Family members represented in the current sample

4

Reflecting recruitment, all respondents included in this study were family members dealing with a relatively severe drug or alcohol issue within the family. Whilst it was not intended, most of the families in this study were dealing with heroin addiction or heavy marijuana use. Poly drug use was also common, particularly alcohol and/or amphetamines; however these drugs tended not to be the focus of concern for families.

In terms of the type of relationship to the drug user, it was interesting to note that most respondents were parents of children dealing with drug issues (large majority). Beyond this, we also interviewed:

- one person dealing with a partner's 'active' addiction
- one person dealing with a spouse's long term addiction to alcohol
- three young people (16+) with parents with alcohol issues
- two people dealing with a sibling's drug addiction (including one youth).

Whilst parents made up the large majority of the sample, there was a range in terms of ages of children – ranging from 15 years through to 35 years+, as well as the type of issue/drug being dealt with.

- Parents of younger children (eg under 18) were typically dealing with issues of heavy marijuana use. The problem had typically been going on for at least a couple of years and was often associated with other drug use, such as alcohol or amphetamines. Parents of these children were sometimes also dealing with mental health issues such as drug induced psychosis or schizophrenia. More of these people were found in the 'infrequent', newer user sample and, as such, had had little interaction with family support services to date.
- Parents of older children were more likely to be dealing with ongoing heroin addiction, again often alongside other drug use. Many had been dealing with the issue for at least ten years, with varying levels of success and had quite long established relationships with family support services such as FDS and NarAnon.

Almost twice as many mothers as fathers attended the research, which reflects a known bias towards women as the seekers of help within the family (eg as noted by counsellors and other people working within the field). Mothers are both more likely to contact agencies for help and support, and more likely to deal directly with treatment programs and intervention.

Given that most respondents had been recruited through a specific set of agencies, it was not surprising that many of them had some form of relationship with these services. In particular, users of the following agencies were represented:

- Holyoake
- Family Drug Support
- NarAnon (recruited through a Newcastle individual/member of this group)
- Dreams
- Al-anon (minority).

In addition to this, most had also had some experience with user intervention and/or treatment programs (detox, counselling) as well as some interaction with other types of agencies.

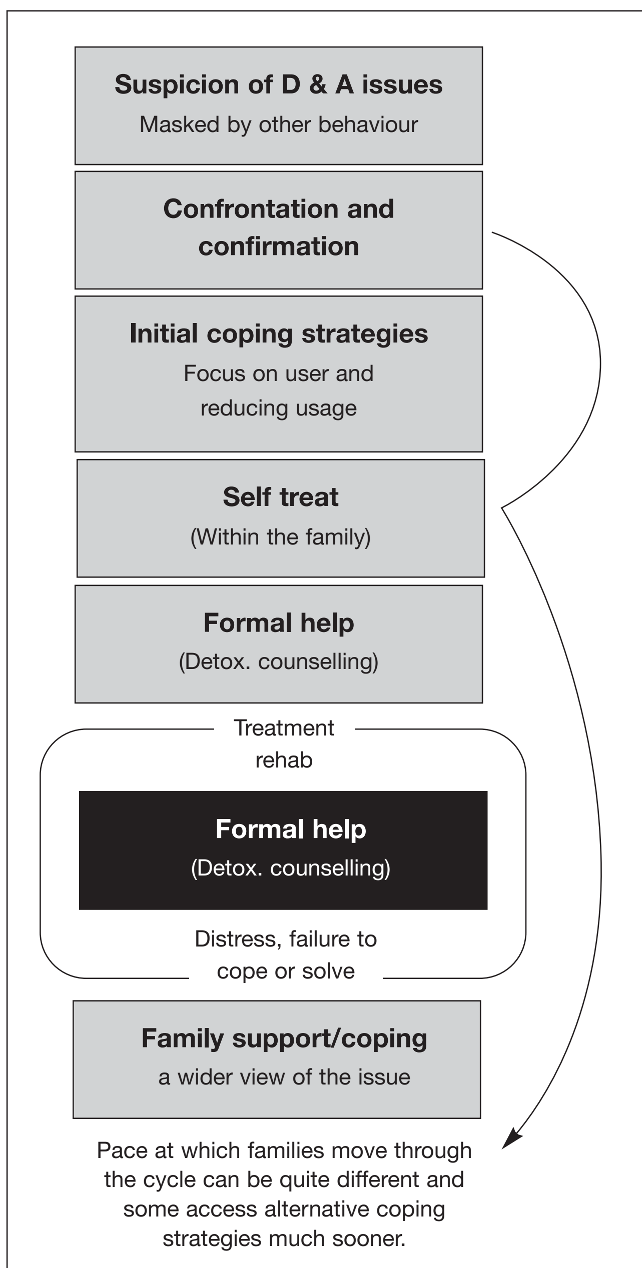
Examples of the types of agencies which may be part of dealing with the issue include:

- government health and medical services – local health authorities, hospitals
- emergency services – police, ambulance
- mental health bodies – counsellors, psychiatrists
- government funded/private counsellors
- school counsellors and other school authorities such as teachers and principals
- treatment agencies and rehabilitation centres
- other government agencies and services – Centrelink, local politicians.

5 Dealing with drug and alcohol issues

How people dealt with drug and/or alcohol issues within the family did differ quite considerably across individual families. Despite this, however a broad 'cycle' emerges with regards to the stages most people go through in dealing with the issues and seeking help – both for themselves and for the person directly affected.

Basic cycle experienced by families/carers



In summary, it was clear from speaking with even a relatively small number of families that drug and alcohol addiction can be as devastating for the family as it is for the person directly involved. Despite this, most ignore their own needs and initially focus on the drug user and trying to 'fix the problem for them' either within the family or with help of treatment/counselling. Often the family begins to move in and out of crisis along with the drug user and encounters a frustrating 'cycle of treatment' where relapse is occurring frequently. Sometimes it is a long period of time before family members recognise the need for help and support directed at themselves. Once accessed however, most families (at least in this sample) found this type of support extremely helpful and an important part of dealing with the drug issue in a more holistic way which proved more manageable as well as more effective.

Clearly people did report moving through these stages at different paces. Some people seek formal help and treatment quite quickly. There was also some variance in how quickly people found/accessed family support services.

Below we have reviewed each stage in more detail.

Suspicion of drug or alcohol issues

Anecdotally, when drug or alcohol issues first emerged within the family, there was often a period of ignorance or denial. In many cases, the drug taking was overshadowed by much more obvious and overt negative behaviour such as poor performance at work or school, withdrawal and increasing secrecy, noticeable aggression and confrontation, illegal behaviour, etc.

Parents in this study talked about teenagers becoming more secretive, spending more time in their rooms or out of the home with peers; and despite wanting to, parents found it increasingly difficult to keep track of their behaviour. Often this increasingly 'bad' behaviour was mirrored at school/university with many showing a lack of interest in studies and difficulty achieving

previous standards. In some cases, negative behaviour was extreme enough to result in school authorities or police becoming involved.

Despite suspicions about drugs and alcohol, family members often ignored the issue, driven by fear and a lack of understanding about drugs or how to deal with the issue. Confronting teenagers was difficult and often met with defensive responses, increased aggression or a refusal to communicate (and further withdrawal). This discouraged many parents from pursuing issues further, particularly if proof of drug usage was not evident.

Given this, many parents ignored or avoided the issue of drugs for some period of time, preferring to confront and negotiate with teenagers on the more overt/obvious negative behaviour. As a result, drug issues, and sometimes quite severe drug taking was not confronted and allowed to continue unchecked longer than may have been warranted.

Confrontation

At some point things did become too difficult to ignore for the families in this study. There was a range of reasons which brought the drug or alcohol issue out into the open. For some, external sources became involved (eg police, school counsellors, emergency services) and the family was confronted by these agencies. In other cases the person using drugs admitted to having a problem, often as a result of a severe episode or crisis such as an overdose or a suicide attempt. In other cases, it was simply that the family was confronted with undeniable proof of drug use/abuse (eg drug paraphernalia).

Acceptance that there was a drug or alcohol issue was a difficult time for families and was associated with anger, fear, blame, frustration and distrust. Even if drug use had been suspected for some time, the problem was often worse than expected, ie more severe, associated with what was perceived as 'harder drugs' or had been going on longer than they expected.

There was also considerable guilt, particularly for parents, who felt responsible for what was happening. This was exacerbated by the fact that many knew little about drugs, their impact or what might motivate their use. Use of perceived 'harder drugs', such as heroin was also met with considerable ignorance, desperation and fear. Families also had to deal with a strong sense of shame or social stigma and concern about how others might judge them. This was heightened in NESB communities where the achievements of children can be considered fundamental to the family's respect and standing in the community.

All these feelings/concerns and issues tended to be exacerbated in cases where confrontation was brought to a head by the involvement of services (police, emergency services, mental health intervention teams). External intervention was often associated with a sense of 'crisis' and heightened the level of emotional stress and fear associated with confronting the issue. Families not only had to accept that drugs or alcohol were a problem but also had an additional 'emergency' which needed to be dealt with.

Not surprisingly many families did not cope well with the issue initially.

Initial coping strategies – self treatment within the family

Guilt and social stigma resulted in many trying to deal with the issue within the family first – with varying levels of success. For most, the initial aim was to stop the user taking drugs by keeping them away from drug or alcohol opportunities. Strategies ranged from pleading, emotional blackmail, aggressive demands/ confrontation, tactics to remove users from drug taking opportunities/peers, severe house rules, even physically barricading youth into bedrooms. Whilst, on reflection, many see their original hope as overly optimistic, it was often driven by the users claiming to want to give up drug use and families desperately wanting to believe that the person had the drug use under control.

> *'I believed he could do it because he said 'mum I want to stop this'... so you can imagine how I felt when I found a pipe in his room again just weeks later.'*

Some did involve outside treatment interventions (eg private detox) however, the focus initially remained on the family helping the individual, rather than outside services playing much of a role in treatment or recovery.

'Self treatment' generally started quite positively and was goal orientated. For most however, it proved more difficult and less effective than families had hoped.

At best, self-treatment strategies kept individuals away from drug or alcohol opportunities for a limited period of time, but did little in the long term and ignored motivations for using drugs. For many, family treatment simply led to broken promises, escalating drug use and increasing strained relationships. In fact, many found themselves in quite negative patterns of interaction with the drug user. For example, 'enabling' behaviour was quite prevalent (eg providing money, support and cycles of forgiveness). Many also found it difficult to set boundaries for that person even faced with increasingly bad and sometimes even violent behaviour because of parental emotional attachment. Some parents even shielded users from police involvement (and even mentioned buying drugs for them to try to keep them 'out of trouble'). On reflection, most admit these responses are likely to have prolonged the issue by allowing the person to avoid his/her responsibilities. However at the time, it was very difficult to break out of the cycle of behaviour without outside intervention or help.[2]

Initial coping – Seeking treatment

As problems worsen families become more willing to seek professional help and external support. This move from 'self treatment' to seeking formal help was difficult for families. It required that they 'upgrade' the issue (see it as more serious), and accept that they could not cope with the problem themselves (sometimes adding to their sense of failure and guilt). There was the social stigma associated with 'going public'. However, despite this, the fact that the user required external help was enough of a reason to access formal services and set aside personal barriers to doing so. (As mentioned, some families experienced quite early intervention from external services via emergency services, police, mental health services, school authorities. These agencies/services tend to recommend formal treatment and refer families onto user services.)

In terms of accessing treatment options, families in this study reported varied experiences. In cases where formal help is driven by crisis (eg an overdose), where families go for initial treatment can be erratic and not well planned. However where there is more time, some families found information on treatment options quite easy to access whereas others struggled to find the information or support they required.

There were stories where families had accessed treatment that was inappropriate to their needs (eg family support programs which advocate a hardline approach) or had been disappointed with the outcome of the treatment program they chose. Overall, this suggests that more consistent/readily available information is required. [In addition, although outside the scope of this project, it is worth noting, that there were also conflicting reports with regards to how easy it was to access treatment when it was required. Some families found it difficult to get their family members into treatment (eg experiencing two-week waiting lists) whereas others had found access to programs easy and generally available.]

Regardless of increasing support and contact with drug and alcohol agencies, help tends to be almost exclusively user focused. Extremely heavy work loads ensure that, even where treatment agencies want to address wider family issues, this can be difficult. Confidentiality issues and conflicts of interest can also interfere with treatment agencies' efforts once the user becomes their client (particularly if creating distance between family members and the user is part of the treatment program). Lack of resources and detailed knowledge of what family services are available and what they offer can exacerbate difficulties faced by agency workers dealing primarily with the user.

Having services which focus on the user initially feels right to families who go through a 'fix it' stage where all they want to do is access treatment for the user – often with a sense of urgency. As a result, they endorse agencies which reflect their interest in finding a solution for the user's problems.

2 Clearly 'self treatment' can work and will be successful in some cases. It is likely that many families deal with drug issues in this way without usage escalating to the point of requiring additional support or assistance. However in more severe cases 'self treatment' may simply prolong the issues and make treatment more difficult.

During this time it may be difficult for support agencies to talk to families about their needs, particularly regarding emotional support, self care, coping strategies, communication issues or family dynamics. (Responses from the sample groups demonstrated that) parents in particular can feel very sensitive at this stage and may confuse broaching these issues with blame and accusation.

Cycles of treatment

Getting the user into formal treatment presents its own difficulties for families as they may know little about treatment and/or have high expectations of success. This is especially so for pharmacological and detox programs (particularly if the user is dedicated and motivated). Not surprisingly when relapse occurs families can be disappointed and tend to lose hope, particularly if the cycle repeats itself two or three times.

As treatment agencies are generally 'user focused', families can receive minimal support during treatment. These agencies are busy, crisis driven centres and although staff may attempt to discuss relapse with families, respondents in this sample group reported that they felt insufficiently informed about relapse and thus felt ill-prepared for 'failure'.

Adding to the strain, families can also feel peripheral to the treatment and recovery process. Some treatment agencies require the family to be excluded from the treatment process. This sense of exclusion was exacerbated by privacy and confidentiality laws, which leave families feeling helpless, disempowered and even more concerned about user recovery. Parents of teenagers remain particularly distressed as a result of these laws and find it almost impossible to accept that they are not able to know the dangers their child is facing, despite information being revealed to counsellors and/or treatment agencies.

> *'At the end of the day, he's my son. I'm the one who has to take responsibility if something goes wrong, they just walk away, but its my son and if he doesn't make it I want to know I did everything possible...'*

Family support

Ongoing treatment and recovery cycles can feel very frustrating and eventually families do begin to realise the need for additional coping mechanisms and support – beyond user focused treatment. Unfortunately feedback from the current sample suggests it is often not until things reach severe limits that families will seek more focused self-treatment and support. Parents in particular recall being overcome by feelings of frustration, anger and exhaustion. This was sometimes associated with severe levels of depression, extreme anxiety, continued feelings of guilt and shame, and difficulty sleeping. Not surprisingly many also experienced stress on other family relationships sometimes leading to the breakdown of partnerships/marriages or very strained relationships with other children.

Why families don't access family services sooner could be dependent on a number of factors:

- The philosophy of treatment and support networks is user-focused and does not necessarily reach out to repair the impact the issue has on the family. As such family members are often overlooked, ignored or even dismissed by the treatment system. This enables or encourages them to do the same.
- Families do not always accept the need for family support or treatment, particularly in the areas of self-care and emotional support which they often initially see as diverting important attention from the drug user. Thus whilst they are open to practical information, knowledge about drugs and user treatment programs, more personal support and treatment can be more difficult to address.
- Even when families are ready to reach out for support, many are not aware that these types of services are available and the process of referral through other agencies does not yet seem effective or efficient.

Once families access support, most are extremely positive about the impact this had on their ability to deal with and cope with the drug issue within the family.[3]

> *'It basically saved my life. I don't know what I would have done if I hadn't found help for myself, I was going crazy with worry, not sleeping, I was a mess.'*
>
> *'It saved my marriage. We couldn't have dealt with it on our own any longer. It was causing so much anger in our house… we didn't even realise what it was doing to us…'*

In fact, most agreed that valuable time had been lost by trying to deal with the issue for too long alone and not understanding the nature and scope of the issue better. Dedicated family services suddenly provided family members with a different perspective of the issue recognising the impact the drug usage has had on the whole family and the needs which result from this. Often this service was the first to directly (and insistently) address their needs as opposed to that of the person using drugs.

Whilst different services approach the issue differently, there was some overlap in terms of the areas covered. In particular people talked about the following skills, information and support areas being very important:

- Emotional support from professionals as well as from other families experiencing similar issues. Not only did this enable them to 'share' the burden, but also helped them understand that drug taking and the resultant behaviour is 'not their fault'. This is very important in helping reduce levels of anxiety, guilt and shame.
- Basic information about drugs and the short/long term impact of different types of drugs including better understanding motivations for trial and the nature of addiction.
- Better understanding of the fundamental nature of drug taking and how to think about and deal with the person using drugs given the impact the substance abuse has on his/her behaviour. In particular:
  - better understanding the nature of enabling behaviour
  - accepting that individuals have their own motivations/reasons for using drugs
  - recognising the need to create distance between themselves and the user
  - learning to better separate the user from his/her behaviour
  - understanding the need to confront unacceptable behaviour, set boundaries
  - accepting that it is the user who needs to take responsibility for recovery
  - user motivation is not always enough to lead to success
  - abstinence may not be a realistic treatment goal
  - recovery may be about more than one treatment episode.
- Understanding of the different treatment options and managing recovery expectations and the cycle of treatment. Knowing what to expect and being able to share experiences with others.
- Learning to cope with 'crisis' situations.
- Learning to better understand family dynamics and interpersonal communication.
- Fundamental skills in self-care such as treating depression, sleep problems, dealing with excessive worry/anxiety, moderating and mediating anger, more positive aspects of self help, repair and recovery, and even enhancement.

3 Note that respondents in this sample had all had experienced either FDS, Holyoake, NarAnon.

Needs and requirements at each stage in the cycle

6

From discussions, a number of key needs can be identified at each stage of the cycle alongside suggestions and recommendations for implementing/meeting these needs. These have been outlined in the diagrams on the following pages.

Key needs

- Ability and confidence to address issues as early as possible.
- A better understanding of drugs – likely signs, motivations for using, short and long term impact (to reduce fear and ignorance).
- Early intervention and prevention advice.
- Improved communication skills – open, non judgmental (parent/teen).
- Emotional support around the issue / strength to confront:
  - lessen impending sense of guilt which often drives denial
  - reduce sense of aloneness (encourage confrontation)
  - reduction of fear, to help them confront issue more openly/honestly.

Family & Carers Training Project (FACT) Research Report

How to address key needs

Suspicion of D & A issues
Masked by other behaviour

Confrontation and confirmation

- Reduce society's norms and expectations on parents (outside brief).
- Ensure access to non judgmental information about drugs/alcohol via general agencies/sources as well as D & A agencies.
- Raise the profile and respect for the impact that drug taking has on families and the need to seek holistic support when dealing with the issues.
- Educate agencies/formal bodies in contact with families who are not D & A focused – eg school authorities, GPs, Charities, NESB support agencies, Centrelink, general counselling agencies.
- Forge better referral links between general agencies and D & A networks.

Initial coping strategies
Focus on user and reducing usage

Self treat
(Within the family)

- Accept that families will try to deal with D & A issues within the home, at least initially. To help, provide drug education and information on 'self help', family based coping strategies, ways to approach 'treatment' options within the home. Approach needs to be enabling, yet realistic. Be honest about success of dealing with issues 'alone' particularly with regards to more severe issues. Highlight drawbacks of entering into a 'treatment' relationship with the user.
- Ensure information/support is available via agencies without strong links to D & A issues (schools, community centers) as well as via more obvious treatment channels which families may access.
- Encourage connections with emotional support as well – as early on as possible. Likely to respond better to informal help/support. Convey the value in 'sharing the problem'. Philosophy should be 'it's a family problem'.

Formal help
(Detox. counselling)

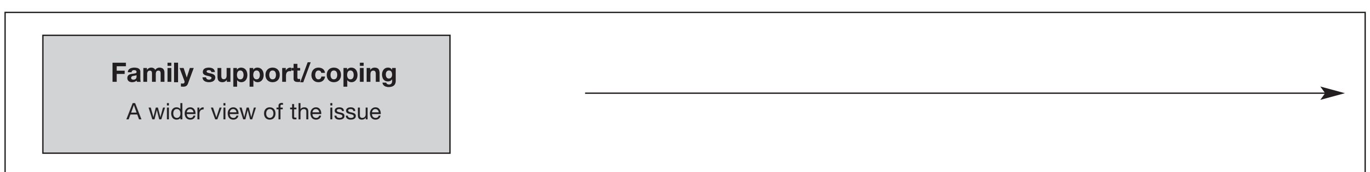
Treatment rehab

Formal help
(Detox. counselling)

Distress, failure to cope or solve

- Rewrite the basic philosophy on family member involvement in treatment/recovery – embrace interested family members.
- Provide treatment and support agencies focused on users with a resource to ensure families receive the information they need as well as appropriate referrals (process needs to be easy to fit busy schedules). Will require intervention/face to face.
- Support agencies (eg counsellors) should also be aware of the types of emotional support and coping strategies available to help advise families and help them seek help. (Treatment agencies unlikely to have time).
- In contact with – GPs, treatment agencies, user support services, informal support from community agencies (NESB), emergency services.

Family support/coping



Once family members have accepted the need to address family issues they should be provided with some fundamental support, education and training. Whilst the advisory committee for this project will be examining specific ways to evolve a resource which supports these needs, below we have summarised the suggestions which emerged from the current research.

Requirements have been presented across four levels, which broadly reflect the progression of needs according to the feedback provided by families in this study.

Level 1 – Basic emotional support to help

- re-establish emotional well being/homeostasis
- address emotional anxiety, depression, sleep issues
- ensure people know they are not alone
- reduce guilt and blame (its not your fault)
- reduce sense of shame, social stigma.

Confirm that drug usage does impact on the whole family – parents, partners, siblings, etc. and can be extremely destructive. Because of this, self-care is as important as caring for the person using drugs.

Level 2 – Continue to develop basic self care/emotional well-being

- educate about drugs
- effects of different substances/recognising use
- understanding user motivations/drivers.

Understand that recovery is their responsibility – you can not do it for them (you must separate yourself from their drug taking behaviour).

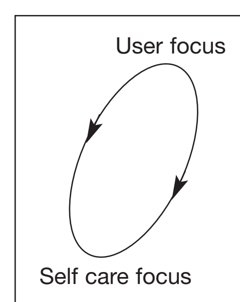
Coping skills (formal training options)

- crisis management – medical, legal, emotional
- setting boundaries/rules
- avoid enabling (co-dependency)
- basic communication/family dynamics.

Treatment options/choices

- putting abstinence into context
- family support programs that advocate a 'hardline' approach (option, not requirement)
- understanding confidentiality issues/dealing with
- managing treatment expectations and coping with relapse
- rehabilitation issues.

Treatment does work, but different things may work for different people – and this may take more than one episode to work.



Level 3 – Moving into much more of a self care focus

- develop communication skills further
- better understand family dynamics and repairing strained relationships
- look at ways to 'self repair' emotionally
- aim for personal enhancement
- living with/accepting drug use.

Accept that relationships within the family have changed, things are not going to be the same again. However positive things can emerge.

In terms of accessing this type of support and information, it is clear that the option to do so should be available to families as early as possible, given that it is likely to provide a different perspective and set of skills to the ones available from more general agencies and agencies which focus on user needs. The essential benefit is in looking at the issue from a holistic perspective which allows for a much wider view on treatment and recovery issues.

Having said that, referring families on to specific services which address their own needs is likely to require some form of (face to face) intervention. Families are not necessarily ready to accept help or support or wanting to reassess the situation from a different perspective. Therefore, any intervention process needs to respect that families may be at different points in the 'cycle' in terms of dealing with the issue and therefore their emotional and informational needs may be different. Despite this, families need to be aware that family services are available and introduced to the philosophy that families can be just as affected by drug usage as the person using drugs.

In terms of intervention points and opportunities – this would vary again depending on where people are in the cycle. However as discussed, the earlier families become aware of these services and the general philosophy of family treatment the better, although this is not to say they will necessarily respond at the first point of contact.

The types of access points which emerged for families in this study included:

- GPs
- school counsellors
- school hierarchies
- emergency services – police, ambulance
- medical services – hospitals, emergency rooms, mental health
- general government services – DOCS, Centrelink
- general services – Salvation Army, NESB community agencies
- D & A treatment services
- D & A counselling services.