

Working with Families in the Alcohol and Other Drugs Sector

Discussion Paper

June 2009

**Compiled and written by Family Drug Support and South Australian
Network of Drug and Alcohol Services**



Discussion Paper

Working with Families in the AOD Sector

Issues and Directions for capacity building arising from the professional development workshop program to help agencies and workers engage with families experiencing AOD issues.

July 2009

Introduction-

During the last decade the family has attracted more interest and some health spending. However, this is still in its infancy. Bridging the Divide is a national project funded by the Department of Health and Ageing (DoHA) part of the Commonwealth Government's increased focus on AOD issues and capacity building in the community.

Some states, such as NSW, have acknowledged the need to support organizations to build such capacity with the support of their peak bodies and an example of this is Tools for Change. A new way of working with families and carers found online at www.nada.org.au

Family Drug Support (FDS) received the DoHA funding to help build the capacity of the Alcohol, Tobacco and Other Drug Sector to work more effectively with families whose members were in treatment. The project encourages family inclusive practice and supports agencies to develop appropriate policies, strategies and processes that would enable them to engage with families.

In May 2009 Family Drug Support (FDS), Centacare and the South Australian Network of Drug and Alcohol Services (SANDAS) conducted a professional development workshop for the AOD NGO sector in South Australia. This, in conjunction with work undertaken by FDS and other SANDAS members such as Streetlink, informs this paper. (See Appendix 3 for a list of participating organisations that attended this workshop)

In the months of April and June 2009, as a part of this project, seven workshops for AOD workers were conducted by the Project Officer of Bridging the Divide (Southern Region). The workshops were held across South Australia, Victoria and Tasmania and attracted 172 participants altogether. A list of participating organisations is attached to this Discussion Paper.

The Tasmanian workshops were organised, promoted and supported by the Tasmanian ATOD Peak Body, ATDC. In Victoria, DASS West and the Bass Coast Community Health Service were the participating agencies.

At each workshop, working groups of around five participants were established to complete issues and practice gathering exercise. The group discussions were stimulated by set questions with a clear indication that the results would shape the basis for a discussion paper that could inform policy and processes within the sector. It was also emphasised that though there were questions that addressed the barriers to family inclusive practice, for both workers and families, it was important to spend time seeking solutions to the arising problems.

This paper seeks to extend that effort and continue the capacity building around working with families and AOD.

Summary of workshop results

The overall response to the need for such family focused capacity building was very positive. It should be mentioned the large workshop in South Australia was oversubscribed with people keen to put their names down for cancellations.

It was clear that many of the participants were aware of the benefits and the growing body of research that supported AOD agencies developing and implementing a family inclusive policy. However workers saw their ability to engage and work effectively with families to be limited. This was largely due to the lack for time and flexibility needed to connect with families and the added complexity that family dynamics would initiate.

KEY ISSUES

Funding

It has already been reported that (The Burden of Submission Writing and Reporting for the Alcohol and Other Drug Non Government Organisations *'Non-government organisations in the alcohol and other drugs sector: issues and options for sustainability'* Australian National Council on Drugs Report 2009) ATOD Workers spend much of their time on paper work and reporting requirements leaving little time to address the work load and specialization needs generated by engagement of the family members.

Another hurdle was the restrictions of the current service agreements that did not allow for flexibility and usually did not include families in the mix. Current funding models tend to have a traditional focus of an agency-individual client- episodic basis. The realistic acknowledgement of the cost benefits of family approaches has not become widely integrated into Commonwealth or State funding streams and therefore the incentives for agencies to adopt such approaches are limited or left to voluntary commitment either of senior management or sometimes of individual workers. Such an ad hoc approach to working with families is not seen as desirable and policy and funding models should be setting capacity building drivers.

It was noted that dealing with families adds yet another multifaceted dimension to an already highly complex caseload. Without purpose funding, or specific training allocations workers were concerned that they would be expected to include this

service under current service agreements and reporting requirements. This would place too much pressure on an already over taxed AOD NGO workforce struggling to recruit, attract and retain workers. It would further potentially erode, through worker loss, those workers with some natural inclination or skill to work with families and a group dynamic.

Risk

The clinical risks that would arise from the introduction of family members were also highlighted. Emphasis on the need for adequate policies and procedures to support family inclusive practice was stressed. It was seen as important to address the skills development and clinical supervision needs of staff when working at this level of complexity to help mitigate against such risk. It was also recommended that highly sensitive aspects of confidentiality would need to be tackled and reviewed during the process of auditing current policy and procedures and the writing of new policies and procedures. This would need to include new policy directions in relation to child protection and other legal complexities which might include aspects of Family Court orders and custody arrangements.

The wider risks of health, social and justice burdens also need to be taken into account by policy makers and funders. These are increasingly being documented and publicized and particular attention needs to be paid to the social cost and financial cost associated with the impact of addictions on other family members (e.g. family violence, absences from work and drain on the medical services for issues such as stress and depression) (Copello & Orford 2002).

Interventions

Activities and approaches suggested in relation to interventions include:-
ATOD organizations: conduct an audit of their policies and procedures in regards to Family Inclusive Practice. It was recommended that such consideration might be reflected in operational areas such as an organization's Strategic Plan, current work practices, the content of the organizations website, workforce development e.g. clinical supervision, professional development, office and service space design. It was recommended that a Customer Service Satisfaction Survey be included as part of the overhauled procedures.

- **Funding bodies:** develop new funding models to reflect the costs and benefits and the need for flexibility so organizations can engage and work with families. Models also need to allow for portability, given the high chances of housing mobility of families as a result of general social disadvantage and significant economic downturn.
- **Education:** family sensitive training to be included in the content review of relevant **TAFE and University curriculum.**

- **Network Building:** developing a sound network of family focused organizations that continue to strive for continuous quality improvement in the area of family inclusion.
- **Special Needs Groups:** it was widely acknowledged that youth, indigenous, and CALD characteristics of AOD affected families needed specific capacity building attention and resourcing. The mainstreaming of services not to acknowledge these needs increases the risk of poor outcomes for these groups.
- **Co morbidity:** families can have co existing AOD and Mental Health issues and workers who engage with families need adequate understanding of these conditions and satisfactory referral processes.
- **Early Childhood Development:** families with AOD issues and young children need to be linked into services that can help with the negative determinants of childhood development, including nutrition, social isolation, school truancy and others.
- **Regional South Australia:** is underdeveloped in terms of family focused services and areas where they are funded by government services there is no clear indication of family focused capacity. Stronger service networks in regions need to be built and need to include partnerships with various providers including GPs

Tools for further family engagement capacity building includes:-

- Education Forums.
- Stronger promotion of currently funded family focused AOD services
- Information Packs to be developed for families.
- Adaption of Family Drug Support Stepping Stones to Success Course to better suit the needs of specific population groups e.g. aboriginal families and youth with parents that are abusing drugs and alcohol.
- Easy to understand referral guidelines for families into and through primary health care structures.
- Support groups for families, both self help and service provider facilitated groups were recommended.
- Telephone counseling and telephone support and where possible 27/7
- Acknowledgement of the health burden of AOD affected families in the development of primary health care models

It is clear that most agencies and workers understand the difficult and roller coaster journey that families endure when faced with a loved one's drug and alcohol misuse. , However there is very real frustration by the restrictions and lack of resources to tackle service development and capacity building that would enable more effective engagement with families and therefore increase the chance of better outcomes for individuals, families and communities.

Nevertheless there is a strong commitment in the sector to seek solutions to these issues some of which do not need major resourcing. However, there does need to be formal policy and funding recognition that such solutions only go a small way to improving outcomes.

It was pleasing to see the resilience of workers and motivation of them to continue to evaluate their professional practice.

Acknowledgements

I would like to acknowledge and thank all those people who participated in the workshops, without your contribution this paper would not have been written. Recognition needs to go to those people who gave of their time to read the draft copy and submit suggestions and comments. A particular thank you needs to go to Andris Banders (EO SANDAS) for his input and support throughout this process.

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For methodologies that were recommended when working with families please refer to Appendix 2 (page 11)

For further information on the questions asked at the workshops please refer to Appendix 1

For collated answers please refer to Appendix 2.

APPENDIX 1

During these workshops, the following questions were posed.

Family engagement- Identifying the barriers and challenges for workers

When considering working with families, what barriers may workers experience?

What are the barriers that families experience when endeavouring to engage with treatment services?

Identifying the rationale and value of including families

What is the rationale and value of including families in treatment plans?

What are the benefits for workers when including families?

What are the benefits for families when treatment services include families?

Methodologies used when working with families

In your experience, when working with families what doesn't work?

In your experience, when working with families, what methodologies work?

Exploring the Challenges of working with families

What are the traps and challenges for workers when working with families?

Identifying the Family Journey

Identify the emotional challenges that the family face.

When considering the issues identified some solutions to these problems were discussed and documented.

Working groups of around five participants were established, a scribe was appointed, and butcher's paper and felt pens were supplied. The facilitators distributed the questions with a clear indication that the results were going to shape the basis for a discussion paper that could inform policy and processes within the sector. It was also emphasised that though there were questions that addressed the barriers to family inclusive practice, for both workers and families, it was important to spend time seeking solutions to the problems arising.

APPENDIX 2

Results recorded from the workshops

Little if any editing has been applied to these answers and they should be taken as raw data. The listing of responses is not prioritised in any way. All suggestions may not have been captured in the table session recording process and for this we apologise. However, if someone wishes to raise a missed issue or elaborate on a point please email lesley@fds.ngo.org.au

Family engagement- Identifying the barriers and challenges for workers

When considering working with families, what barriers may workers experience?

Some of these complexities were as follows:-

- Concern was raised regarding the family's unrealistic expectations on the treatment service/ wanting a magic wand and the expectation that the agency/ treatment service would or should fix the problem.
- Since many family members did not see that they had a problem and were focused primarily on the user, it took a significant amount of time to assist families to seek the support they needed to remain resilient and deal with the presenting issues.
- It was noted that inclusion of families was not usually a one off session and that ongoing support was needed.
- Since workers need to adhere to confidentiality policies and procedures, it was noted that family involvement would require sensitive negotiation with the client/ user regarding family.
- It was noted that a clear understanding of what constitutes a family would need to be addressed by the organisation so workers had clear guidelines.
- It was documented that workers required a high level of clinical skill and a heightened awareness of the capacity for 'splitting' to occur, for 'colluding' to occur and that issues of trust could arise between counsellor and client (user) or between counsellor and family.
- It was noted that workers needed to know their limitations and only attempt intervention when they had adequate experience and training to do so.
- Consideration was needed to be given to cultural differences, educational levels, including literacy.
- The lack of clinical supervision was also cited as a difficulty for workers. It was considered that given the additional complexities of working with families that regular clinical supervision was a necessity
- Some workers reported that they lacked the confidence to work with families and believed that they needed specific skills to do so.
- Counselling room space was cited as another issue that impeded the engagement of family. Small counselling spaces were considered inadequate for family counselling. Small physical spaces are not conducive to family counselling.

- It was considered important, not only to setup a safe physical space (that is emotionally safe as well), to setup guidelines, purpose and guidelines for engagement as well. Again this is time consuming.
- Lack of agency and clinical guidelines regarding family inclusive practice was also cited as an issue for workers. They were unclear what their duty of care was and what appropriate measures to introduce when working with families.
- Some workers expressed their fears around losing control of the session given the complexity and often volatile dynamics of the families involved.
- It was noted that many families lack of knowledge of substance misuse and harm minimisation and that the families understanding of successful outcomes was often limited and unrealistic.
- Families desire to want to control the situation and not understanding the nature of addiction was seen as a barrier to engaging and connecting effectively with families.

Family engagement- Identifying and solving issues for families

Question: - What are the barriers that families experience when endeavouring to engage with treatment services?

- Families reported frustration regarding confidentiality and that this stopped them being able to get information regarding their loved one.
- Barriers were identified because some services were anti families and could demonise the family and brand them as toxic, encouraging the client/user to reduce or separate from the family unit. In some cases this lead to families being excluded from being part of the treatment plan.
- Workers reported that families were often looking for a “magic wand” and became disillusioned when there was no quick fix.
- Families frequently focusing on the user and did not acknowledge their issues, their responsibilities and their needs.
- It was noted that many families lacked knowledge regarding drug and alcohol issues
- It was noted that intergenerational drug use and socio economic disadvantage was a barrier to the engagement with families. They were suspicious of authority and feared the consequences of interventions by health workers.
- The use of professional jargon and patronising attitudes was seen as a barrier.
- It was cited that intake access systems are often not able to manage drug and alcohol enquiries and that caused frustration and angst for distressed family members. That these intake access systems rarely had the skills to engage with the families. That these workers need to be able to engage and refer appropriately (e.g. brief intervention)
- Another barrier to engagement of families was sometimes their unrealistic expectations. These unreal expectations caused them to become frustrated and angry leading to them disengaging.
- Past negative experiences with treatment services were cited as a barrier for families, since this can lead to them being defensive and closed to engaging with treatment services.

What are the expectations of family members have when making contact with a treatment service?

- Families often want a quick fix or a magic wand.
- They expect the drug and alcohol worker to have the cure and become frustrated when treatment does not result in the families desired outcomes.
- They are focused on abstinence even when the client/user is not motivated to give up.
- Their lack of understanding of the policy of harm minimisation leads to them feeling let down by services and not supported.

When considering the issues identified some solutions to these problems were discussed and documented.

Solutions that would assist worker to engage and work more effectively with families were:-

- For agencies to conduct an audit of workers skills in regards to working with families and develop a professional development program that would assist workers acquire further skills, experience and confidence. It was recorded that particular consideration should be given to new recruits by providing family sensitive training.
- For agencies to provide adequate clinical supervision to deal with the complexities of family inclusive practice.
- That agencies provide adequate debriefing for workers working with the complexities of family dynamics hence guarding against vicarious trauma and desensitisation.
- For agencies to address the need for adequate physical space when working with families.
- For agencies to develop and implement a Family Inclusive Policy, procedures and guidelines. A model/framework or minimum standard of practice for working with families also be developed as part of the policy.
- To seek funding for family specific workers, who are able to address the needs of families.
- For funding bodies to review the service agreements that limit workers to working with user only.
- For the agencies to develop comprehensive Information Packs for families and/or hold information/education nights for families. These packs and/or information nights were seen as a way to assist families to understand the cycle of change, harm minimisation and the treatment process. The workers saw this as way of engaging families and reducing the conflict some families had with workers, the treatment service and treatment goals. The reduction of conflict and misunderstanding was seen not only as a benefit to the family members, the client/user but also as an additional benefit to the workers. It was seen as reducing the conflict and hence paving the way for improved engagement.
- Inclusion of family sensitive training in TAFE and University course material was seen to benefit the sector and raise the awareness of up and coming workers to the importance of Family Inclusive Practice.

- The Family Drug Support Stepping Stones Course Training and Family therapy training was also recommended as a way of up skilling workers.
- Where physical space was an issue that the agency look for space elsewhere in the community
- That the dissemination of research regarding the benefits of family inclusive practice would be useful.
- That a Customer Satisfaction Survey be introduced to assist workers to ascertain the needs of families and receive feedback regarding improving services.

Solutions for clients/users to understand the benefits of family engagement were:-

- To assist clients (user) to understand the benefits of family inclusion and understand clearly their rights to confidentiality. This information would need to be made clear before they agreed to release of information and signed the appropriate documents.
- To explain the benefits of family sessions and to make clear the guidelines and purpose of these sessions.
- For the worker to have a broad understanding of what constitutes a family without the constraints of the conventional family setting.
- To access community groups in particular CALD Elders was considered to be helpful for some clients. This could lead to a greater community support network.
- To develop clear guidelines of engagement was seen to be reassuring for both the user and the family members.
- To assist both client and family to develop skills that could lead to change taking place without trauma, violence and chaos would be advantageous to both parties
- To conduct an audit of current assessment and treatment plan processes to ascertain changes that could be introduced so treatment services delivered a more family inclusive program. (see Things to consider when reviewing assessment and treatment plans)
- To establish more residential family programs.

Solutions for improved family engagement by the treatment services were:-

- To provide education sessions for families. It was recommended that harm minimisation, stages of change and the confidentiality policy and the rights and responsibilities of families and clients/users be included in these sessions.
- For the agencies to develop comprehensive Information Packs for families and/or hold information/education nights for families. These packs and/or information nights were seen as a way to assist families to understand the cycle of change, harm minimisation and the treatment process. The workers saw this as way of engaging families and reducing the conflict some families had with workers, the treatment service and treatment goals. The reduction of conflict and misunderstanding was seen not only as a benefit to the family members, the client/user but also as an additional benefit to the workers. It

was seen as reducing the conflict and hence paving the way for improved engagement.

- The development of an Information Pack for families was considered a way of engaging, educating and supporting families
- The recommended contents for the Information Packs were:-
 1. Referral info, program availability and useful contacts
 2. Possible benefits of family seeking support
 3. Possible benefits for client/user of the family seeking
 4. Brief outline of treatment goals and processes
 5. General drug and alcohol information
 6. Brochures of family friendly services
- To explain the benefits of family sessions and to make clear the guidelines and purpose of these sessions.
- To develop clear guidelines of engagement would be reassuring for both the user and the family members.
- To assist both client/user and family to develop skills that could lead to change taking place without trauma, violence and chaos would be advantageous to both parties. Introducing strategies was seen as helpful and supportive.
- To invite family to reviews and counselling sessions when appropriate.
- Offer family specific intervention
- Improve agency websites to include resources, referral and references for families to access
- Education for General Practitioners regarding the needs of families and the importance of brief intervention was seen as a useful strategy to assist families to receive adequate assistance.
- That a Customer Satisfaction Survey be introduced to assist workers to ascertain the needs of families and receive feedback regarding improving services.

Identifying the rationale and value of including families

Question: - What is the rationale and value of including families in treatment plans?

- It was considered that the value of including families in the treatment plan could lead to increased understanding of the treatment process and the nature of addiction and therefore the family would be in an improved position to better support the user. In particular it was noted that families who did not appreciate the process of recovery/ drug free life could and sometimes did jeopardise this process. An example that was cited was families who did not accept or respect the client/ ex users decision to stay drug free and offered, even encouraged the ex user to 'have a drink' or smoke a 'joint' reiterating that 'one want hurt you'. On the other hand families sometimes found it difficult to understand relapse or lapses and were unaware that this is, at times, part of the journey. This misunderstanding has lead to the family experiencing more stress and not knowing how to respond adequately to these situations.
- It was noted that the needs of siblings can be overlooked when parents are focused on the user. Intervention with the family members may be able to

address these issues by assisting with the overall well being of the whole family unit.

- Another advantage of family inclusive practice was the opportunity it offered to identify what isn't working in the family unit and address these matters. It was documented that the family may be part of the problem so it made sense to make them part of the solution.
- Chance to address intergenerational drug use
- Research shows that families are important to the treatment process and that they can play an important part in improving outcomes for users.

Inclusion

What does inclusion look like?

- Inclusion is collaborative.
- It can foster clear communication and improve relationships.
- Inclusion does not alienate or ostracise any member of the family unit.
- When dealt with effectively, inclusion is a unifying experience for all involved.
- Effective inclusion leads to healing and understanding.
- Inclusion avoids collusion.

The benefits for workers and organisations when including families in treatment.

Question:-What are the benefits for workers and organisations when including families?

- A more balanced and improved understanding of the family dynamics would assist workers to better tailor the treatment options.
- Engagement that was an affirmative experience for families could foster trust in treatment services and break down the 'us and them' dynamics that can arise. This could assist workers by developing open and clear communication. All parties involved would have a clearer understanding of their rights and responsibilities.
- Since evidence based research is showing that family inclusive practice has improved treatment outcomes, workers may experience increased job satisfaction.
- The inclusion of family friendly policies and practice will assist organisations in their endeavour to address continuous quality improvement.
- Engagement of the family may lead to workers being able to address the social determinants influencing the family unit which could lead to improved outcomes.

The benefits for families when engaging families.

Question:-What are the benefits for families when treatment services include families?

- It was noted that families could support the user in a positive way if they had the information and education regarding the treatment process. For example a clearer understanding of the harm minimisation policy, of relapse and addiction could assist both the user and the family to deal more confidently with the presenting issues.
- The possibility of strengthening family links and building the resilience of the family unit was cited as a possible outcome.
- The reduction of isolation and stress was seen as a benefit.
- The potential opportunity for dealing with the friction and conflict that frequently arises within families due to opposing attitudes, reactions and solutions to the presenting issues.
- The possibility of utilising the family strengths and building on these was seen as an additional benefit that may lead to improved outcomes for the family and for the user.
- The capacity to offer assistance for siblings was seen as an additional benefit. Engagement of the family unit had the extra bonus of nurturing a pathway for early intervention for siblings struggling with the stress and isolation these issues cause.
- Engagement gave an opportunity for healing the damaged relationships within the family.
- It was also noted that family engagement could lead to the whole family (or some of the family members) having an active role and taking responsibility for their own well being. This was seen as a positive step leading to a greater sense of empowerment and a deeper understanding of each other's rights and responsibilities.
- Positive connect with the family could lead to improved and more relevant referral.
- It was considered that contact with families could lead to a greater sense of hope, less blaming and more realistic treatment goals.
- Enhanced life skills e.g. communication skills were cited as a possible outcome of family intervention.

Methodologies used when working with families

In your experience, when working with families what doesn't work?

Approaches that don't work were:-

- Assuming a narrow view of what constitutes a family.
- Thinking that one size fits all. Workers need to tailor interventions to individual family needs.
- Outcome driven policies that pressure staff to work at an unrealistic pace.
- Wanting to fix the situation.
- Lack of adequate resources.
- Patronising and condescending attitudes of some workers.
- A blaming and divisive attitude will not work.

- A directive approach.
- Using jargon was seen as an issue that would impede engagement.
- Being rigid and not considering culture, circumstances etc

In your experience, when working with families, what methodologies work?

Approaches that best work when engaging families were:-

- The use of Genograms.
- Recognising all progress large and small.
- Respecting diversity of family values.
- Family Therapy
- Single Session therapy
- Reflective Listening
- Highlighting successes.
- Solution focused therapy
- Strengths perspective
- Family partnership approach
- Cultural awareness
- Mediation
- Narrative therapy
- Cognitive Behavioural Therapy
- Education about services, addiction, and realistic treatment outcomes
- Assisting the development of effective communication,
- Conflict resolution skills/ negation skills

Exploring the Challenges of working with families

What are the traps and challenges for workers when working with families?

Challenges and traps were:-

- No provision of childcare.
- Restricted hours / nine to five, no after hours service
- Need for more clinical supervision. This was seen as even more necessary when the family unit became involved which added to an already complex situation.
- The possibility of becoming the ‘Meat in the sandwich’
- Safety factors – home visits. It was sometimes difficult to ascertain the safety factors when a home visit was the only option.

How can workers work effectively to assist families to shift their focus from the user to taking responsibility for their own needs?

- Addressing self responsibility.

- Highlighting the need to maintain one's own well being and role modelling responsible behaviour.
- Focusing on what the family member has power to change and emphasising that they are unable to change someone else's behaviour.
- Emphasising that acceptance is not the same as approval.

Identifying the Family Journey

Identify the emotional challenges that the family face.

The emotional challenges that were identified were:-

- Fear of what may happen in particular death or prison.
- Shame
- Guilt
- Blaming themselves and/or others (user)
- Emotional exhaustion
- Isolation
- Anxiety
- Grief and loss
- Ambivalence
- Relief when user seeks support
- Rejection
- Disgusted
- Abuse
- Trauma
- Family Relationships suffer and get stretched
- Depression
- The anxiety attached to the unpredictability of the situation
- For some families, cultural exclusion and alienation.
- Judgements from family and friends.
- Denial
- Frustration

As an AOD Worker working with a family member, name what would you consider being significant and positive outcomes?

Positive outcomes were:-

- Developing empathy, rapport and a positive relationship with the family member.
- If the family began to have a greater understanding of addiction and treatment options.
- If they understood their rights and responsibilities.
- If the family felt heard by the treatment service.
- If appropriate referral was achieved.
- If the family felt more empowered and less stressed.
- If the family were able to support the user/ex user more effectively.
- If the family members were to find a support group that they identified with and that gave them the assistance they needed to face the challenges.
- If reconciliation with their loved one was achieved.

APPENDIX 3

Below is a list of organisations that attended the Working with Families in the AOD Sector Workshop in Adelaide.

Department of Families and Communities
Uniting Care Bowden
Centacare
CWYHS
Relationships Australia
Uniting Care Adelaide
Department of Correctional Services
Families SA
Mental Illness Fellowship South Australia
Child and Adolescence Mental Health Service
Angilcare
Offenders Aid and Rehabilitation Service
Nunkawarrin Yunti
Streetlink
Savive
Southern Junction Community Services
MAYFS