opportunity to engage in harm minimisation education about STIs as well as BBVs (hepatitis C and HIV).

The gendered experience of drug use also extends to injecting behaviour where women are frequently introduced to injecting drug use by male partners who may then control the attainment of drugs and injecting equipment (Pinkham & Sempruch 2007; Shannon et al. 2008). Women have been found to be more likely than men to use drugs with many partners; share paraphernalia after a partner has injected; have difficulty negotiating condom use with their sex partners; and, exchange sex for money or drugs (Maher & Hudson 2007; Ashley et al. 2009)

The prevalence of women entering treatment who have in the past year exchanged sex for money and/or drugs is high (30-40%) (Burnette et al. 2008; Sallmann 2010). Women who work in the sex industry, particularly street-based sex workers, have high rates of drug and alcohol use and dependence, including intravenous drug use and poly-drug use, as well as increased risk of contracting blood borne viruses (Roxburgh 2008; Simpson & McNulty 2008). A recent study found that women who work in the illegal sex industry have significantly poorer mental health than those working in brothels or privately (Seib et al. 2009).

An investigation into street-based sex work in Sydney found that many workers initiated sex work to obtain money for drugs (Roxburgh 2008). Working in the sex industry is associated with higher risk of physical and mental health problems, primarily among those involved in street-based sex work, and is often linked with socio-demographic disadvantage.

Harm reduction and outreach are indicated as best practice approaches for women who engage in street-based sex work, given their transience. However, AOD treatment services that use best practice modalities (as outlined in **Section 2.6**) that are gender-responsive and trauma informed are also effective.

ESTABLISHING AN ENVIRONMENT THAT PROMOTES SEXUAL SAFETY

Having awareness of the impact of past experiences of sexual assault on women that present for support to AOD treatment services, is essential to ensure that future sexual safety be a consideration – particularly in mixed-gender residential services. The following aspects of AOD service provision should be considered in order to promote sexual safety.

- Review the environment by specifically taking into account sexual safety.
- Review policies and procedures that relate to how staff and clients use the physical spaces.
- Integrate trauma informed care organisation-wide and to all aspects of treatment.
- Clearly display education material regarding sexual safety.
- Provide education to all clients about sexual safety and their responsibilities regarding the sexual safety of others.
- Ensure there are policies and procedures regarding response to alleged sexual assault.
- Make links with specialist services regarding sexual safety and sexual trauma.
- Availability of condoms, dental dams and lube.

For information on safety for women in a mixed-gender setting see **Section 6.1.**

Find out more...*about sexual safety (examples taken from the mental health sector).*

Sexual Safety of Mental Health Consumers Guidelines NSW Health 2013

The purpose of these guidelines is to support mental health services to meet their responsibilities in relation to the sexual safety of mental health consumers through the provision of practical advice and strategies; promote sexual safety to key stakeholders, health staff and managers, consumers and their families and carers; clearly outline the information consumers and their families and carers should receive about their rights and obligations in relation to the sexual safety of consumers; and improve collaboration and strengthen relationships between mental health services and sexual assault services.

Promoting Sexual Safety, responding to sexual activity, and managing allegations Vic. Health 2009

This Chief Psychiatrist's guideline sets out the relevant legislation and policy, and establishes minimum standards for the clinical management of sexual activity, and the appropriate staff response to patients who report inappropriate sexual activity in adult acute inpatient units. It provides guidance on decision making processes and clarifies the circumstances where clinical discretion may apply.

Find out more...*about women sexual and reproductive health.*

Sexual Health Info Link: NSW Sexually Transmitted Infection Programs Unit (STIPU)

Phone: 1800 451 624
Website: **www.shil.nsw.gov.au**

This website and hotline provide resources, access to information and education and the contact details for services related to STIs.

Women and Sexual and Reproductive Health: Position Paper AWHN 2012

This paper advocates for a rights-based approach to ensuring all women can access comprehensive sexual and reproductive health care appropriate to their needs, regardless of their location, age, sexuality, financial status and religious and cultural background.

2.7 Assertive follow-up, outreach and continuing care

Continuity of care when working with women in AOD treatment can take a number of forms, but what is important is the consistent provision of quality care over time. In practice, there are three interventions that support women when they are in the community that provide support whether they are actively involved in other AOD treatment or not. These are:

1. **Assertive follow-up**
   A process of checking in with clients via SMS, phone call, email or letter as a means of support or following up missed appointments.
2. **Outreach**
   A type of AOD service provision that seeks out women who may not otherwise access their service, usually conducted as a mobile service.
3. **Continuing care**
   The provision of support and/or services after or at the conclusion of a specific AOD treatment program, it may take the form of a support group, leisure activity, supported accommodation or case management.

Assertive follow-up for those who miss appointments can help by providing the opportunity to reschedule, to identify and discuss any problems, and to remain engaged. Post-treatment outreach and aftercare services provide the opportunity for transitional support back into the community and to consolidate skills learnt in the treatment setting, including relapse prevention, problem-solving, harm-reduction and self-help skills. Women with complex needs have an increased chance of experiencing setbacks, so post-treatment follow-up can be key to helping them maintain healthy treatment outcomes.

Best practice research indicates that people who participate in follow-up or continuing care after exiting a service have better long-term outcomes. Structured aftercare programs can help provide additional support for people during the transition from treatment into the community. Family, carers or other support people in the person's life should be involved in continuing care planning and treatment where possible (NADA, Complex Needs Capable 2013).

Participation in self-help or continuing care programs is a strongly supported modality for female substance users. Self-help participation was more strongly associated with moving from 'using' to recovery for women than for men in substance use treatment. This finding is consistent with the results of a longitudinal study showing that women seeking help for alcohol problems were more likely than men to participate in self-help groups and to have greater reductions in drinking concurrent with their self-help participation at both 8 and 16-year follow-ups (Grella et al. 2008).

3 IMPROVING ACCESS AND RETENTION FOR WOMEN FROM DIVERSE BACKGROUNDS

KEY POINTS AND PRINCIPLES

- Recognition of diversity and a demonstrated understanding of the issues experienced by women from diverse backgrounds are essential in creating a sense of safety, support and trustworthiness at a worker and organisational level.
- Diversity is a strength that can both motivate and sustain improvements in a client's life and in relation to their general wellbeing.
- Cultural sensitivity and competency are essential to the AOD treatment workforce.
- "Ask the question…" Enquire about potential diversity and show an interest in the response (including expressions of social and cultural identity, sexual orientation and gender identification).
- Working effectively with diversity is about adapting best practice approaches through collaborations with representatives from the specific groups you wish to target.
- Family and community-inclusive practice facilitates improved outcomes for women from diverse backgrounds.
- Forging strong partnerships with specialist diverse population services is an effective way of drawing on already established networks and best practice strategies.
- An awareness and appreciation for diversity among the clients that access AOD treatment can allow for unique opportunities for intervention.

Identifying the qualities that are associated with specific social and cultural backgrounds can become a focus for building identity, belonging and empowerment. Diversity and the related best practice approaches with specific diverse populations of women are explored in this section.

3.1 Working effectively with Aboriginal and Torres Strait Islander women

Cultural awareness and sensitivity are central elements for working effectively alongside Aboriginal and Torres Strait Islander women. "Cultural competency can be understood to involve working within a framework that recognises and respects the central importance of culture and identity to Aboriginal and Torres Strait Islander people and communities, working in ways that safeguard the importance of culture, and supports Aboriginal and Torres Strait Islander people's capacity to strengthen the place of culture and identity in promoting social and emotional wellbeing." (NIDAC 2014).

The complexity of issues faced by many Aboriginal people include high rates of trauma (including intergenerational trauma), histories of family separation or disruption and elevated experiences of grief related to early deaths and high rates of incarceration (Lee et al. 2013).

"Past Australian government policy and practices enabled the destruction of Indigenous kinship groups, languages and cultural rituals through the forcible removal and separation of Aboriginal and Torres Strait Islander children from their families and kinship networks over some five generations (Ranzijin et al. 2010).

The B*ringing Them Home report* (HEROC 1997) concluded that the forcible removal of children was an act of genocide and that the consequences for Indigenous peoples continue to reverberate today" (NADA 2013). Overt recognition and compassion for the historical experiences of oppression experienced by Aboriginal people by AOD treatment organisations is a useful starting point from which to improve work practices with Aboriginal women.

Indigenous women commonly have many responsibilities within their extended families and household, often having main responsibility for looking after the health of children and other family members (Burns et al 2010). Aboriginal women may also have increased concerns and fears of intervention from child protection agencies and other services, which act as a barrier to their engagement in treatment (Lee et al. 2014, Allan & Campbell 2011).

The National Indigenous Drug and Alcohol Committee identified key principles for the effective AOD treatment with Aboriginal women. They have been adapted from NADA *Working with Diversity in Alcohol and Other Drug Settings* (2014) resource and presented here:

- **Evidence-based and evidenced-informed treatment**
  Adaptations of evidence-based mainstream interventions that integrate culturally specific practices, including traditional values and reference to spirituality have been shown to be more effective than mainstream services. These elements increase the credibility and relevance of treatment to Aboriginal and Torres Strait Islander people (Terrell, 1993; Anderson, 1992; McCormick, 2000; Brady, 1995b; Gray et al., 2014).
- **Cultural competency, safety and security**
  For workers and services, cultural competency can be understood to involve working within a framework that recognises and respects the central importance of culture and identity to Aboriginal and Torres Strait Islander people and communities.
- **Family and community involvement**
  When working with Aboriginal and Torres Strait Islander people, involvement of family and community members can be pivotal in achieving best outcomes for an individual (Nagel et al., 2009).
- **Aboriginal and Torres Strait Islander ownership of solutions**
  Indigenous ownership of solutions is identified as needing to occur, from inception and planning, through to implementation and provision, and then monitoring and evaluation of any solutions.
- **Integrated services and partnerships**
  Given the complex, multiple needs of people with AOD issues, it is important for specialist AOD treatment services and other services to be well integrated to ensure that people receive all of the services and support they need in a timely fashion and in a way that is easy to access.

Recommendations for responding to Aboriginal women are similar to those recommended for non-Aboriginal women, including addressing co-occurring trauma and mental health issues by "holistically and simultaneously, within an Aboriginal worldview, using a strengths-based approach" (Niccols 2012:331), including linking the support of mothers with their children and cultural components. For example, gender mixing in some services may conflict with cultural perspectives (Taylor et al. 2010).

The Community Reinforcement Approach (CRA) and its adjunct program Community Reinforcement Approach and Family Training (CRAFT) are effective behavioural approaches that use social, family and recreation as positive reinforcers for not drinking alcohol – in contrast to the reinforcing factors that may maintain problematic drinking (Meyers et al. 2011). These interventions are considered to be consistent with the influential role that family and community can play in the lives of Aboriginal and Torres Strait Islander people (Calabria et al. 2013). In a NSW-based study among Indigenous adults, over 90% of participants found that this intervention was considered acceptable to be delivered in their community (Calabria et al. 2013).

For Indigenous women specifically, an evaluation of a 'soft entry' drug and alcohol intervention strategy aimed at Aboriginal Australians in an area of rural NSW found that the approach demonstrated great effect, particularly in regard to increasing the number of Aboriginal women accessing drug and alcohol services in that community (Allan and Kemp 2011). Drug and alcohol counsellors provided access to their services at Aboriginal community events, groups and gatherings. Although no treatment outcomes were measured, the study found the soft entry approach provided services in a way that was acceptable to those receiving them and women were particularly positive.

"Our service has achieved greater engagement with Aboriginal women in our community by facilitating groups and offering services in a lively non-threatening environment and encouraging consumers to bring another community member to share the learning experience and build community capacity."

Our day program idea is attractive for Aboriginal women. They like the idea that they don't have to go away [to rehab]... this gives women anonymity and they can be discreet... they've told me "No one knows I'm in a treatment program – I'm just not available for a few hours a day. I say I'm doing a course."

While it is not always possible to implement significant program changes quickly, the instigation of mutually beneficial partnerships with either Indigenous-managed or Indigenous-focused services can be an extremely powerful place to begin. "It is preferable that all drug and alcohol and mental health services identify and form partnerships with a local Aboriginal health service if they do not have an Aboriginal worker within their team. This helps provide culturally appropriate care." (NSW Health 2009). Developing a Reconciliation Action Plan (RAP) is a concrete way to demonstrate a commitment to reconciliation and support for Aboriginal and Torres Strait Islanders by your organisation. Furthermore, actively seeking to employ Indigenous staff can enhance program delivery to Aboriginal and Torres Strait Islander clients.

Find out more...*about working with Aboriginal women.*

Alcohol and other drugs treatment guidelines for working with Aboriginal and Torres Strait Islander people – in a non-Aboriginal setting

While we know that Aboriginal Community Controlled Health Organisations are essential in the provision of specialist AOD treatment for Aboriginal people, it is important that non-Aboriginal service settings are safe and accessible for Aboriginal people who access these services.

The Guidelines are intended to support services to establish better relationships and linkages with Aboriginal organisations and in Aboriginal communities. The Guidelines also provide practical guides and resources to support workers and organisations to improve their service delivery when working with Aboriginal service users.

Website: **www.nada.org.au**

Handbook for Aboriginal Alcohol and Drug Work University Of Sydney 2012 (Lee et al. Ed.s)

This book has been written as a practical tool to use in everyday AOD work, and to be combined with individual skills and local knowledge. It offers a detailed look at alcohol and other drug work from clinical, through to prevention, early intervention and harm reduction. This handbook takes into account the complex challenges facing workers when helping clients, their families and, sometimes, whole communities.

Aboriginal-specific Community Reinforcement Approach (CRA) Training Manual NDARC 2014 (Rose et al)

The Community Reinforcement and Family Training (CRAFT), approach has been used in a number of settings with different population groups. The approach includes two components; the Community Reinforcement Approach (CRA) for working with individuals who are at risk of alcohol related harm and Family Training (CRAFT) for working with their families and loved ones. Evaluations suggest this two-sided approach is more effective for encouraging individuals into alcohol treatment and for assisting family members to feel less depressed, anxious and angry. Most importantly CRAFT appears to fit well with Indigenous views of health and health care that are holistic and dedicated to '… the social, emotional and cultural well-being of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community'.

Implementing a soft entry approach to AOD intervention with Aboriginal women Lyndon Community 2014

This presentation discusses the outcomes of delivering a soft entry approach via an existing community group (Apollo House) in an Aboriginal community in Dubbo. Feedback from a focus group comprised of a variety of community members who have accessed drug and alcohol support in this community will highlight the way day to day practice assesses the suitability and applied evidence of the soft entry approach.

NIDAC AOD Treatment Report NIDAC 2014

This paper was developed by the National Indigenous Drug and Alcohol Committee (NIDAC) in response to a misperception that effective AOD treatment is not available for Aboriginal and Torres Strait Islander peoples. The paper aims to allay these misperceptions by outlining who can benefit from receiving treatment. what treatment is known to work; key principles that should guide the application of treatment and what constitutes effective treatment for Aboriginal and Torres Strait Islander people.

Working with Diversity in Alcohol and other Drug Settings NADA 2014

The resource has been developed to support non government alcohol and other drug services work with the diversity of clients that access our services and represent the NSW population. It contains examples of best practice.

A supplementary document: ***Working with Diversity in Alcohol and other Drug Settings – Useful Resources*** NADA 2015 also provides a comprehensive list of updated resources of use.

Australian Indigenous HealthInfonet

A web resource that is a 'one-stop info-shop' for people interested in improving the health of Indigenous Australians.

Website: **www.healthinfonet.ecu.edu.au**

3.2 Increasing supports for culturally and linguistically diverse women

The last census conducted in Australia revealed that over a quarter of the population was born overseas (ABS 2012). Multiculturalism is one of the themes of Australian life however the responses to the needs of people from different cultural heritages have not kept pace. That culturally and linguistically diverse (CALD) communities' have low levels of engagement with AOD treatment services is reflected in national data on treatment utilisation. Although CALD populations may have lower alcohol and other drug use issues when compared to Aboriginal, Torres Strait Islander and Anglo populations, it is apparent from treatment data that those who do experience difficulties are less likely to seek or complete treatment due to cultural attitudes, religious beliefs and conventional patterns of use.

Women from CALD communities commonly experience two key issues related to potential problematic drug or alcohol use: the stress of migration and mental health problems (Browne & Renzaho 2010, Flaherty et al. 2010). Among those in the CALD community, refugees and asylum seekers in Australia are particularly vulnerable to, and affected by, homelessness. Women from CALD backgrounds may also experience violence at increased rates and be at greater risk of victimisation than women from non-minority backgrounds (Roarty & Saggers 2009). Women from CALD backgrounds come into contact with AOD treatment services often as a result of the substance use of a family member or loved one (Lee et al. 2014).

A range of issues have been identified that present barriers for CALD communities accessing treatment, and highlight specific needs and areas relevant for treatment practices. They include:

- language difficulties and lack of availability of translation services
- social stigma
- lack of family and/or community support
- insecure living conditions
- immigration statuses that impact on eligibility for many social and health supports
- cultural perceptions including spirituality and beliefs around health and/or drug and alcohol use that may be different to western models of health and harm reduction approaches (Roarty & Saggers 2009, Flaherty et al. 2010)
- for older women in particular, language barriers and the social stigma attached to seeking treatment can both be major factors in accessing help.

More time may be needed to build the trust and rapport of CALD women. Also, additional services such as long-term English-language learning and one-on-one case worker support are recommended to assist women to engage in treatment and support their long-term recovery (Roarty & Saggers 2009). Best practice would also indicate the need for training in the area of cultural sensitivity, which enables workers to better appreciate the influence of culture on identity and the experiences of women from different cultural backgrounds.

Many of the strategies and best practice approaches already indicated as effective for women more generally (eg, trauma informed services) are also relevant for services aimed at engaging women from CALD backgrounds. Experiences of trauma specifically related to war and state-sanctioned violence may require additional specialist assistance which may be sought through partnerships with refugee-related services. It is particularly important that treatment programs build on women's strengths, use supportive rather than confrontational approaches, and involve women-only groups or mixed-gender programs that incorporate strong policies related to sexual harassment and safety (Roarty & Saggers 2009). Attention needs to be given to family structures and different cultural approaches to parenting within the context of adapting to the Australian culture. Experiences of difference around the family system and an Australian approach to health and family violence may also be barriers to seeking assistance.

Services in NSW have reported variable success in attracting women from CALD backgrounds. Feedback from services involved in the needs analysis that informed this resource identified a lack of understanding about women's cultural backgrounds and lack of research into the literacy needs of women from CALD backgrounds as gaps in service provision for these women.

We have good mix of staff with different languages… it does help to have a team with different languages.

We try to celebrate the different cultural events as we have women for 12 months...

We don't capture as many [women from CALD backgrounds] as we would like to… we don't recruit well either...

This feedback from the frontline is a good indication of areas needing improvement in order to work effectively with CALD women. It also allows us to put forward some solutions:

ISSUE TO BE ADDRESSED	INTERVENTION
The need to learn and understand different cultural backgrounds and the experience of living in a different culture	• Engage women to 'tell their story' specifically in relation to the story of their culture and what it is like to be in Australia. • Celebrate different cultural events, foods, practices, leisure activities, films within the context of the therapy.
Language barriers	• Examine recruitment processes for staff and volunteers from different cultural backgrounds and with different language skills. • Develop resources in different languages. • Foster the use of peers from CALD backgrounds. • Find out about services with bilingual staff.
Lack of supports and networks	• Engage specialist social and cultural organisations and ethno-specific agencies. • Explore cultural support networks unrelated to AOD treatment. • Include CALD training in regular professional development plans. • Identify women-only services or gender-separated programs if preferred.

Find out more...about CALD communities

Respect: Best practice approaches for working with culturally diverse clients in AOD treatment settings DAMEC 2014

Simple tips for working with clients from culturally and linguistically diverse backgrounds in alcohol and other drug treatment settings. This broadsheet draws on DAMEC's previous research, service evaluations and sector-wide consultation processes to draw together 10 key strategies for practitioners.

Website: **www.damec.org.au**

Common Threads, Common Practice Best Practice Guide: Working with Immigrant and Refugee Women in Sexual and Reproductive Health Multicultural Centre for Women's Health(MCWH) 2012 (Hach)

Common Threads, Common Practice provides a concise, easy to use reference guide for best practice when working with immigrant and refugee women in sexual and reproductive health. It is informed by the Common Threads Research Report published in 2012 by MCWH, which is also available for download.

Website: **www.mcwh.com.au**

Working with Diversity in Alcohol and other Drug Settings NADA 2014

The resource has been developed to support non government alcohol and other drug services work with the diversity of clients that access our services and represent the NSW population. It contains examples of best practice.

A supplementary document: ***Working with Diversity in Alcohol and other Drug Settings - Useful Resources*** NADA 2015 also provides a comprehensive list of updated resources of use.

Working with refugees family project Australian Centre for Child Protection, University of South Australia 2009

This report outlines the findings of a three stage research project designed to examine why recently arrived families from refugee backgrounds are presenting to the child protection system and to identify culturally appropriate strategies and models for intervention.

Talking therapies for people with problematic substance use Te Pou o Te Whakaaro Nui 2010

This guide provides useful background information on problematic substance use, suggestions for interventions during the various stages of treatment, and information on the range of talking therapies currently utilised by practitioners in New Zealand. Also includes sections on Maori, other Pacific Islander cultures and working with refugees.

Helping asylum seeker and refugee background communities with problematic alcohol and other drug use: A guide for community support and AOD workers QNADA 2015 (Pont B and Jaworski A)

The guide is divided into two sections, the first is for workers supporting people from refugee backgrounds across the general health and community services sector who may not have specific training or experience in alcohol and other drugs service provision. And the second is for those working in the AOD sector and discusses issues that are relevant across the range of treatment settings.

3.3 Enhanced service-provision for women from LGBTQ+ communities

Sexuality and gender diverse people include cis and trans women who are lesbian, queer, bisexual, or pansexual, as well as trans women who are heterosexual. This can also include non-binary people of all sexualities, but it is important to not include non-binary people under the label of women, as while many non-binary people share the health experiences of women (trans and cis), non-binary people are not women and should not be referred to or treated as such.

Sexuality and gender diverse women may also have intersex characteristics, or belong to other minority population groups – Aboriginal and Torres Strait Islander, culturally and linguistically diverse communities, people living with a disability – making an intersectional lens vital to understanding each individual's experiences and health needs.

For more information about specific LGBTQ+ communities, see sections **3.3.1** and **3.3.2**

The Sydney SWASH Report (Mooney-Somers, J, Deacon, et al 2018) found that the rate of smoking amongst lesbian, bisexual and queer (LBQ) women is double that of non-LBQ women. In addition, an NDSHS 2016 found 13% of women in Australia reported using any illicit drug in the past 12 months, compared to 47% in the sample from the Sydney SWASH Report (2018) who reported using any illicit drug in the past 6 months. Echoing these disparities, the NDSHS found homosexual and bisexual people (not disaggregated by gender) generally reported recent illicit drug use several times higher than heterosexual people.

The First National Trans Mental Health Study (Hyde Z, Doherty M, et al 2014) reported that "Participants (trans and non-binary people) were approximately twice as likely to have used an illicit drug than the general population in the last 12 months."

International research has shown that while LGBTQ+ people may have greater unmet substance use treatment needs than non-LGBTQ+ people, they are often reluctant to seek treatment because of expectations of prejudice and discrimination from health care providers (Couch et al. 2007; Burgess et al. 2008, Grella et al. 2009, Senreich 2009 – source from ACON Health AOD Strategy). A study of young same sex attracted women and men in Sydney showed that while drug treatment utilisation was high compared to estimates in the general population, it was low relative to the proportion of participants reporting harmful patterns of substance use (Lea et al. 2013).

> "Preventing discrimination and stigma is an essential aspect of any comprehensive approach to reducing AOD and MH (Mental Health) problems amongst GLBT. Measures which reduce the stigma and discrimination against GLBT people are likely to have powerful public health impacts." (ACON 2013).

A range of specific characteristics and treatment needs have been identified for LGBTQ+ substance users. Due to the elevated prevalence of drug and alcohol use in the LGBTQ+ community, and potentially earlier age of commencing use, LGBTQ+ clients may enter treatment with more severe substance use problems than non-LGBTQ+ clients and have an elevated prevalence of preventable mental health issues (Green & Feinstein 2012). Socialising in the LGBTQ+ communities often occurs in settings where drugs or alcohol are available, increasing the risk of substance use and relapse after treatment (Senreisch 2009; Drabble & Eliason 2012).

People from LGBTQ+ communities face unique barriers when seeking and staying in substance use treatment, including providers and other consumers who hold homo/bi and trans phobic beliefs and attitudes or who lack knowledge about the LGBTQ+ community and their health needs (Senreisch 2009; Drabble & Eliason 2012; Green & Feinstein 2012). Furthermore, elevated levels of substance use in the LBTI community can lead to unique expectations and perceived normality around drug and alcohol use, increasing the likelihood of individuals choosing to drink heavily or use drugs and consequently affecting treatment goals.

A comprehensive literature review on the prevalence of mental health issues, AOD problems, and intervention responses in the LGBTQ+ community conducted by NDARC in 2012 concluded that:

- Prevention is a priority principle with LGBTQ+ people; both AOD and mental health (MH) problems are preventable, and interventions such as supportive counselling during adolescence are likely to reduce the risk of later mental health or substance use problems.
- Preventing discrimination and stigma is an essential aspect of any comprehensive approach to reducing AOD and MH problems among LGBTQ+ people.
- All AOD and MH services should be LGBTQ+ sensitive. This entails ensuring an adequately trained workforce, culturally appropriate services and a non-judgemental attitude by all staff across the service.
- The variety of treatment interventions, such as (CBT), motivational interviewing, 12-step programs, ACT, Mindfulness Based Relapse Prevention and the community reinforcement approach have all been shown to be effective with LGBTQ+ people.

3.3.1 Sexuality diverse women

Research literature that explores substance use among Lesbian, Gay, Bisexual, Transgender and Intersex (sexuality and gender diverse) communities indicates that lesbian and bisexual women show higher levels of risk in relation to alcohol consumption and problematic drinking than heterosexual women (AIHW 2020; Ritter et al. 2012). Furthermore, according to the Australian Longitudinal Study of Women's Health (ALSWH) lesbian and bisexual women report higher tobacco use.

The 2020 Sydney Women and Sexual Health survey (SWASH), a comprehensive survey of health issues relevant to lesbian, bisexual and queer women engaged with Sydney's LGBTQ communities found that in the preceding six months 54% had used any illicit drug, a significant increase from the 47% of respondents who reported any illicit drug use in 2018 (Mooney-Somers, J, Deacon, et al 2018). In 2020 half of SWASH respondents reported drinking in excess of National Health and Medical Research Council recommendations to drink two standard drinks or less a day and 16% percent of respondents reported that they usually drank more than four standard drinks on any drinking occasion, increasing their risk of alcohol related injury (Mooney-Somers, J, Deacon, et al 2020).

Qualitative research by Parks (1999) in lesbian communities suggests that bars and social drinking are important aspects of building relationships in the community, creating a welcoming environment, and may create pressure to fit in through the adoption of similar drinking practices (Ibid.).

Best practice guidelines to treat LGBTQ+ women with alcohol and drug issues also emphasise the need for cultural competence and inclusive, person centred approaches. Best practice responses will acknowledge the likelihood of LGBTQ+ clients having lived experience of trauma due to stigma, sexism and homophobia (Eliason et al. 2009). Services are advised to develop trauma informed treatment and consider the specific needs of sexuality and gender diverse women and non-binary people in assessment procedures and treatment planning (e.g., 'coming out', the role of 'gay' venues, the need for substance free social networks for recovery, the impact of homo/bi/transphobia).

Case study

Lenny is a 33-year-old single cisgender lesbian woman. Two months ago she exited a residential rehabilitation program where she had been after an alcohol use relapse. Over the past 10 years, she has accessed residential treatment on several occasions for what she describes as "alcoholism". Lenny was diagnosed with a bipolar condition in her early twenties and regularly sees a psychiatrist for medication reviews. She is in maintenance stage of recovery, attends a 12-step group daily and would like to develop more strategies to assist her in remaining abstinent and also stop smoking.

Lenny is socially isolated from both the LGBTQ+ community and the general community with most of her social relationships being with other 12-step group members. She sees her isolation a consequence of her difference – her shyness, mental health condition and sexuality all making her feel marginalised and she reports that she does not feel "normal". She is conscious of having felt this since early childhood.

Lenny has identified that her harmful drinking increased when she first started frequenting lesbian venues and social scenes as it helped her feel less socially anxious and more confident. The long-term impact of her substance use has added to and reinforced her negative self-beliefs of being incapable and being different. Lenny has expressed a desire to access an LGBTQ+-inclusive service to maintain her goal of abstinence. Long-term goals for Lenny are to find a meaningful purpose for her life through study and work; establish independence and autonomy from her family while maintaining the strong relationship she has with her parents; and to feel confident enough in her sexuality to pursue intimate relationships with others.

The intervention approach to working with Lenny includes individual counselling (Acceptance and Commitment Therapy) designed to address some of her internalised homophobia as well as anxiety relating to her sexuality; a referral to the GP for nicotine replacement therapy and Quit supports and referral to Rainbow Recovery (an LGBTQ+ 12-step group). This combination of treatment interventions provided to Lenny gave her the opportunity to expand her peer support within an environment that is safe and inclusive for sexuality and gender diverse people.

The most meaningful progress the client has made continues to occur outside the counselling room. Her skills and abilities in a particular creative field have been recognised by others who have encouraged her to pursue a training and career opportunity in that field. Having a goal that is beyond abstinence and is connected to an endeavour she values has brought meaning and purpose into her daily life.

*The case study explored above corresponds with many of the best practice approaches outlined in **Section 2**. While it is apparent that the treatment provided occurred in the context of a LGBTQ+ inclusive service, it is in the exploration and acknowledgement of sexuality that improved practice begins.*

Find out more….

ACON Health has a range of resources, support services and research projects you can access to improve your service knowledge and service provision regarding the LGBTQ+ Community, including training to develop a culturally safe and competent service and workforce.

Website: **www.acon.org.au**

3.3.2 Trans and gender diverse women

It is important that we understand the different ways that trans and gender diverse people access and require health care, not only because the health needs of trans and gender-diverse people may look different from that of cis people, but also because many trans people report negative experiences while accessing healthcare.

The term trans is an umbrella term for a population of people whose gender is different to what was presumed for them at birth and means all people of diverse gender experiences, or those who are not cisgender.

Trans and gender diverse people, just like cis people, can have different relationships with substance use. Given the level of discrimination and stigma faced by trans people, it's no surprise though that some trans people shoulder a heavy burden of harmful substance use.

The First National Trans Mental Health Study (Hyde Z, Doherty M, et al 2014) reported that "Participants (trans and non-binary people) were approximately twice as likely to have used an illicit drug than the general population in the last 12 months."

It's important to remember that not all trans people seek affirm their gender medically or legally. Some people do not experience discomfort in their body or legal existence and are only interested in socially affirming their gender. Others may not be able to undertake medical affirmation due to cost or health concerns.

In mixed gender services, trans women are often placed with a cohort of men or in isolated rooms. Unless a person is at risk of harm from others, there is no reason to not accommodate trans women in women's services.

The Gender Centre and ACON's TransHub outlines these specific tips for enhancing AOD worker support for transgender women:

- Build trust and rapport by being open, sensitive and respectful.
- Don't assume gender or sexuality, ask open questions: "How do you identify your gender?" "what is your current gender identity" (male/female/non-binary/something else____) followed by "what sex/gender were you assigned at birth?" (male/female), and reflect as an organisation as to whether the second part of this question is essential to the care being provided.
- Ask what pronouns the person would like to be used in the case of a non specified gender.
- Focus on behaviour rather than labels or perceived roles, and remember that all people change and develop along their life cycle.
- Avoid forcing any person to act in ways which are congruent with their birth sex but incongruent with their identity as it will not resolve their feelings of incongruence and may lead to poor outcomes such as depression, anxiety, poor self-esteem, self-harming behaviours and issues of suicidality.
- Offer reassurance and acknowledge the "bravery" of the person in choosing to disclose.
- Assure the person of your confidentiality and make it very clear with whom this information must be shared.
- Allow the transgender person to express all the emotions they are feeling and reassure the person that this experience is not unique - they are not alone.
- Ask what support the person has and what supports they feel they are likely to need.
- Indicate your acceptance of the person; acknowledge their diversity and validate it by letting them know it is okay to feel the way they do.

One of the key areas for reform identified by The First Australian National Trans Mental Health Study (2014) was "Government agencies, service providers, and other organisations should ensure that their staff are adequately trained to work with trans people in a respectful and affirmative manner. They must develop policies to actively prevent discrimination and to make trans people feel welcome when accessing their services."

Find out more….*about positively engaging with trans and gender diverse people.*

ACON Health

ACON Health has a range of resources, support services and research projects you can access to improve your service knowledge and service provision regarding the LGBTQ+ Community including training to develop a culturally safe and competent service and workforce.

Websites: **www.acon.org.au** / **www.pridetraining.org.au**

The Gender Centre

The above content was contributed by The Gender Centre, Sydney. The Gender Centre offers a wide range of services to transgender and gender diverse people, their partners, families and friends in New South Wales. It also acts as an education, support, training and referral/resource centre to other organisations and service providers. It specifically aims to provide a high-quality service which acknowledges human rights and ensures respect and confidentiality.

Website: **www.gendercentre.org.au**

TransHub

TransHub is NSW's leading trans and gender diverse information resource for gender affirmation, community health, allies, and clinicians.

Website: **www.transhub.org.au**

The First Australian National Trans Mental Health Study: Summary of Results
Curtin University 2013 (Hyde Z, et al)

This report provides an overview of the findings of The First Australian National Trans Mental Health Study. The study was designed to investigate the mental health and wellbeing of trans people living in Australia.

4 PREGNANCY AND PARENTING IN AOD TREATMENT

KEY POINTS AND PRINCIPLES

- All AOD workers can benefit from having an awareness of health care issues relating to alcohol and other drug use in pregnancy.
- Providing factual information that is support-oriented, can encourage women to seek assistance via AOD treatment and other specialist services.
- Women with problematic alcohol and other drug use who disclose pregnancy or child care responsibilities should be provided education, brief intervention and referral to specialist medical assistance – with support.
- A coordinated care/case management approach assists with managing the multiple supports that are necessary for providing best practice treatment for women who are pregnant and/or have children in their care.
- Pharmacotherapy is best practice for pregnant women who are opioid dependent.
- There should be a no wrong door approach to accessing treatment.

Women who use alcohol and other drugs while pregnant and/or who have children in their care face stigma and discrimination that can impede AOD intervention. While tackling societal values is an ongoing challenge for women and workers in the AOD sector, there are some fundamental approaches and strategies that can be used to improve outcomes for women, children and their loved ones and this will be explored in this section. Making factual and support-oriented information available to women will educate them about the harms associated with substance use in pregnancy and can show how sustained/problematic use can impact upon parenting.

Fortunately, there is evidence that for some women, pregnancy and parenting can be influential motivators for change in relation to their substance use, entering and engaging with treatment (Greenfield et al. 2007, Mitchell et al. 2008, Jackson & Shannon 2012). In a study of over 100 pregnant women entering inpatient detoxification, qualitative data indicated pregnancy was the top motivator for seeking treatment, with other motivators being recognition of needing help, family, and being tired of the lifestyle (Jackson & Shannon 2012). Similarly, another US study comparing drug using women who were pregnant and not pregnant found pregnant women were more than four times as likely to express a desire or motivation for treatment (Mitchell et al. 2008).

4.1 Alcohol and other drug use in pregnancy: Improving pre-natal care outcomes

According to the National Strategy Household Survey (2014), over 50% of pregnant women consumed alcohol before they knew they were pregnant and 1 in 4 continued to drink even once they knew they were pregnant. Of those who did consume alcohol, most (96%) usually consumed 1–2 standard drinks per day (AIHW 2014). A small minority of women that continue to drink at high levels are likely to require support to reduce consumption. These women face significant stigma; "Such is the stigma and guilt associated with alcohol use during pregnancy that only a minority of pregnant women with alcohol use disorders access treatment." (Burns & Breen 2013).

Pregnant women who use alcohol and other drugs are more likely than non-users to be smokers, to have a psychiatric condition, to be single, Aboriginal, experience greater social and economic disadvantage, to be living in a metropolitan area, younger, unemployed, Australian-born, and to have previously given birth (Kennare et al. 2005; Taylor et al. 2012). Access to a comprehensive range of well-connected services, such as social support, case management, and mental health services for these women is best practice.

Pregnant women with alcohol and other drug issues require services that can support them throughout their pregnancy and provide post-natal support for themselves and their baby. Among pregnant women who use alcohol and other drugs, opiate use remains most prevalent; however, use of other drugs, such as methamphetamine, is of increasing concern due to their impact on women's mental and physical health and the heightened risk they pose for obstetric complications (Taylor et al 2012).

For those organisations that do not have the capacity to cater for women who use substances and who are pregnant or who have children in their care, there is still the opportunity for brief intervention, education and supported referral. The specific and complex needs of pregnant women who use alcohol and other drugs requires a coordinated response using a multi-disciplinary team approach to include specialists across neonatal, drug and alcohol, mental health and social work fields. Applying a coordinated case management or care management approach can assist in bringing together the specialist services needed by women that the AOD treatment service cannot provide in isolation. Care coordination involves deliberately organising client care activities and sharing information among all of the participants concerned with achieving safer and more effective care. This means that the client's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate and effective care to the client.

Women on pharmacotherapy need information that empowers and supports them to make choices and decisions about how their pregnancy, birth and the period after birth is managed. Regular benzodiazepine use during pregnancy is associated with neonatal abstinence syndrome as are opioids. However, benzodiazepines may be administered for symptomatic relief during inpatient alcohol withdrawal if required with appropriate supervision and neonatal care (NSW Health 2015). For pregnant women who are dependent on benzodiazepines, best treatment approaches aim for tapering of dose and subsequent discontinuation of use if and when this is safely achievable. Benzodiazepines are generally unsafe for use while breastfeeding and can cause significant withdrawal symptoms for the newborns of dependent mothers (Keegan et al. 2010).

For opioid-dependent pregnant women, induction to methadone maintenance as part of comprehensive treatment programs is considered best practice (Minozzi et al. 2008; Keegan et al. 2010). Commencement of methadone should ideally take place in an outpatient setting, with maternal and obstetric supervision - as is common practice in Australia, and supported by the American College of Obstetricians and Gynaecologists (ACOG). Continued buprenorphine treatment is safe for women who become pregnant while already in this type of treatment, achieves similar outcomes in reducing maternal drug use and promotes positive neonatal outcomes to methadone, and appears to result in a less severe neonatal abstinence syndrome compared to methadone (Jones et al. 2012; Young & Martin 2012). However, as buprenorphine induction may place the foetus at risk from precipitated maternal withdrawal and potentially trigger relapse in mothers, methadone is recommended for active opioid users who need to be inducted to pharmacotherapy during pregnancy (Young & Martin 2012).

Case study

Sally is 19 years old. She first presented to the service when she was 17 years old with a long history of substance use – including cannabis use from age 13, heroin use at age 15 and misuse of prescribed benzodiazepines. Her eldest sister died of a heroin overdose when Sally was 15 and her parents separated. Sally was engaged in a methadone program at the time she presented for treatment. She also reported experiencing multiple mental health issues including panic attacks and periods of feeling suicidal.

While Sally's continued substance use has had an impact on her family relationships in the past she has a supportive relationship with her mother, younger sister and her mother's partner. Support from her stepfather has included providing childcare for Sally's young daughter while she attends a support program and, more recently, TAFE.

In spite of initial lack of engagement with the AOD treatment service, assertive follow-up techniques were employed, flexibility in terms of accessibility was provided as well as a harm minimisation approach. Counselling appointments were arranged in order to develop strategies to manage her high anxiety, creating trust with the service and support to stabilise her drug use so that she could attend a day treatment program.

On commencing the program Sally discovered she was pregnant, with no support reported from the father. Sally's pharmacotherapy clinic referred her to the Chemical Use in Pregnancy Service (CUPS) which has links with child protection, DCJ. She was required to have contact with them throughout the pregnancy and she was advised that Family and Community Services could become involved if there was any indication of drug use throughout the pregnancy and concerns once the baby was born. This then led to a series of monitoring mechanisms being put in place with the expectation that Sally comply. This included weekly appointments to the CUPS service and random drug screen urine testing.

Sally responded to the news of the pregnancy by immediately stopping all use of illicit substances. She committed to maintain stability on the methadone treatment and to only take the benzodiazepines as prescribed. She also began the day program. Her mother became involved in supporting Sally to meet the obligations of her ante-natal care plan. The progressing pregnancy and her experiences with the ante-natal system resulted in Sally requesting extra support. This support involved such things as securing practical equipment and needs for the expected baby as well as support and advocacy in navigating the hospital and ante-natal systems. It also included providing information relevant to her about pregnant women on methadone programs.

Sally completed the day program and then participated in an aftercare group until the birth of her child. Having the ongoing support of AOD workers throughout the process assisted Sally in coping with experiences of stigma and discrimination during the birth and in relation to breastfeeding. Sally continued to attend aftercare programs and brought the baby to groups.

This case study highlights the importance of working with the client where they are at. For Sally to be able to establish an effective therapeutic relationship with an AOD worker, they needed to be flexible, patient and yet persistent in the early stages of engagement. The role of advocacy became vital to ensuring that Sally receive access to the ante-natal care that any pregnant woman is entitled to. When this was denied, the role of the worker was to challenge and ask why.

The outcomes of pharmacotherapy interventions are significantly enhanced for pregnant women with the support of evidence-based psychosocial interventions and a range of other supportive processes including:

- treatment engagement strategies
- treatment approaches that begin during pregnancy
- programs that incorporate standard evidence-based practice treatment modalities
- home-based interventions
- comprehensive treatment that includes perinatal care, mental health services, child-care and other supports
- service integration approaches, where addiction services are provided with onsite services related to pregnancy, parenting, or other child-related services.

There are a number of specialist services for pregnant women who use alcohol and other drugs in NSW, including those that cater for pregnant women enrolled in an opioid pharmacotherapy program. These services are available across New South Wales and are called Substance Use in Pregnancy and Parenting Services (SUPPS). Visit the NSW Health Your Service Hub to find one in your local area.

Gold standard treatments for women who are pregnant and use substances include extended hospitalisation if required, additional support during birth and post-delivery, and the option of assertive follow-up of the mother and child through the child's formative years to assist the woman in the areas of healthcare, navigating social services, accessing housing and positive parenting (Burns & Breen 2013). Women-only and gender-specific treatment programs are best suited to respond to the specific health and medical needs of pregnant women with substance use issues (Greenfield et al. 2007).

The Clinical Guidelines for the Management of Substance Use During Pregnancy, Birth and the Postnatal Period, released in 2014 is the key resource in NSW when working with AOD use in pregnancy. The guidelines have been developed based on "the best currently available evidence, developed through a rigorous process in which international and Australian research literature was reviewed by experts and consensus achieved."

Find out more...*about substance misuse in pregnancy.*

Clinical Guidelines for the Management of Substance Use During Pregnancy, Birth and the Postnatal Period. NSW Ministry of Health 2014

These guidelines contain information on the use of buprenorphine maintenance treatment during pregnancy; cannabis use in pregnancy; a recommendation for abstinence from alcohol during pregnancy; and updated information on child protection legislation in NSW. New sections include prescription opioids use in pregnancy; use of antidepressants in pregnancy; management of withdrawal; management of incarcerated pregnant women; and management of women in rural and remote areas.

Your Room, Your Service Hub. NSW Health and St Vincent's Alcohol and Drug Information Service 2020.

Refer to your service hub for information about substance use in pregnancy services in your area. Your Service Hub provides a list of up to date programs for women who are pregnant.

Website: **www.yourroom.health.nsw.gov.au**

Pregnancy Guidelines Alcohol. Australian Government Department of Health 2020.

The Department of Health website has detailed information and resources developed by experts in the alcohol field that you can use in your work with women who are using alcohol or are at risk of using alcohol during pregnancy.

Website: **www.health.gov.au**

MotherSafe is a free telephone counselling and advice service for pregnant and breastfeeding women across NSW (9am-5pm).

The MotherSafe website also hosts a number of factsheets for alcohol and other drug use in pregnancy – Alcohol, Cannabis, Tobacco, Opioids, Amphetamines, Benzodiazepines.

Phone: 9382 6539 (Sydney Metropolitan Area); 1800 647 848 (Non-Metropolitan Area); Non-English speakers can access an interpreter through TIS National by phoning 131 450.

Website: **www.mothersafe.org.au**

4.2 Introducing child-sensitive service provision and support for positive parenting

Women who have children and experience issues with their drug and/or alcohol use are more likely to have a range of material and personal support needs; a higher prevalence of psychiatric symptoms; early childhood and lifetime trauma experiences; and lack social support. These issues present significant clinical challenges, and many of these factors may also inhibit the mother's attachment to her infant, the advancement of their parenting skills and their capacity to maintain child custody. In addition, mothers may face difficulties maintaining engagement with, or completing, AOD treatment (Greenfield et al. 2007).

Significant maternal alcohol or other drug use is associated with a variety of caregiving, child and family functioning problems, including a greater likelihood of neglect or abuse of children, reduced emotional involvement and attachment, increased punitive behaviour toward children, insensitive and interfering behaviour, ambivalent feelings about retaining custody, feelings of guilt and increased parenting stress (Fraser et al. 2010; Suchman et al. 2011). The continuing presence f alcohol or other drugs significantly reduces an individual's dopaminergic response to stress, leaving the mother highly vulnerable to negative otions and potentially lacking feelings of pleasure or reward ordinarily associated with caring for young children (Suchman et al. 2011).

Being engaged in AOD treatment can provide women with an opportunity for addressing and reducing the risk of harm to children. Best practice treatment services for women with children include:

- women-centred treatment that involves children such as women-specific outpatient clinics and day programs; women-only residential treatment including residential services that allow children to stay with their mothers and/or family residential services
- specialised health and mental health services, particularly pre and post-natal health interventions and specialist mental health interventions such as individual or group therapies
- home visits, typically by a nurse, focusing on providing maternal support, promoting healthy parent-child interactions, and providing information and linkages to material resources
- concrete practical assistance, such as transportation, childcare, and worker assistance to link with treatment services
- short-term targeted interventions, including psycho-educational groups, counselling or support groups and contingency management approaches
- comprehensive and holistic interventions, including programs that integrate several of these components.

The following is a summary of a specific parenting program delivered within an AOD treatment setting. The descriptions are sourced from Gruenert and Tsantefski (2012) *Responding to the needs of children and parents in families experiencing alcohol and other drug problems.*

Circle of Security

It is important that parenting programs and interventions provided to mothers assist to heal the parent-child relationship, as 'experiencing abuse and neglect in the family not only carries with it direct and indirect injuries to parents and children, but it also undermines the parent-child relationships (Bromfield 2010). To support the healing of a mother-child relationship, attachment issues need to be addressed. The Circle of Security program is an effective intervention that can be delivered in an AOD setting, that has been developed to specially address attachment concerns. The Circle of Security program is a relationship-based, early intervention program designed to enhance attachment security between parents and children.

For more information about the Circle of Security refer to Circle of Security International – Website: **www.circleofsecurityinternational.com/**

Parenting Under Pressure

Another program that was developed to address the needs of high-risk families is Parenting Under Pressure (PUP).

The Parents Under Pressure (PUP) program, developed by Professor Sharon Dawe (Griffith University) and Dr Paul Harnett (University of Queensland), is designed for families with multiple problems and where children are at risk of adverse outcomes. It is an intensive multicomponent program comprising 10 modules, delivered in 12 sessions of 1.5 hours duration each. PUP has been used where there is problematic parental substance use and there are concerns about child wellbeing and protection. The program is delivered by a trained staff member, generally in the family home, and focuses on a range of parental challenges. Beginning with parents' perception of themselves, PUP encourages parents to acknowledge their own strengths and identify and comment on their children's positive behaviours. The program helps parents to identify the various factors that make parenting difficult and devise strategies to overcome these challenges.

Website: **www.pupprogram.net.au**

Find out more...*about parenting support in AOD treatment.*

Strengthening Aboriginal family functioning: What works and Why? Child Family Community Australia, Australian Institue if Family Studies 2014 (Lohoar, Bureta & Kennedy)

Website: **www.acon.org.au**

Emerging Minds: The impact of parental substance use on the child A suite of resources including elearning, fact sheets and best-practice principles.

4.3 Working effectively with Department of Communities and Justice and non-government child protection services

While it is essential to avoid any assumption that parental AOD use automatically increases risks for dependent children, the links between maternal substance use and the risk of neglect and harm to their children have been well-documented. Parental drug use is considered to be a key factor in recent child death reviews (NSW Child Death Review Team, 2012, 2013, 2014). Other studies into the links between parental substance use and child abuse and neglect have indicated that:

- Parents experiencing alcohol and other drug use problems tend to have poorer parenting styles. Mothers with AOD use issues are more likely to be more harsh, punitive and inconsistent in their parenting.
- Families involved with significant drug use are more likely to be facing unemployment, poverty, housing instability and social isolation.
- Children's medical, nutritional, social and emotional needs are more commonly neglected.
- Family violence is more common in households where there is significant use of alcohol and other drugs. (NSW Community Services, 2010)

The above findings are just a sample of the concerns that can occur where parental drug use impacts on dependent children. It is also important to note that maternal substance use is only one of a number of factors that can contribute to risks associated with neglect and harm of children; factors such as mental illness, history of trauma, socio-economic disadvantage and isolation can commonly co-occur with substance misuse. It is, of course, important to view substance use and any impact this may have on parenting capacity within context rather than assuming that AOD use is the causal factor (Dawe, Harnett and Frye, 2008).

Given the increasing evidence of the potential impact of substance use on parenting capacity and the subsequent risks for children, it is imperative that child protection and family support services across both government and non government sectors be involved in providing support for parents and protection for children deemed to be at risk of neglect and harm.

It is essential to begin from the premise that Department of Communities and Justice (DCJ) involvement with women who are experiencing AOD use issues with dependent children is, ideally, a positive protective factor and can lead to significant change and positive outcomes for families.

"I never felt like Kait and Charlotte were just my caseworkers, it felt like we were a team – that we all had the same goal. This made it easier to give up drugs. Kait and Charlotte were looking out for me and I didn't want to let them down." (Hannah, mum in Shining a Light on Good Practice, NSW Family and Community Services, 2014.)

Women with dependent children who are involved with significant levels of substance use are commonly involved with DCJ. It is estimated that among the 309,600 children reported to DCJ in 2008-2009, the prevalence of substance use problems amongst their parents ranged between 50 and 80%. A review of the case files families reported to DCJ indicate that in 41% of cases at least one parent was known to misuse drugs, and 46% misused alcohol (NSW Community Services, 2010).

Due to a number of factors, not least the inherently coercive role of DCJ in directing mothers to address their AOD problems, there is often a significant level of stress and uncertainty where DCJ are involved.

PRINCIPLES OF STRENGTHENING A WORKING ALLIANCE WITH DCJ

DCJ involvement with children of substance using mothers invariably brings legal pressure on the parent to address their AOD concerns.

To best support women who have DCJ involvement it is useful for you to be aware of the child protection system. The NSW Women's Legal Service have several helpful and very practical resources. For more information refer to the following links:

www.wlsnsw.org.au/help-facs-has-removed-my-children/

www.wlsnsw.org.au/wp-content/uploads/WLS_FaCS_booklet_A5_6.pdf

DCJ SERVICES AND PRINCIPLES

DCJ Communities agencies provide services across three key areas:

1. Prevention and early intervention
2. Child protection
3. Out-of-home care

For more information about these key services refer to:

www.facs.nsw.gov.au/families/Protecting-kids

These key services follow the principles and values highlighted in the NSW Practice Framework which was launched in 2017. The Practice Framework is part of DCJ's commitment to positive change and to ensure that the child or young person and their family is at the centre of their work.

For more details about the framework refer to:

www.facs.nsw.gov.au/providers/children-families/child-protection-services

Practice First

An important component of the Department of Communities and Justice's (DCJ) Practice Framework is an initiative referred to as Practice First.

Department of Communities and Justice developed Practice First as a model for child protection service delivery in 2011. Its approach is unique to NSW, and draws on the best of national and international models and contemporary research (Communities and Justice, 2020). Practice First focuses on changing the practice culture across the spectrum of work with families including assessment, intervention and collaboration with partner agencies. It aims to achieve safety for children and families through skillful child protection practice, shared management of risk and building genuine relationships with families and the community.

There are three essential components to Practice First:

1. Principles of practice guide the model. They are evidenced based, reflect contemporary research about what works in child protection and provide a solid framework for improved outcomes.
2. People and practice leadership – casework is delivered by teams, not individuals, and teams have the support of administrative staff and timely clinical and specialist support. Skill development is ongoing and requires practitioners to have insight into the impact of their own practice on families, and to strengthen their skills in working with families to change
3. Realignment of systems – a clear mandate giving legitimacy to family work has been emphasised, freeing casework time from administration, and sharing risk and decision making across teams.

Group Supervision is at the heart of Practice First. Caseworkers, managers, casework specialists, psychologists and other specialist staff meet each week to discuss families and reflect on practice. Partner agencies are regularly invited to group supervision sessions, which can include local drug and alcohol services. This genuine partnership has many benefits: it creates more efficient and effective referrals and information sharing, shared understanding of the risks and protective factors, greater transparency around decisions, more purposeful case plans and wrap-around services, and ultimately, better outcomes for children and families.

For more information on Practice First, refer to:

www.facs.nsw.gov.au/about/reforms/NSWPF/practice-first

For AOD workers involved with women and their children, the implications of the Practice Standards and the Practice First initiative should be that there is an improvement in the collaborative nature of the relationship between services and a greater level of transparency in regards to decisions made within DCJ. Drug and alcohol workers should contact the Community Services Centres they are working with to find out how the practice standards might help them in working together. If they are a Practice First site this could include being involved in group supervision when discussing shared clients.

For more information on the practice standards, refer to:

www.facs.nsw.gov.au

Find out more…*about the DCJ Care and Protection Practice Framework*

NSW Practice Framework, Department of Communities and Justice.

The framework shows how DCJ works with children and families in NSW. It includes the principles, values, mandates, approaches and systems that underpin their work.

Website: **www.facs.nsw.gov.au/providers/children-families**

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5 BUILDING STRONG PARTNERSHIPS TO INCREASE POSITIVE OUTCOMES FOR WOMEN

- Women need to be invited to take an active rather than passive role in the development of care plans and in the selection of external support services.
- Establishing strong respectful partnerships with other services can fill the gaps that may not be covered by AOD treatment.
- There are a number of important factors that can support good partnerships such as clear goals, clearly defined roles and responsibilities, and documentation that explains the nature of the partnership and that relates to governance.
- Creating seamless service provision to women can be supported by collaborative care planning and the implementation of supported referral processes.

Women accessing AOD treatment present with multiple complex issues and as a result may be overwhelmed by how they can navigate various services in order to improve their wellbeing and have their needs met. In parallel, many AOD workers also feel confused by the best ways to assist their clients – particularly if they feel unable to provide the services that are required. The most effective and useful response in this situation is to establish strong respectful partnerships with other services that can fill the gaps that may not be covered by AOD treatment such as childcare support, specialised mental health support, practical welfare interventions and health care.

In this section of the resource different types of partnerships are explored. It begins with the most valuable partnership – that formed with women who engage with a service for AOD treatment – then goes on to present specific community-based partnerships, followed by those partnerships that can help ensure effective aftercare.

5.1 Involving women in effective case management

In keeping with a strengths-based approach and the goal of self-determination by women engaged in women's AOD treatment, involvement in case management is essential. What this means in practice is women take an active rather than passive role in the development of their care plans and the selection of external support services.

Women who are central to decision making about their care and treatment are more likely to have an investment in its outcome. Feeling that they have been genuinely consulted and presented with options from which they can make a choice is empowering – and may have a significant impact on the experience of AOD treatment. Some useful considerations for effective case management that actively considers the needs of clients is outlined below by Gelb & Rutman 2011:

- Establish a trusting relationship with the person.
- Establish close and frequent communication with them (e.g. check-ins and regularly scheduled meetings).

- Develop a care plan based on their goals, strengths and needs.
- Facilitate transportation for important appointments.
- Liaise with other service providers with consent.
- Assist the development of life skills and/or the person's participation in healthy, safe activities.
- Establish close communication with supportive significant others in the person's life.
- Advocate for improved communication among service providers, continuity of care and access to care/services.

Case study

Samantha is a 27-year-old woman with a history of alcohol use. She has previously engaged in residential treatment, but was discharged for non-compliance and aggressive behaviour towards other residents. Samantha was encouraged by her parole officer to try residential treatment again as she has a number of outstanding criminal justice issues, including a breach of an Apprehended Violence Order against her mother and grandfather. Samantha is concerned about her relationship with her family, particularly her grandfather who she has always been close to but who she recently assaulted when under the influence of alcohol and for which she was charged.

Prior to attending for treatment, Samantha was drinking 10-15 cans of beer every day. She also smoked methamphetamine, but her primary drug of concern is alcohol. She began drinking at age 14 and smoking methamphetamine at age 22. Samantha has engaged well with the support provided to her, including that provided by another resident.

Samantha has body image issues. When she attended the service previously she would wear large clothes to cover her body up and was not eating at all. This time she wore normal clothes, was eating well and focusing on her physical health as one of her goals. Samantha has been supported to identify her immediate treatment goals, which include a plan to rebuild and reconnect with her grandfather. Her other treatment goals include sharing her story with the treatment community and focusing on her physical health.

Samantha has agreed to be referred to a specialist that works with clients with complex needs and that will work with her while she is in treatment. She will also attend appointments with the visiting mental health nurse and the visiting psychiatrist.

In the case study explored above, there is clear evidence of client-led case management. Samantha identified the goals she wanted to focus on and, with support, has started to address them. Also her more complex issues – such as the mental health concerns identified – are more likely to be considered by the client to require intervention if it has been established that it is her decision. For women who have had previous poor experience of AOD treatment, coupled with criminal justice or custodial experiences, it may take time for trust to be built and for them to arrive at a decision to tackle complex issues such as mental health. The benefit of working in this way is that the outcomes are likely to be sustained as the client has made an investment of their own free will.

5.2 Building community-based partnerships

While it may be possible for an AOD treatment service to put in place changes that reflect gender-responsive, family-inclusive and trauma informed practices, it is not the expectation that AOD treatment has the capacity to address all needs. There are some useful tips in guiding the management of good partnerships across organisations. These tips, adapted from Hunter and Perkins (2014) include:

- clear goals and purpose
- clearly defined roles and responsibilities
- documentation that explains the nature of the partnership
- robust monitoring and evaluation
- sharing of information with clear protocols
- use of 'local champions' within partner organisations
- for long-term partnerships, a clear purpose and governance structure is recommended.

Useful partnerships to consider might be with child/youth organisations that provide support around the substance use of a parent, collaborations with outreach or drop-in services that can provide after-hours support for non-residential services, coordination with women's specialist antenatal care services or other local primary health centres.

"While partnerships can be established at a personal level, sustainable partnerships are likely to require formalisation at the agency–agency level where possible, with clear aims and objectives, inter-agency protocols and information sharing, supported by policies, procedures, and documented referral pathways. It is acknowledged that good partnerships take time and effort to develop" (Grenert & Tsantefski, 2012:10).

Other ways of creating seamless service provision for women is through collaborative care planning (as outlined in **Section 2.5** of this resource) and the implementation of supported referral processes. A 'warm' or 'supported' referral means that there is some personal contact from the worker who is making the referral. This might take the form of an introductory phone call to the service in order to make introductions on behalf of the client, or attending the initial appointment with the client as a support, or it might be that a representative from the service being referred to attends the AOD treatment service to establish some rapport with the client.

There is evidence to suggest that women appear more likely to seek treatment in non-speciality settings (Ettorre 2004; Greenfield 2010). This suggests a need for collaboration and/or co-location of drug and alcohol treatment services with other social and health agencies. In turn, these services could offer treatment that address these needs and issues common to women with problematic substance use. Recognising complementary services for women in the community such as GPs, playgroups, childcare facilities and creating support links that encourage referrals to specialist AOD treatment services has the potential to increase accessibility for women experiencing substance use issues.

We have got to have women's and children's services, but we also need to be looking at better access to childcare so women can attend a day program if they choose.

Working on partnerships that will continue to support women into aftercare (see **Section 2.7**) is essential to sustaining AOD treatment outcomes. For more information and resources related to building partnerships explore the Partnerships information on the NADA website: **www.nada.org.au/whatwedo/partnerships.**

Find out more…*about building strong partnerships.*

Promoting partnerships: Mental Health Coordinating Council

MHCC is working towards promoting partnerships in two ways:

- Building structures and processes that enhance effective partnership behaviour.
- Building capacity in the sector to work in effective partnership arrangements.

This section of their website explores in detail these two aims with supplementary resources for each stage.

Website: **www.mhcc.org.au**

No Wrong Door (Ovens & King Community Health Service, Victoria)

The No Wrong Door website has various functions, with its primary focus to enable workforce capacity to better identify, assess, respond and treat people with dual diagnosis presentations. The website provides a platform to host regional policy, procedures, protocols, pathways, committees and educational opportunities for the member agencies. In addition, this website is designed to host a discrete area for consumer and carer representatives to better support them in their roles with their employers.

Website: **www.nowrongdoor.org.au**

5.3 Identifying partnerships that support effective continuing care

Making the transition from AOD treatment to the community requires planning and a focus on building sustainable community-based supports that will assist women to maintain the changes they have made to their lives. Best practice aftercare planning occurs as part of treatment, specifically in relation to identifying the types of supports that may have been lacking in a client's life prior to entering treatment, such as:

- stable accommodation and/or financial supports
- ongoing psychiatric or psychological support
- general health supports
- vocation, education and/or employment
- childcare supports
- engagement in leisure activities.

I've had several clients who did well over six months [in the program] but they finish and go back to the community, back to their old environments, and there's not enough support… even for clients who are having counselling it's only one hour a week – it's not enough support, and they often relapse.

The biggest problem for aftercare is housing. The Department of Housing policy is to retain the accommodation for three months only and we have a six-month program – if a woman has to give up her property she'll be deterred from coming in – she'll be homeless… If a woman has lost her baby she is less likely to come into treatment for fear of losing her housing, and if they do come in and lose their accommodation, six months isn't enough time to find other accommodation for them.

Identifying potential partnerships that may assist you and your organisation to facilitate these different supports within an aftercare plan, are likely to ensure sustainable treatment outcomes and prevent potential relapse.

Find out more…*about building strong partnerships.*

The NADA website ***Partnership Webpage***
Provides information, resources and tools to establish effective partnerships.
Website: **www.nada.org.au/whatwedo/partnerships**

Joining Together: Tackling AOD harms through a regional partnership (Dunne 2013)
Is a case example of an effective regional partnership and the journey taken to get there.

The Partnering Toolbook
The Partnering Toolbook builds on the experience of those who have been at the forefront of innovative partnerships and offers a concise overview of the essential elements that make for effective partnering.
Website: **www.thepartneringinitiative.org**

6 ORGANISATIONAL CHANGE AND SELF-CARE FOR WORKERS

- Organisational change requires a commitment by all levels of management and staff to embrace the implementation of new approaches to treatment.
- Change management is a process that requires planning, coordination and review.
- Audits of current approaches and practices against the proposed change can assist in identifying where energies should be focused and prioritised.
- Conducting a pilot of an intended change and then evaluating the outcomes of a particular approach can assist in staff engagement.
- Professional development and training staff is essential in harnessing commitment to change in approach or practice.
- Promoting a culture of inclusion and support for staff is vital in maintaining best practice approaches with clients. Workplace practices that promote effective supervision and self-care are key parts of a supportive organisational culture.

All the frameworks and practices outlined in this resource have been incorporated into AOD treatment services in Australia and overseas, in varying degrees. Implementing best practices approaches with women accessing AOD treatment requires a whole-of-organisation commitment and implementation process in order for there to be consistency. From policy and procedures through to support structures for workers, there should be evidence of agreement throughout the organisation and its practices.

"It's important to remember that, although training and education are crucial to increasing the capacity of drug and alcohol services in responding to the emerging needs of the community, they are not sufficient on their own to bring about sustained improvement in service delivery and system responses (Roche & Skinner 2005). To bring about sustained improvement through organisational change management, an effective process is essential" (NADA 2013).

The specific steps that make up an effective organisational change process are explored as part of a set of resources developed by NCETA within the *Theory Into Practice Strategies (TIPS) Tool Kits: Organisational Change Management* resource, and are presented here:

Stage 1: Unfreezing

Investing time at the start of a change program to prepare and support workers is an essential step to minimise reluctance to change and ensure successful implementation of new work practices.

Issues to be addressed at the unfreezing stage include:

- acknowledging current work practices
- supporting workers' readiness for change
- providing sufficient organisational resources for change
- providing professional development (e.g. education, training) for new work practices
- managing uncertainty associated with change.

Stage 2: Changing

Strategies to assist the transition from old to new work practices include:

- conducting trials of change
- engaging in ongoing monitoring and evaluation
- supporting workers to change their behaviour (e.g., support, feedback, rewards, professional development).

Stage 3: Confirming and Supporting

Strategies to ensure new behaviours become standard work practice include:

- continuing to offer workplace support for the new work practices
- continuing with monitoring and evaluation of change – including making required modifications to the new work practices.

All staff should be involved in assessing and evaluating the current strengths and challenges of the organisation before the change implementation process commences, ensuring all staff have input and take ownership of the change process. A change management plan should incorporate space for staff to discuss challenges, frustrations and success stories, as implementing change can have a significant impact on organisational culture. Clients should be included in the organisational assessment process. This may involve speaking to current and past clients as well as their family and carers.

Find out more…*about organisational change management.*

Organisational Change. Workforce Development TIPS (Theory Into Practice Strategies): A Resource Kit for the Alcohol and Other Drugs Field (Skinner NCETA 2005).

The Workforce Development (WFD) 'TIPS' Kit provides a unique range of user-friendly and practical WFD tools and resources for the AOD workforce targeted at supervisors, managers, policy makers and other key individuals within the AOD field who are likely to engage in WFD activities and interventions.

6.1 Areas for review and enhancement in mixed-gender organisations

Although there is evidence to suggest that women experiencing issues with substance use are best placed in women-only services, there are a number of ways to enhance mixed-gender organisations to better meet the needs of female clients. As indicated in the previous section, organisational change requires commitment and consultation. In order to demonstrate here how a mixed-gender organisation might adopt a family-inclusive approach as an example, the principles of the organisational change model developed by NCETA (2005) will be explored.

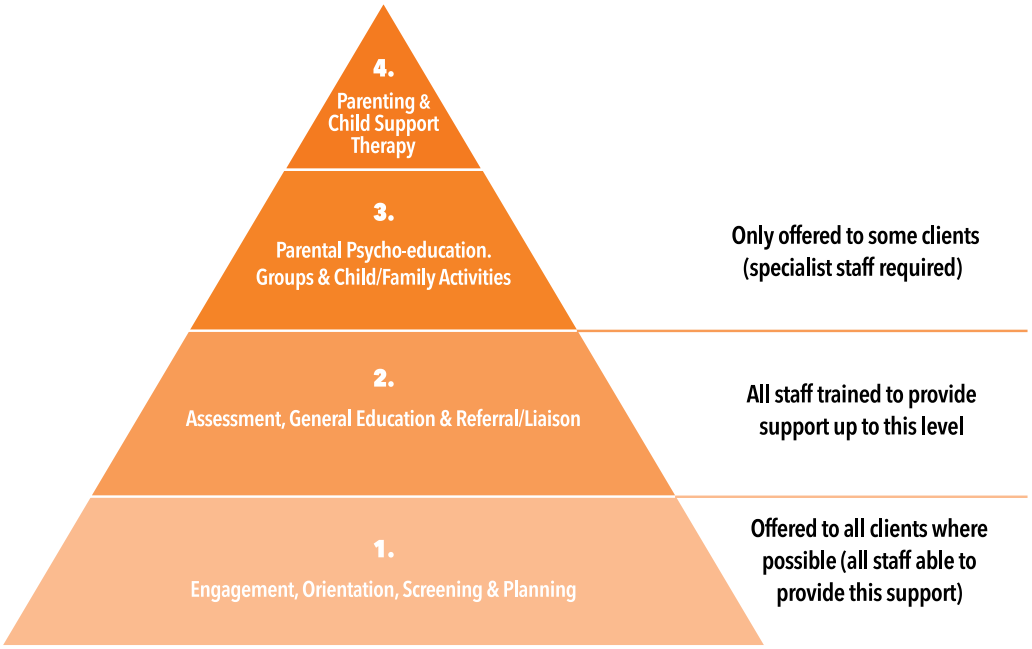
STEP 1: UNFREEZING

One of the first steps in the change management process is to acknowledge the current work practices that fit with family-inclusive approach and/or that work to support the same goals as family inclusive practice within the mixed-gender organisation. It is important to address the potential discomfort workers may feel as part of the change process – just as their clients do in treatment.

It is also important at this stage in the process to inform staff of the nature of the changes. In the case of mixed-gender organisations it might be providing the evidence base for family-inclusive practice and the range of supports that will be put in place to support staff in this area – through training, for example. It may also be helpful to have an expert in the area attend the service as motivation. They will be able to respond to staff concerns about how they might incorporate the approach into their work. Providing information in the form of handouts and research literature, diagrams and support tools will also support any training that takes place.

It may also be possible to arrange a site visit to an AOD treatment service where family-inclusive practice has been implemented successfully. This will enable staff to see where the organisation is heading and witness the approach in practice. It may also be helpful to involve staff in considering what is possible in terms of change towards a family-inclusive practice approach.

The framework presented below is a useful starting point in considering what level of organisational change is possible/practicable and the specific areas that require review.



Harnessing the curiosity of staff in applying something that will enhance their practice is the best approach to commencing organisational change and this can be achieved by effective communication, inclusion and support.

STAGE 2: CHANGING

Implementing actual change is best done in stages and a smaller pilot of the practices might be the best place to begin. For example, after a review of the assessment form and practises, a mixed-gender organisation might decide to trial the new process within a specific timeframe and then evaluate it. This staged approach assists with the change process and allows staff to reflect on how the changes shape their work practices. It may also identify areas for further training and/or support. "Changes that can be tested and evaluated in a trial bases are more likely to be accepted by workers" (Tornatzky & Klein 1982 in Armenikas et al 1999).

A checklist developed by NCETA, *Checklist for Family Sensitive Practice in the AOD Field*, covers the following elements of organisational practice that might require review:

1. Assessment

2. Intervention

3. A partnership and empowerment approach that explores the role of clients, families and communities involvement in program development

4. Multi-agency and cross-sectoral working

5. Workforce development

6. Organisational and systems development

7. Building leadership and integrated government policy

8. Accountability and monitoring

Each element poses some important questions for consideration by the organisation and will help it assess the fit between current practices and what might need altering in order to reflect a family inclusive approach. In practical terms it might be best to formulate a clear plan of staged introductions of new interventions starting with some of the organisational culture aspects first, such as language, policies and procedures. From here, a process of regular audits and evaluations of screening, assessment and treatment planning tools can also be implemented.

An example of some of the questions you might pose when exploring implementing family-inclusive practice is as follows:

1. Undertake an organisational checklist or audit in regard to child-friendly practices to ensure that each treatment agency has child-friendly policies and procedures in place. An example of a checklist for this purpose would be one developed by NCETA: Checklist for Family sensitive practice in AOD services.

2. Expand education and training of staff to undertake child and parent-sensitive practice.

3. Engage in appropriate clinical supervision for all staff and services where clients have children.

4. Include questions regarding clients' parenting roles and responsibilities as part of a routine assessment and clinical review.

Another useful resource that explores the implementation of family-inclusive practice into AOD treatment, "*Responding to the needs of children and parents in families experiencing alcohol and other drug problems"* by Gruenert and Tsantefski (2012), provides some key informants' top tips for workers, organisations, and governments and other funders.

Key informants' top tips for workers

- You do not have to be an expert in family therapy to ask clients about their children or other family members. Be yourself, honest, genuine, open and interested.
- Do not make assumptions. Aim to have some communication with relevant family members and encourage greater communication between family members.
- You probably already have the skills to contact other family members and identify their needs.
- Be aware that trauma and grief may go beyond individuals, and impact families and whole communities.
- Be open and respectful to all you speak with and anticipate some level of anxiety, conflict and shame. The stigma of having an AOD problem while being a parent can be enormous.
- Where possible, family members should be informed about their rights and responsibilities, what information will be shared, and how this will be done.
- Provide families with some information and support to address the effects of trauma and build hope for recovery.
- Take a supportive and strengths based approach rather than a punitive or risk focused approach. This will help engagement with parents and improve the likelihood of real change, not simply compliance.
- Include child and parent focused goals in your treatment plan. Think about what children need to be healthy and happy, in addition to any safety issues. Learn more about child development levels and timeframes, and discuss these in supervision and case reviews.
- Setting and monitoring goals is important. So is having a plan B for the care of children. As lapses are common in the recovery process, a parent's functioning may vary considerably over time.
- Ensure pregnant women get specialist antenatal support and care.
- Consider inviting a trusted family member or significant person to attend a session with your client. This may be especially important for building trust when meeting families for the first time, and with Indigenous and CALD communities.
- Help parents to understand or explore the possible impact of their AOD use or treatment on their children. Support parents to access material needs and develop new parenting strategies, especially around limit setting for their children.
- Help parents to strengthen their social network.
- Get to know your local child and family support and child protection workers. Know where the maternal and child health and education services are located. Identify child care options.
- Seek and respect children's opinions, but not at the expense of their safety.
- Help children to understand what is happening to their parents. They may need help to understand that family problems are not their fault, and that their parents love them, even if they are unable to care (or adequately care) for them at present.
- Provide children with opportunities to share their experiences with other children in similar circumstances. Tutoring and recreational activities may help children feel normal.
- Older children and young people may need their own intensive and specific long-term support and follow-up.

(Gruenert and Tsantefski 2012)

Within this process of change it is important to set up feedback mechanisms and meet regularly in different forums (all staff, groups of staff, administrative/executive groups) in order to assess how the change process is progressing. This provides an opportunity for staff to be acknowledged and appreciated for the work they are doing. Rewards such as flexi-time, support for professional development or attendance at conferences are also useful in supporting the change process.

STAGE 3: CONFIRMING/ SUPPORTING

In this final stage, the new approach, family-inclusive practice, is incorporated into standard work practice. "The 'new way' becomes the 'normal' way" (NCETA 2005:15).

It is important in this stage to continue to provide support to workers and to maintain regular review, evaluation and feedback.

Find out more…*about Organisational Change.*

Organisational Change. Workforce Development TIPS (Theory Into Practice Strategies): A Resource Kit for the Alcohol and Other Drugs Field. NCETA 2005 (Skinner, N In N. Skinner, A.M. Roche, J. O'Connor, Y. Pollard, & C. Todd (Eds.).

Website: **www.nceta.flinders.edu.au/workforce**

The Resource Kit comprises 14 chapters: an introduction to workforce development and 13 workforce development topics relevant to the AOD field. Each chapter contains evidence-based strategies to address a particular workforce development issue, as well as resources and tools that can be used to implement the strategies. Each chapter can be treated as a stand alone section, however, as workforce development topics are inherently interrelated, links between chapters are identified throughout the Kit. Organisational Change is the 7th chapter in the Resource Kit.

6.2 Enhancing organisational approaches that promote self-care

Working in the AOD treatment sector can be very rewarding. However, it is an accepted part of the work that clients who present for treatment are complex and that problematic substance use is a chronic, relapsing condition. What this means in practice is that without comprehensive support and supervision, the challenges of working with AOD clients can become overwhelming – leading to stress and potential burnout.

As we've seen, women who present for AOD treatment can frequently experience domestic violence and trauma, legal concerns, child protection issues and difficulty with finding adequate housing. These challenges, when coupled with negative attitudes within the community towards women who use drugs, can lead to an increased need for workers to advocate for their clients. As such, workers must sometimes bear the brunt of negative attitudes expressed towards them personally. In order to establish a culture of self-care in an AOD treatment organisation there needs to be a range of options that engage AOD workers to reflect on their practice, learn new skills and debrief about their concerns.

A number of strategies can be employed by an AOD treatment organisation to enhance worker self-care. They can include:

- peer supervision
- external clinical supervision
- training and professional development
- team building exercises and leisure activities
- access to a robust Employee Assistance Program.

NCETA suggests a two-pronged approach to addressing stress and burnout in drug and alcohol services (Skinner 2005):

1. There should be organisational strategies that focus on altering the work environment and/or the conditions causing the stress and burnout.
2. The individual worker should focus on developing coping strategies and stress management techniques.

The following table highlights the strategies services can implement to provide workplace support.

	SOCIAL/EMOTIONAL SUPPORT	INSTRUMENTAL SUPPORT
Organisation	• Ensuring fairness of treatment • Providing valued rewards • Ensuring supportive supervision	• Ensuring good job conditions (physical safety, job security, promotion paths, autonomy) • Addressing work overload • Addressing role ambiguity or conflict • Providing access to high-quality resources and equipment
Managers/ supervisors	• Channelling/facilitating organisational support • Providing positive social interaction (praise, encouragement, caring, respect) • Recognising and rewarding good work • Involving workers in decision-making	
Co-workers	• Providing positive social interaction (praise, encouragement, caring, respect)	• Providing help and advice • Filling in when others are absent • Assisting with heavy workloads • Providing constructive feedback • Appreciation and recognition • Sharing duties and responsibilities

Find out more…*about AOD worker self-care and support.*

NADA Worker Wellbeing Resources

Designed for the non government AOD sector, NADA's worker wellbeing resources ask workers to invest as much time and care looking after their health as they do others..

Website: **www.nada.org.au**

NCETA Workforce Development 'TIPS' (Theory Into Practice Strategies): A Resource Kit for the Alcohol and Other Drugs Field (NCETA 2005).

This toolkit has a two specific sections that focus on Worker Wellbeing and Worker Support.

Website: **www.nceta.flinders.edu.au/workforce**

The Feeling Deadly-Working Deadly Indigenous Wellbeing Toolkit NCETA 2013

The *'Feeling Deadly, Working Deadly'* Resource Kit is aimed at reducing stress and burnout, and enhancing wellbeing amongst Aboriginal and Torres Strait Islander alcohol and other drug (AOD) workers. It forms part of NCETA's work on Aboriginal and Torres Strait Islander Worker Wellbeing. It was funded by the Australian Government Department of Health.

Counselling guidelines: Alcohol and other drug issues 3rd Edition WA Drug and Alcohol Authority (Marsh et al. 2013)

These guidelines includes over 50 chapters exploring some of the key skills needed to work at an individual level with people who have AOD problems including a case management, group work, referral, working with intoxicated and incarcerated clients, clinical supervision and stress and burnout.

7 | RESOURCES AND GUIDELINES

The resources and guidelines section provides a brief selection of information and support services, resources and toolkits for workers, and government produced guidelines and strategies which relate to working with women engaged in the AOD sector. It is by no means an exhaustive list, however many of the websites noted here provide further useful links to an expansive array of support documents and resources.

7.1 Information and support

ALCOHOL AND OTHER DRUG SUPPORT

Alcohol and Drug Information Service (ADIS)

ADIS is a 24-hour helpline which provides alcohol and other drug related information, support, crisis counselling and referral to NSW services.

Phone: 02 9361 800 or 1800 422 599

Website: **www.yourroom.com.au**

Alcohol, Tobacco and other Drugs Association of ACT (ATODA)

ATODA is the peak body representing the non-government and government alcohol, tobacco and other drug (ATOD) sector in the ACT.
Website: **www.atoda.org.au**

Alcohol, Tobacco and other Drugs Council of Tasmania (ATDC)

The ATDC is the peak body representing the interests of the community service organisations that provide services to people with substance misuse issues in Tasmania.

Website: **www.atdc.org.au**

Association of Alcohol and other Drugs Agencies in Northern Territory (AADANT)

AADANT is the peak body for the non government alcohol and other drug sector in the Northern Territory.

Website: **www.aadant.org.au**

Drug and Alcohol Multicultural Education Centre (DAMEC)

DAMEC was established in 1989 as an access and equity initiative designed to promote access by culturally and linguistically diverse (CALD) clients to alcohol and other drug services. DAMEC provide counselling and support for CALD people and have a research and information focus. DAMEC works within a harm minimisation framework, and uses the term alcohol and other drugs to describe both licit and illicit drugs, including alcohol, tobacco and prescription medicines that are used outside medical advice.

Phone: 02 9699 3552
Website: **www.damec.org.au**

Drug and Alcohol Specialist Advisory Service (DASAS)

DASAS is a free alcohol and other drug-related advisory telephone service for doctors, nurses, and other health professionals. Specialist medical consultants are on-call 24 hours to provide advice on diagnosis and management of patients. DASAS is especially designed to support regional and rural areas in NSW, but is available to any health professional.

Phone: 02 9361 8006 or 1800 023 687

Family Drug Support

Family Drug Support (FDS) was formed in 1997 after its founder, Tony Trimingham lost his son to a heroin overdose. FDS is a caring, non-religious and non-judgemental organisation, primarily made up of volunteers who have experienced firsthand the trauma and chaos of having family members with drug dependency. FDS provides a 24 hour/7 day a week telephone support line, website, support groups and courses for family members and significant others.

Phone: 1300 368 136
Website: **www.fds.org.au**

Foundation of Alcohol and Research Education (FARE)

FARE is an independent, not-for-profit organisation working to stop the harm caused by alcohol.

Website: **www.fare.org.au**

Network of Alcohol and other Drugs Agencies (NADA)

NADA is the peak body for the non government alcohol and other drugs sector in NSW.

Website: **www.nada.org.au**

NSW Users and AIDS Association (NUAA)

NUAA is the peak drug user organisation in NSW. It is a not-for-profit organisation advocating for people who use drugs, particularly those who inject drugs. NUAA provides education, practical support, information and advocacy to users of illicit drugs and their friends and allies.

Website: **www.nuaa.org.au**

Queensland Network of Alcohol and Drug Agencies (QNADA)

QNADA is the peak organisation representing the views of the non-government alcohol and other drug sector in Queensland.

Website: **www.qnada.org.au**

South Australian Network of Drug and Alcohol Agencies (SANDAS)

SANDAS is the peak body providing independent, statewide representation, advocacy and support for non-government organisations working in the South Australian alcohol and other drug sector, through networking and policy development.

Website: **www.sandas.org.au**

Victorian Alcohol and Drug Association (VAADA)

VAADA is the peak body representing drug and alcohol services in Victoria; it provides leadership, representation, advocacy and information to both drug-and-alcohol and non drug and alcohol related sectors.

Website: **www.vaada.org.au**

Western Australian Network of Alcohol and other Drug Agencies (WANADA)

WANADA is the peak body for the drug and alcohol education, prevention, treatment and support sector in Western Australia.

Website: **www.wanada.org.au**

Acquired Brain Injury Services

A not–for-profit specialist service for people with an aquired brain injury (ABI). Its aim is to enhance people's lifestyle by maintaining and promoting independence and providing opportunities for socialisation and community integration with appropriate and quality service provision.

Website: **www.abis.org.au**

Ageing Disability and Homecare (ADHC) ABI Web Resource

A webpage dedicated to ABI on the Family and Community Services Ageing Disability & Home Care website provides information on care and support pathways for people with an ABI, as well as information on the new ADHC training resource (web-based and face-to-face training options available).

Website: **www.abistafftraining.info**

arbias

arbias provides support to people with an acquired brain injury, specialising in alcohol and other drug related brain injury in NSW and Victoria. arbias is a case management, specialist assessment and intervention service targeted at people living with an alcohol-related acquired brain injury aged 16 to 65. arbias also provides a comprehensive range of training package options. Its training program provides practical strategies for working with people with acquired brain impairment and associated complex support needs.

Website: **www.arbias.org.au**

Brain Injury Australia (BIA)

BIA is the peak ABI advocacy body representing, through its state and territory member organisations, the needs of people with an ABI, their families and carers. It works at a national level to make sure all people living with ABI have access to the supports and resources they need to optimise their social and economic participation in the community.

Website: **www.braininjuryaustralia.org.au**

Community Restorative Centre (CRC) NSW

CRC is a NSW community organisation dedicated to supporting people affected by the criminal justice system, particularly prisoners, ex-prisoners, and their families and friends. Staff offer personal and practical assistance such as counselling, accommodation, a subsidised transport service, a court support service, outreach to prisons, information, advice and referrals.

Website: **www.crcnsw.org.au**

National Organisation for Fetal Alcohol Spectrum Disorder (NOFASD)

NOFASD Australia is an independent not-for-profit charitable organisation. NOFASD are the national peak organisation representing the interests of individuals and families living with Fetal Alcohol Spectrum Disorders (FASD). The website provides information, training and support related to FASD.

Website: **www.nofasd.org.au**

FAMILY AND DOMESTIC VIOLENCE

The Domestic Violence Line

This service provides telephone counselling, information and referrals for women and same-sex partners who are experiencing or have experienced domestic violence. Trained female caseworkers are sensitive to the needs of people who have experienced domestic violence. Domestic Violence Line staff are aware of the special needs of Aboriginal women and women from other cultures, as well as those living in rural and remote areas. Interpreters and TTY can be arranged where necessary to ensure that all people, regardless of their language or disability can use the service. The service has an extensive list of contacts, people and services across NSW who can help. For information, support and referrals regarding FDV contact the Domestic Violence 24 Hour Hotline.

Phone: 1800 656 463

Domestic Violence NSW (DVNSW) is the peak, state-wide representative body for a range of specialist domestic and family violence services.

Website: **www.dvnsw.org.au**

Domestic Violence Service Management (DVSM) aim to prevent domestic and family violence and homelessness, and support recovery. They provide professional services to the community services sector and client service delivery based on a social justice framework.

Website: **www.dvnswsm.org.au**

Domestic Violence Website

Includes information regarding FDV including telephone referral lines, tips and apps that can be downloaded, providing information for those experiencing FDV and/or those experiencing it.

Website: **www.domesticviolence.nsw.gov.au**

MENTAL HEALTH

Beyond Blue

Beyond Blue is an independent, not-for-profit organisation working to increase awareness and understanding of anxiety and depression in Australia and to reduce the associated stigma. They offer support via a 24 hour/7 day a week helpline and also offer web chat services.

Phone: 1300 22 4636

Website: **beyondblue.com.au**

Dual Diagnosis Australia and New Zealand

Dual Diagnosis Australia and New Zealand is a resource repository created to contribute to better outcomes for persons with co-existing substance use and mental health disorders.

Website: **www.dualdiagnosis.org.au/home**

Mental Health Association

Mental Health Association runs both the Mental Health Information Service and the Anxiety Disorders Information Line. These lines provide information, telephone support and referral for issues relating to mental health.

Mental Health Information Service – Phone 1300 794 991

Website: **www.mentalhealth.asn.au**

Mental Health Coordinating Council (MHCC)

The MHCC is the peak body for community mental health organisations in NSW. MHCC provides leadership and representation to its membership and seeks to improve, promote and develop quality mental health services for the community. MHCC provides a range of training and education through its Learning and Development Unit.

Website: **www.mhcc.org.au**

WOMEN'S HEALTH

Aboriginal women and sexual assault: 'Hey sis, we've got your back'

The Aboriginal Women's Sexual Assault Network was borne out of collaboration between Mudgin-Gal Aboriginal Corporation and Rape and Domestic Violence Services Australia (formerly NSW Rape Crisis Centre). Rape and Domestic Violence Services Australia is currently managing the initiative, with the assistance of an Advisory Committee of respected Aboriginal women.

The network seeks to bring together Aboriginal women who are working against sexual assault in their communities, or who would like to stand strong and support others in their communities who have experienced or been impacted by sexual assault. Through sharing stories and knowledge of what works and what doesn't, through the provision of culturally appropriate training, and through working together to develop and implement initiatives to prevent sexual assault at the community level, the network aims to reduce the rates of sexual assault in Aboriginal communities.
Website: **www.heysis.com.au**

ACON Health

ACON Health provide specific support services that relate to the health and wellbeing of Lesbian, Bisexual and Transgender women. In addition, through partnerships with academic institutions, ACON Health has engaged with significant research projects aimed at improving health outcomes for the LGBTQ+ community as a whole.
Website: **www.acon.org.au**

Australian Women's Health Network

The Australian Women's Health Network is a health promotion advocacy organisation that provides a national voice on women's health, based on informed consultation with members. Through the application of a social view of health, it provides a woman-centred analysis of all models of health and medical care and research. It maintains that women's health is a key social and political issue and must be allocated adequate resources to make a real difference.

It aims to foster the development not only of women's health services but of stronger community-based primary health care services generally, which it sees as essential to improve population health outcomes. It advocates collaboration and partnership between relevant agencies on all issues affecting health.

Website: **www.awhn.org.au**

Women's Health NSW

Women's Health NSW (WHNSW) is an association of statewide women's health centres and specialist women's centres. All centres are non-government, community based, feminist services that provide choices for women to determine their individual health needs. WHNSW centres aim to improve the health status of women by providing a unique, holistic, woman-centred approach to primary health care. The centres aim to blend medical and clinical services and a range of counselling, health promotion, education, self-help and consumer advocacy services. They also aim to provide women with the knowledge, skills and resources to enable women to take more responsibility over factors the adversely affect their health.
Website: **www.whnsw.asn.au**

7.2 Practice resources and toolkits

ABORIGINAL RESOURCES

Alcohol and other drugs treatment guidelines for working with Aboriginal and Torres Strait Islander people – in a non-Aboriginal setting (Wallace and Allan 2019).

While we know that Aboriginal Community Controlled Health Organisations are essential in the provision of specialist AOD treatment for Aboriginal people, it is important that non-Aboriginal service settings are safe and accessible for Aboriginal people who access these services.

The Guidelines are intended to support services to establish better relationships and linkages with Aboriginal organisations and in Aboriginal communities. The Guidelines also provide practical guides and resources to support workers and organisations to improve their service delivery when working with Aboriginal service users.

Aboriginal-specific Community Reinforcement Approach (CRA) Training Manual
NDARC (Rose et al. 2014).

The Community Reinforcement Approach (CRA) as it is described in this manual has been adapted from a comprehensive explanation as published in Meyers and Smith (1995) Clinical Guide to Alcohol Treatment: The Community Reinforcement Approach. This adapted CRA manual is designed for Indigenous Health and Family Workers and other Workers within Australian Indigenous community settings to support people who are at risk for alcohol related harm.

Australian Indigenous Health Infonet

A comprehensive web resource for working effectively and supportively with Indigenous Australians that provides information, training resources, projects, latest news and links. A web resource that is a 'one-stop info-shop' for people interested in improving the health of Indigenous Australians.

Website: **www.healthinfonet.ecu.edu.au**

Implementing a Soft Entry Approach to AOD intervention with Aboriginal women
Lyndon Community 2014

This is a PowerPoint presentation outlining a unique and effective approach used by the Lyndon Community to make contact with Aboriginal women with the aim of potentially providing alcohol and other drug support.

National Aboriginal and Torres Strait Islander Women's Alliance

The National Aboriginal and Torres Strait Islander Women's Alliance (NATSIWA) was established in 2009 to empower Aboriginal and Torres Strait Islander Women to have a strong and effective voice in the domestic and international policy advocacy process.

Website: **www.natsiwa.org.au**

NIDAC AOD Treatment Report NIDAC 2014

This paper was developed by the National Indigenous Drug and Alcohol Committee (NIDAC) in response to a misperception that effective AOD treatment is not available for Aboriginal and Torres Strait Islander peoples. The paper aims to allay these misperceptions by outlining who can benefit from receiving treatment; what treatment is known to work; key principles that should guide the application of treatment; and what constitutes effective treatment for Aboriginal and Torres Strait Islander people.
Website: **www.nidac.org.au**

Strengthening Aboriginal Family Functioning: What works and why? Child Family Community Australia, Australian Institute if Family Studies 2014 (Lohoar, Bureta & Kennedy)

This paper explores and discusses the contemporary evidence base to provide insights into the protective effects and risks that influence forms of functioning among Aboriginal families. It also has a section on specific resources.

NADA RESOURCES

Working with Families

NADA in partnership with Family Drug Support and the Ministry of Health NSW Government, developed training and resources for the AOD sector and other primary health contacts to build the capacity of workers to better support families who are impacted by someone else's substance use.

Resources include the eLearning modules to increase your knowledge and ability to apply evidence based practice approaches that support families and significant others using the facilitator guide [PDF] and slides [PPTX] to run your own in-service that specialises in supporting families and significant others impacted by the AOD.

Complex Needs Capable: A Practice Resource for Drug and Alcohol Services NADA 2013

This resource provides practice tips, tools and templates that can support alcohol and other drugs staff and organisations working with clients with complex needs such as acquired brain injury, intellectual disability, fetal alcohol spectrum disorders and contact with the criminal justice system.

Website: **www.nada.org.au /www.complexneedscapable.org.au**

From Individuals to Families: Single Session Consultations (DVD) NADA 2012

This DVD, developed in partnership with NADA and The Bouverie Centre, provides a practical case example from an alcohol and other drug service. It also included interviews with staff from three NADA members discussing the implementation of the single session approach to working with families in alcohol and other drug settings.

Tools for Change: A New Way of Working with Families and Carers NADA 2009

Tools for change provides a range of interventions, practice tips, service models, resources and training organisations to assist services in working with families.

Website: **www.nada.org.au**

Working with Diversity in Alcohol and other Drug Settings NADA 2014

The resource has been developed to support non government alcohol and other drug services work with the diversity of clients that access our services and represent the NSW population.

A supplementary document: ***Working with Diversity in Alcohol and other Drug Settings - Useful Resources*** NADA 2015 also provides a comprehensive list of updated resources of use.

NADA recognises that there are other populations that have not been included such as young people, women, children, and those with a disability. For best practice examples in working with young people, access the Dovetail Youth Alcohol and Drug Good Practice Guide.

Website: **www.nada.org.au**

FAMILY AND DOMESTIC VIOLENCE

Can I ask…? An alcohol and drug clinician's guide to addressing family and domestic violence NCETA 2013 (White et al.)

Can I ask…? explores the relationship between AOD and FDV, with a focus on identifying how the AOD sector can better support clients who have co-existing AOD and FDV issues, and minimise associated harms experienced by their children.

The **Domestic Violence Resource Centre Victoria** (DVRCV) provides training, publications, research and resources to those experiencing (or who have experienced) family violence, and practitioners and service organisations who work with family violence survivors.

Website: **www.dvrcv.org.au**

Supporting Women with Complex Needs: The relationship between substance use and domestic and family violence Women's Council for Domestic and Family Violence Services (WA) and WANADA 2009

This resource explores how service providers can work in collaborative and respectful ways with women who have experienced violence and who have substance use concerns. It identifies how common it is for women to experience both concerns, and how critical is it for service providers to assist women to make the links and to determine paced and achievable paths to change, growth and safety.

Walking a Tightrope: Alcohol and other drug use and violence: A guide for families NCETA 2014

Walking a Tightrope is a comprehensive resource for people who have a family member who uses both alcohol and other drugs (AOD) and violence in their relationships. The resource has been produced through a partnership between Family Drug Support (FDS) and the National Centre for Education and Training on Addiction (NCETA) and was funded by the Department of Social Security.

FAMILY INCLUSIVE PRACTICE

Children of Parents with a Mental Illness Website

The COPMI (Children of Parents with a Mental Illness) national initiative develops information for parents, their partners, carers, family and friends in support of these children. This information includes online training courses developed by COPMI for professionals to support families either individually or through community services and programs.

Website: **www.copmi.net.au**

Familiar Needs; Working with Children and Families VAADA 2011

Resource developed by VAADA to provide AOD treatment services with a snapshot of resources available and practice tips for working with families and children.

Families and friends affected by the drug and alcohol use of someone close NSW Health 2004

This resource answers common questions and concerns of those who are experiencing the challenges of having someone they care about engage in problematic substance use.

Family Focus Project Toolkit Eastern Drug and Alcohol Service 2010

The Family Focus Toolkit is a collection of selected resources including screening tools, questionnaires and worksheets gathered from the sector, research and professional bodies.

For Kids' Sake: A Workforce Development Resource for Family Sensitive Policy and Practice in the Alcohol and Other Drugs Sector NCETA 2010 (Battams et.al.)

For Kids' Sake, A Family Sensitive Policy and Practice Toolkit aims to minimise cases of child abuse or neglect by increasing collaboration between child and adult service agencies. It is a new initiative developed by NCETA to improve the safety and welfare of children with parents who misuse alcohol or drugs. The toolkit builds a bridge between the alcohol and other drugs treatment and child protection sectors to improve cooperation and collaboration.

From individuals to families: A client centered framework for involving families, The Bouverie Centre, La Trobe University

This document was developed for adult mental health and alcohol and other drug services providers as a framework for a comprehensive service response to a client's family, social network or kinship group in the context of client-centred care and sets out key issues in implementing this framework. The ideas presented can guide both individual services and groups of services to determine how they can best involve and respond to the needs of families.

From Individuals to Families: Single Session Consultations (DVD) NADA and the Bouverie Centre 2012

This DVD, developed in partnership with NADA and The Bouverie Centre, provides a practical case example from an alcohol and other drug service. It also included interviews with staff from three NADA members discussing the implementation of the single session approach to working with families in alcohol and other drug settings.

Legal Aid Care and Protection Factsheets

These fact sheets provide information that helps people navigate the Children's Court and children's services. The five factsheets in the series cover the process of going to the Children's Court and the role of Family and Community Services. The *Kids in Care* fact sheets have been translated into 10 community languages – Arabic, Bengali, Dari/Farsi, Dinka, Kirundi, Chinese (Sim), Swahili, Tamil, Thai and Vietnamese.
They can be **ordered** and are also available online.

Website: **www.legalaid.nsw.gov.au/publications/**

The signs of safety: Child protection practice framework Department of Child Protection Western Australia 2011

Is a policy document that seeks to create a more constructive culture around child protection organisation and practice. Central to this is the use of specific practice tools and processes where professionals and family members can engage with each other in partnership to address situations of child abuse and maltreatment.

Tools for Change: A New Way of Working with Families and Carers NADA 2009

Tools for change provides a range of interventions, practice tips, service models, resources and training organisations to assist services in working with families.

Website: **www.nada.org.au**

CALD COMMUNITIES

Drug and Alcohol Multicultural Education Centre (DAMEC)

DAMEC was established in 1989 as an access and equity initiative designed to promote access by culturally & linguistically diverse (CALD) clients to alcohol and other drug services. DAMEC provide counselling and support for CALD people and have a research and information focus. DAMEC works within a harm minimisation framework, and uses the term alcohol and other drugs to describe both licit and illicit drugs, including alcohol, tobacco and prescription medicines that are used outside medical advice.

Helping asylum seeker and refugee background communities with problematic alcohol and other drug use: A guide for community support and AOD workers QNADA 2015 (Pont B and Jaworski A)

The guide is divided into two sections, the first is for workers supporting people from refugee backgrounds across the general health and community services sector who may not have specific training or experience in alcohol and other drugs service provision. And the second is for those working in the AOD sector and discusses issues that are relevant across the range of treatment settings.

Immigrant Women's Speakout Association NSW

Immigrant Women's Speakout Association is the peak advocacy, information/referral and research body representing the ideas and issues of immigrant and refugee women in NSW. The Association also undertakes community development projects and provides direct services including in the areas of domestic violence and employment, education and training. Speakout is a community-based organisation, managed by women of non-English speaking background. There are a number of resources available via the website, including training opportunities.

Website: **www.speakout.org.au**

Respect: Best practice approaches for working with culturally diverse clients in AOD treatment settings. DAMEC 2014

Website: **www.damec.org.au**

Perinatal Mental Health for Women from CALD Backgrounds (Beyond Blue)

This is a brief guide for health care workers that covers a number of issues and barriers CALD women experience in accessing support during pregnancy, birth and in relation to parenting. It attends to the needs of CALD women and how health services can be more responsive in relation to the experience of pregnancy, birth and parenting.

Website: **www.beyondblue.org.au**

Talking therapies for people with problematic substance use Te Pou o Te Whakaaro Nui 2010

This guide provides useful background information on problematic substance use, suggestions for interventions during the various stages of treatment, and information on the range of talking therapies currently utilised by practitioners in New Zealand. Also includes sections on Maori, other Pacific Islander cultures and working with refugees.

LGBTQ+ COMMUNITIES

AOD LGBTIQ inclusive guidelines for treatment providers

Although members of LGBTQ+ and HIV positive communities use AOD for many of the same reasons as the population at large, there is evidence to suggest that shared experiences of LGBTQ+ related discrimination can lead to patterns of AOD misuse specific to LGBTQ+ people. This includes the use of AOD at higher levels than the general population and potentially for longer durations.

Website: **www.nada.org.au**

Best Practices for Lesbian/Bisexual Women with Substance Use Disorders (Eliason 2009)

This paper reviews what we know about substance abuse patterns among lesbian and bisexual women and suggests best practices.

GLBTIQ Domestic Violence Toolkit

A resource for agencies and service providers supporting GLBTI victims of domestic violence and their families.

Website: **www.avp.acon.org.au/anti-violence/resources/GLBTIQDV-toolkit**

Lesbian Relationships and Abuse – Domestic Violence Resource Centre Victoria

Help and advice on the DVRCV website that provides information regarding the experience of domestic violence within lesbian relationships.

Website: **www.dvrcv.org.au**

TRANS AND GENDER DIVERSE WOMEN

The Gender Centre

The Gender Centre offers a range of services to trans and gender diverse people, their partners, families and friends in NSW. They also act as an education, support, training and referral/ resource centre to other organisations and service providers. The Gender Centre aim to provide a quality service that acknowledges human rights and ensures respect and confidentiality.

Website: **www.gendercentre.org.au**

The First Australian National Trans Mental Health Study: Summary of Results Curtin University 2013 (Hyde Z, et al)

This report provides an overview of the findings of The First Australian National Trans Mental Health Study. The study was designed to investigate the mental health and wellbeing of trans people living in Australia.

COMPLEX NEEDS

Complex Needs Capable: A Practice Resource for Drug and Alcohol Services NADA 2013

This resource offers practice tips, tools and templates that can support alcohol and other drugs staff and organisations working with clients with complex needs such as acquired brain injury, intellectual disability, fetal alcohol spectrum disorders and contact with the criminal justice system.

Website: **www.nada.org.au /www.complexneedscapable.org.au**

Counselling guidelines: Alcohol and other drug issues 3rd Edition WA Drug and Alcohol Authority (Marsh et al. 2013)

These guidelines includes over 50 chapters exploring some of the key skills needed to work at an individual level with people who have AOD problems including a case management, group work, referral, working with intoxicated and incarcerated clients, clinical supervision and stress and burnout.

Guidelines on the Management of Co-Occurring Alcohol and Other Drug and Mental Health Conditions in Alcohol and Other Drug Treatment Settings NSW Department of Health 2009

Available from: **www.ndarc.med.unsw.edu.au/**

Mental Health Reference resource for Drug and Alcohol Workers NSW Department of Health 2007

Available from NSW Ministry of Health: **www.health.nsw.gov.au**

MHCC Trauma Informed Care and Practice webpage

This website contains a range of resources and events listings and a network on trauma-informed care and practice.

Website: **www.mhcc.org.au**

NSW Clinical Guidelines for the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings NSW Department of Health 2009
Available from NSW Ministry of Health: **www.health.nsw.gov.au**

Pathways of recovery (Rickwood 2005)

This monograph raises the vital issue of the role of relapse prevention in the recovery process for people who have been seriously affected by mental illness. While preventing further episodes of mental illness should be a routine component of treatment and continuing care for people with mental illness, feedback from consumers and carers shows that frequently this is not the case. Too often the experience of consumers, and their families and carers, is of a crisis-focussed mental health system that doesn't respond early enough to avert further episodes, nor prioritise rehabilitation and relapse prevention as essential components of ongoing continuing care to facilitate recovery. Although relapse prevention has traditionally been viewed as an illness focussed approach, it is reconceptualised here as one of the essential components of a recovery-oriented mental health system.

PREGNANCY AND PARENTING

It's time to have the conversation: Understanding the treatment needs of women who are pregnant and alcohol dependent. (NDARC 2013).

This report presents a narrative literature review of treatments available to pregnant women who have alcohol use disorders and findings from interviews with key stakeholders regarding current treatment practices and areas requiring improvement.

Supporting Pregnant Women who Use Alcohol or other Drugs: A guide for primary health professionals NDARC 2014.

Health care professionals can make a substantial difference to the health of women and their babies by identifying and supporting women who use alcohol or other drugs during pregnancy. This guide is intended for a range of health professionals, in a variety of settings to help support and provide information to pregnant women who use alcohol and other drugs. It also contains a detailed resource list of additional support services and resources.

What Family Sensitive Practice Means for Alcohol and Other Drug Workers: A Survey Report NCETA 2010 (Trifnoff et al.)

The **report** is the first of a range of publications being developed by NCETA to address the issue of child and parent-sensitive practice. The initial phase of this project involved a survey of the drug and alcohol workforce to identify current work practices, individual knowledge and attitudes and organisational policies and support in relation to child and parent-sensitive work practice. This report presents the results of the survey and outlines.

TRAUMA INFORMED CARE

Adults Surviving Child Abuse (ASCA)

ASCA is a national organisation that works to improve the lives of adult survivors of child abuse throughout Australia. ASCA offers a number of training courses and has resources suitable for professionals working with adult survivors of child abuse.

Blue Knot Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery 2019

Blue Knot's Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery present the collective wisdom of the last two decades of national and international research in the trauma field. They are poised to revolutionise possibilities for recovery for the large numbers of people with unresolved "complex trauma" - child abuse in all its forms, neglect, family and community violence and other adverse childhood events. They establish insights that optimism about recovery from complex trauma is warranted, and that childhood trauma can be resolved.
Website: **www.blueknot.org.au**

Education Centre Against Violence (ECAV)

ECAV is a state-wide unit responsible for training programs in the specialised areas of adult and child sexual assault, domestic and Aboriginal family violence and physical and emotional abuse and neglect of children across NSW. ECAV provides the mandated training for specialist child protection, sexual assault and Aboriginal family health workers, as well as targeted training for mental health and drug and alcohol workers in government and non-government organisations
Website: **www.ecav.health.nsw.gov.au**

Guidelines for Trauma-Informed Practices in Women's Substance Use Services Jean Tweed Centre for Women and their families 2013

This Canadian resource sets out to specifically focus on the intersections of trauma and substance use issues among adult women. It provides background information and best practice approaches to working with women engaged in substance use services from a trauma-informed approach to practice.

NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)

STARTTS supports refugees recover from their experiences and build a new life in Australia. STARTTS is committed to assisting and resourcing people and organisations to provide appropriate and culturally sensitive services to refugee survivors of torture and trauma. Additionally, STARTTS provides a range of counselling and therapeutic services.
Website: **www.startts.org.au**

Trauma-Informed Organizational Toolkit for homelessness services (Guarino et al. 2009)

This toolkit offers homeless service providers with concrete guidelines for how to modify their practices and policies to ensure that they are responding appropriately to the needs of families who have experienced traumatic stress. AOD services can also use this resource to assist them in becoming trauma informed.

7.3 Government guidelines and strategies

Child Wellbeing and Child Protection – NSW Interagency Guidelines NSW Department of Family and Community Services 2006

These guidelines were produced to support collaborative efforts to improve child wellbeing and child protection in NSW. They cover inter-agency collaboration initiatives; roles and responsibilities of agencies in child protection matters; making a child protection report voluntarily or through mandatory reporting requirements; exchange of information with DCJ; criminal proceedings; and best practice in working with children and families.

Clinical Guidelines for the Management of Substance Use During Pregnancy, Birth and the Postnatal Period 2014

These guidelines contain information on the use of buprenorphine maintenance treatment during pregnancy; cannabis use in pregnancy; a recommendation for abstinence from alcohol during pregnancy; and updated information on child protection legislation in NSW. New sections include prescription opioids use in pregnancy; use of antidepressants in pregnancy; management of withdrawal; management of incarcerated pregnant women; and management of women in rural and remote areas.

Keep Them Safe: A shared approach to child wellbeing

In response to findings from the Wood Special Commission of Inquiry into Child Protection Services in NSW, the NSW government enacted a five year plan entitled Keep Them Safe, which spans the years 2009-2014. Keep Them Safe was designed to enhance the broader service system in NSW to improve prevention and early intervention services; protect children at risk; support Aboriginal children and families; and to strengthen partnerships with non government agencies to improve service delivery to vulnerable families. As a result of Keep Them Safe, a number of guidelines and legislative changes have taken place in the child protection arena in NSW, which are described briefly below.

Website: **www.keepthemsafe.nsw.gov.au**

Neonatal Abstinence Syndrome Guidelines NSW Ministry for Health 2013

These guidelines outline the minimum standards for the management of babies born to mothers with a history of opioid use or dependence, including women receiving opioid substitution therapy or using prescription pharmaceutical opioids. The guidelines cover antenatal care, the management of withdrawal syndromes in neonates, and postnatal care.

NSW Health Drug and Alcohol Psychosocial Interventions: Professional Practice Guidelines NSW Dept. of Health 2008

The Drug and Alcohol (D&A) Psychosocial Interventions Professional Practice Guidelines are the first generic professional guidelines for psychosocial interventions to be developed in NSW for drug and alcohol practice. The Guidelines take a stepped care approach to drug and alcohol treatment, which focuses on the adoption of best practice models for people with drug and alcohol issues, and reflects current best evidence and practice in the drug and alcohol counselling field.

NSW Health Framework for Women's Health 2013 NSW Ministry of Health 2013

The Women's Health Framework has been developed to focus action not only within the Health system, but also promotes opportunities for the co-ordination and delivery of NSW Government services and programs with the potential to enhance the health of all women across the state. This Framework brings together these aspects – highlighting the different needs of populations of women, the evidence for investment in health priorities, and the framework for collaboration across government and non-government sectors to deliver appropriate services and programs for the diverse needs of women in all of our communities.

NSW Mandatory Reporter Guide NSW Department of Family and Community Services 2014

All non government drug and alcohol service providers in NSW are mandatory reporters under child protection legislation. To assist workers to navigate the 'grey areas' and make confident decisions when considering making a child protection report to Family and Community Services.

Supporting Families Early Package – SAFE START Guidelines: Improving mental health outcomes for parents and infants NSW Department of Health 2009

Safe Start is one of a suite of three documents aimed at integrating care for women, infants and families in the perinatal period. This document provides guidance on conducting psychosocial assessment, risk prevention and early intervention. Strategies to coordinate clinical responses to issues identified during assessment are also suggested, including effective responses to parental mental health problems and perinatal psychosocial issues, as well as advice on assisting mothers that have problems with substance use.

7.4 Training and workforce development centres

Blue Knot: **www.blueknot.org.au**

Centre for Community Welfare Training (CCWT): **www.acwa.asn.au/CCWT**

Education Centre Against Violence (ECAV): **www.ecav.health.nsw.gov.au**

Family Worker Training & Development Program Inc: **www.fwtdp.org.au**

Intellectual Disability Rights Service (IDRS): **www.idrs.org.au**

Mental Health Coordinating Council (MHCC), Learning & Development Unit: **www.mhcc.org.au/learning-and-training/default.aspx**

NSW Ombudsman: **www.ombo.nsw.gov.au/trainingworkshops/index.html**

NSW Institute of Psychiatry (NSWIOP): **www.nswiop.nsw.edu.au**

Uniting Care Institute of Family Practice: **www.ifp.nsw.edu.au**

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