

What's needed for a 'family inclusive' alcohol and other drug sector?

Creating Synergy

University of Wollongong

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Family Programs & Resources



- ❖ Youth & Family program
- ❖ Parent Support Group / Multi-family groups
- ❖ Family Eclipse program
- ❖ Therapeutic Community Family program
- ❖ Nobody's Clients Project
- ❖ Parenting Support Toolkit for AOD workers
- ❖ Counting the Kids / Brokerage Fund
- ❖ Kids in Focus
- ❖ Mirror Families
- ❖ *Raindrop and Walking in Other Shoes*
- ❖ 2010+
 - ❖ Practice Guidelines
 - ❖ DVD & Manual
 - ❖ Online family training modules

What do we mean by “Family”?

www.ancd.org.au/publications

Who has the Drug problem?

* The Parent



* The Young Person



Key Points



- Problematic alcohol or other drug use can, and usually does, have a significant impact on other family members, including children.
- Most family members need and welcome some level of information and support in their own right.
- Outcomes for individuals are better when we include family members in treatment and prevention initiatives.
- Given this, why don't we routinely assess and respond to the needs of family members as standard practice across the entire AOD sector?

Family Voices



- Families members report a range of needs and experiences

- Odyssey House Victoria
 - Nobody's Clients Report, 2004
 - Counting the Kids, 2009
 - Family Eclipse Program, 2010

Children's Voices



7-10 year olds

"I finished cans of dad's beer when he wasn't looking ... yeah I like it" **Kia, aged 7**

"My dad's in goal and my mum's very tired. I love my dad, he's my best part of my family"
Ruby, aged 8

"I had to stay at the hospital. Once I think she fainted or fell over. She used to say she took tablets that helped her but they made her drowsy. She was always tired". **Caleb, aged 9**

"Do you know why I hate going to counselling? Its because she is old and wrinkly and pretends we are playing games when all she wants to know is my business! Well, its none of her business and her office is ugly and all the kids in the waiting room always look sad. I told my nanny I'm not going back – I'd rather come to group." **Sarah, aged 9**

Children's Voices



“They always thought I never knew that Mum was on the drugs. I asked why I had to live with my Nanny and they said Mum has gone on a holiday. I knew she was in jaol, cos I heard the adults talking. I told Nanny I saw Mum using the needle drugs and that I sometimes I was with her when she bought them & Nanny nearly fainted. I am more happy at Nanny’s she drives me places, washes my clothes and cooks me food”.

Kane, aged 7

“Mum goes crazy on drugs, sometimes she cleans the whole house at night and wakes me up with the vacuum cleaner. Other times they make her tired and she sleeps a lot. I hate it when Mum’s on drugs, she doesn’t have any energy and she yells more and doesn’t like to go to the park. But I still love her because she tells me all the time she loves me”.

Zoe, aged 9

“We don’t have much money. Dad rings mum, mum gets upset: I don’t want to cause dramas but I get angry. I kick and bang the wall, scream in my pillow to let my anger out. I feel like I have to help them both. I feel sorry for them. It bothers me.”

Ben, aged 13

Children's Voices



“She had a terrible drinking problem and used to get drunk every night. It was terrible from my point of view what she was doing, ruining her life and ours. She spent all the money on alcohol. Even my pocket money. I never had the guts to tell her the way I felt because I thought that she would get angry at me. I just acted as if I was fine. I also felt very upset all the time, not for her, but for me. I was scared and worried about what would happen and what would become of my two brothers”

Lara, aged 12

Children's Group - Sarah aged 7 & Rory aged 10

Sarah focused mostly on her understanding of ‘needle drugs and marijuana. She wanted to disclose more but Rory kept reminding her that she was “talking too much and could get Mum & Dad in trouble”. When reassured that was not the purpose of the group, Rory responded with “yeah that’s how you get put in foster care”. Sarah stated to him that she didn’t care ...“they always put you back after you go to court anyway....”

John, 8 years



Counting the Kids Brokerage Fund



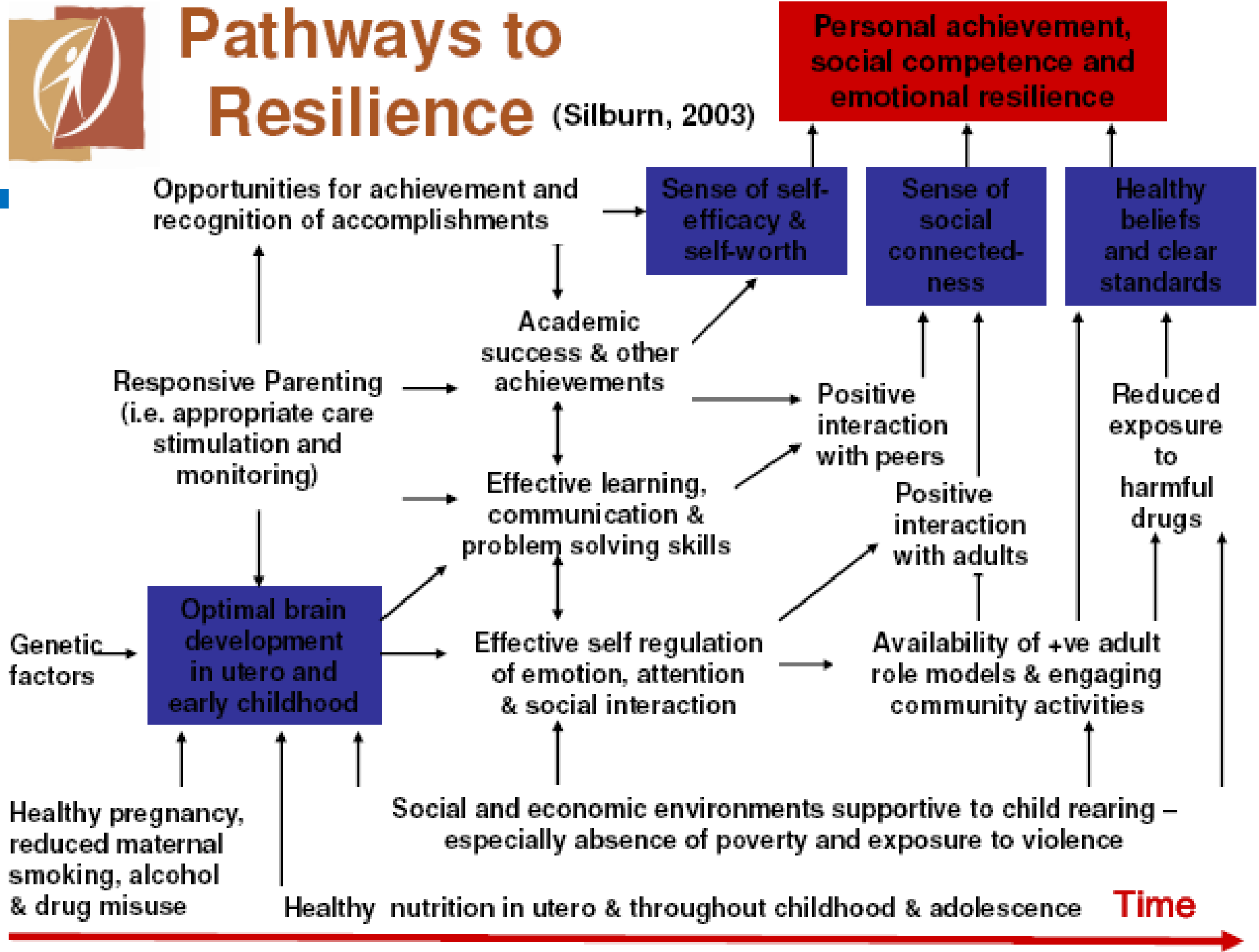
“On assessing *the family as part* of the application for this fund I discovered that *Ben* did not have a bed and that this was a source of concern to his mother. I would probably not have heard of this had I not asked directly.” (AOD worker)

“It was a wonderful opportunity to make more regular contact with the family. Opened up a channel of communication between school staff and family, revealing information about *Harry’s* “growing up” history , an understanding of *Harry’s* family relationships and his father’s recovery process.” (Teacher)

“I love playing tennis and Nan is always there to watch. I feel safe and happy. I love my tutor. She is cool and she makes the work fun and I am better with my maths as well. I don’t feel like stupid so much anymore.” (Grant recipient)



Pathways to Resilience (Silburn, 2003)



Children's Needs



- Best way to support children as a first step is to work with their parents (parenting support, drug treatment, emotional regulation, housing, relationships, etc)
- All children need opportunities to be “normal” children
 - Play, recreation, supervision, guidance, praise, predictable routines, material needs, stimulation, school, support from family and friends etc
- Young children should be protected from parental problems and concerns
- Older or traumatised children may need their own support and counselling-referrals to youth services, child mental health etc.

Jenny, 26 years



“When not using I’m a super-mum. I have more time for him, I set boundaries, we have good communication, we play a lot. When (I’m) using, he becomes the parent, he gets out pre-prepared food from the freezer, he misses school, he gets bored, he gets worried about me ... chaotic routine of mum being sick. I snap at him, yell, have no patience. There’s not much affection or supervision. I feel a lot of guilt ...

..... I tried to protect him from it”

Parenting Support needs



Parents need substantial support during recovery to:

- improve parenting capacity (focus on parent-child relationship)
- improve life-skills
- work on underlying issues
- strengthen family relationships
- ensure the safety of children

The needs of children and their parents are intrinsically entwined.

To neglect one or the other is in nobody long-term interest.

Families where a young person has a dual diagnosis – accessing family therapy (Deakin University, 2010)



Mothers:

“For my husband and I to be included was important for us – his behaviour has an impact on the whole family.”

“The frameworks helped me to put our troubles and my daughter’s behaviour in context. ...The handouts and exercises in communication were a good reminder.

It helped me to focus on some positives. Talking through problems with a facilitator skilled in this area has helped us remain calm.”

“I used to have problems overanalysing things – I’ve learnt not to look too deeply into things that aren’t my issue. I have to let go, I can’t fix the world. I learned to step back, to recognise my own burnout. I think that’s one of the biggest lessons I’ve learnt – to self care.”

“I would find it really beneficial to talk to other parents. I feel quite isolated, I struggle.

Fathers:

‘More information needs to be made available to parents – we need to know what’s going on....He could be 40, he’s still my child, I still need to know what’s going on. I ask where he is, no one can tell me. I don’t know if he’s safe. It may be a good idea to include some kind of permission (written) for him to check (tick) when he talks with you to say “You may tell my family I’m here” or something like that. Parents need to know where their kids are.’

It’s allowed (young person) and I to discuss things in a safe environment – no one to dominate the situation.”

“I didn’t receive real help for him. I don’t need help for me. Lots of information but so much was directed to me, not him.”

Family Needs



Most family members / significant others want to:

- be included
- have their questions answered
- be listened to and understood
- be informed about treatment options and what to expect
- be educated about AOD and associated co-occurring issues including mental health, legal etc
- be helpful and supportive
- be supported

Primary Barriers to implementation across AOD



Lack of:

1. frameworks for implementation
2. confidence (most believe it is highly specialized)
3. time/capacity (most workers feel overwhelmed)
4. foundation level skills/knowledge
5. investment - resources to establish service policies, practices, environments & supervision
6. standardized Screening and Assessment tools
7. communication / collaboration with other sectors



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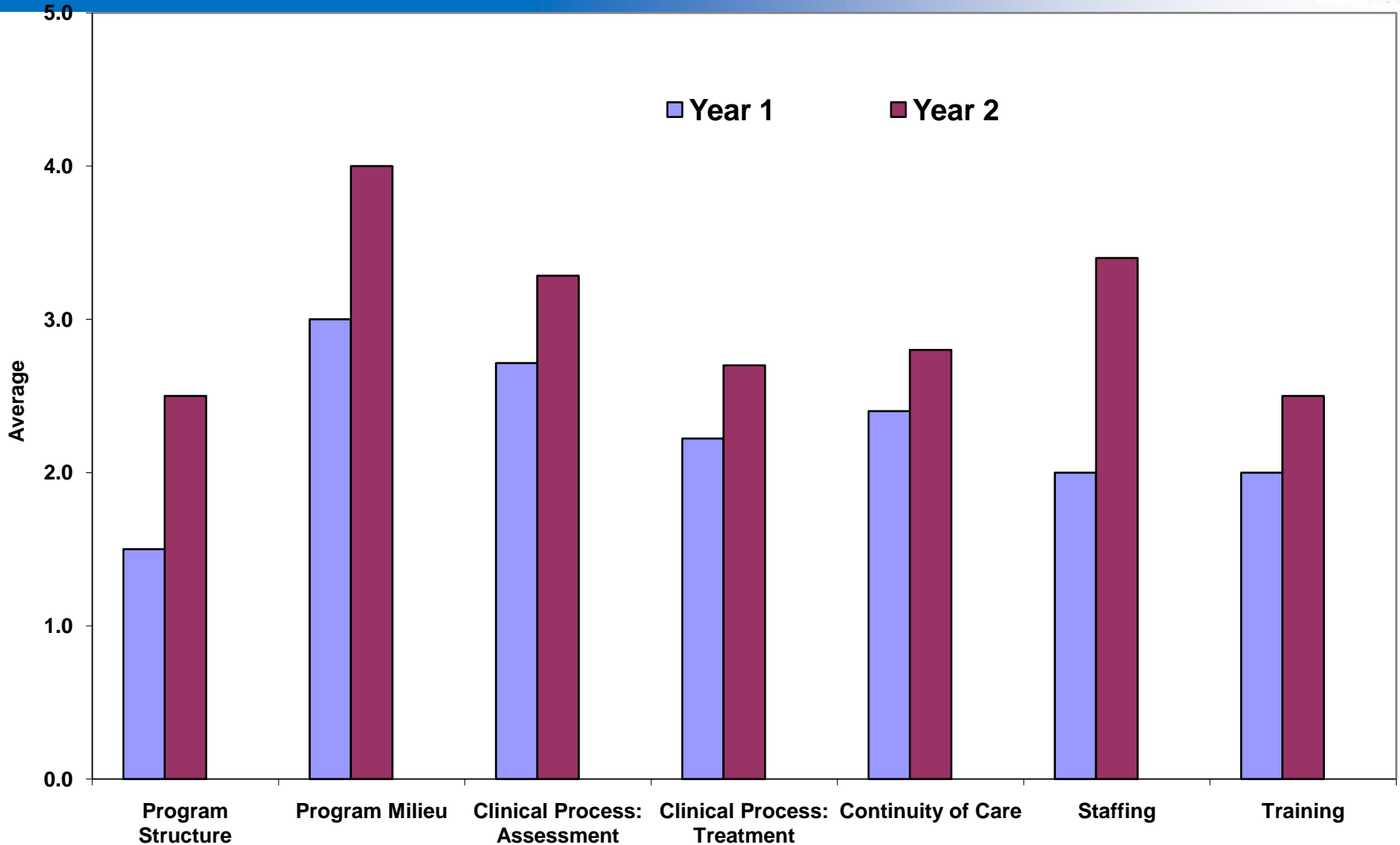
1. Frameworks for implementation

AOD Sector - last 5 years



- Until recently, little mention of children or families in policy documents
- Increased desire to be family inclusive, but few additional resources
- Many examples of best practice programs and champions around AUS but inconsistent practice
- Child Death Reviews indicate poor communication between CP, FS, FV & AOD
- Emphasis has been on building mental health capacity of AOD workforce

Dual Diagnosis Capability in Addiction Treatment (DDCAT)



2. Time / capacity

(most workers feel overwhelmed)

Implementing Family Inclusive Practice is “Change Management”



- Expect Resistance – don't trigger “fight or flight”
- “Carrot & Stick” approaches don't work that well
- New Approaches involve:
 - Clear Vision – regularly & clearly articulated
 - Information to give “Insight” into why the change is necessary
 - Opportunities to practice the change in non-threatening environments

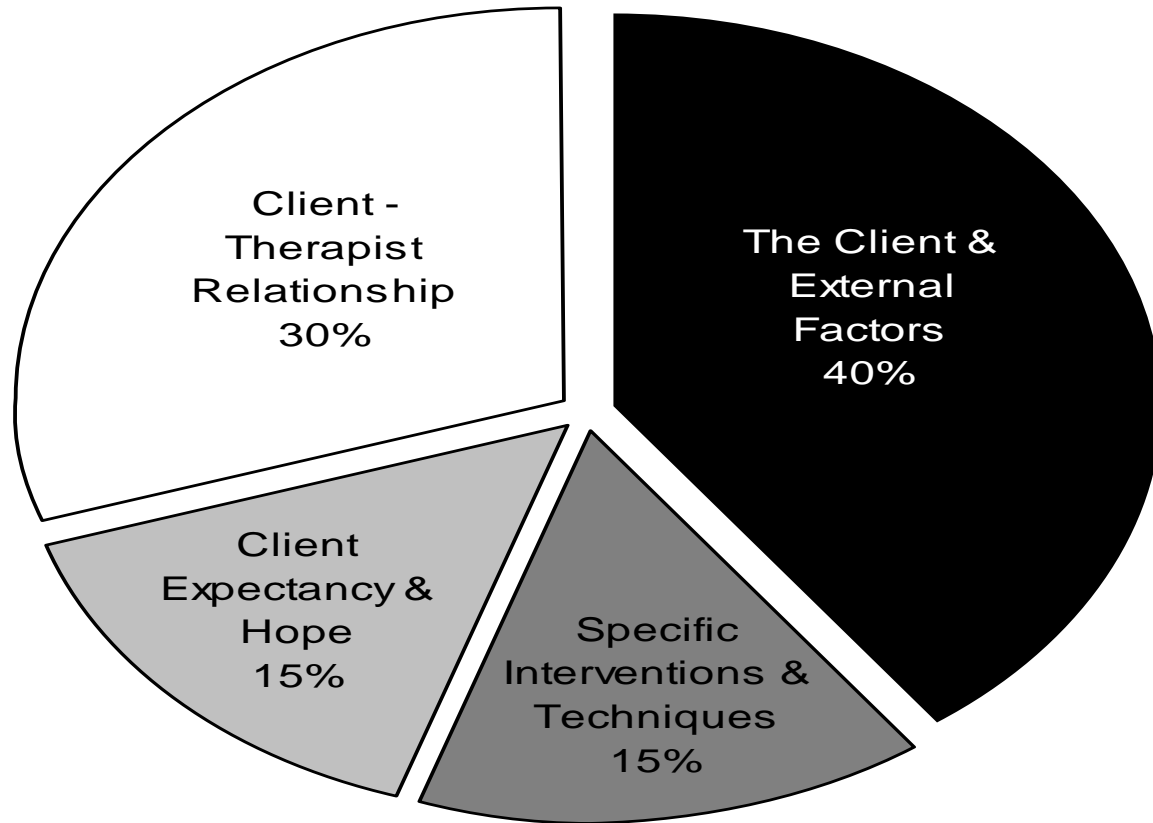


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3. Worker confidence

What is the “active ingredient”

Factors Contributing to the Effectiveness of Counselling
(Lambert, 1992)



Helpful attitudes and values



- A commitment to both children's and parent's needs
- A belief that parents rarely intend to harm their child
- Understanding parental concealment of AOD use or minimisation of symptoms as an attempt to protect themselves, the child and the family unit
- Respect for the role of parents and extended family in ensuring children's safety and wellbeing
- Preparedness to seek out and listen respectfully to the opinions of other professionals involved with or who have a history with the family
- Neither expecting the worst of parents **nor** wearing rose-coloured glasses

Helpful attitudes and values



- The family (including the person with the identified problem) is an integral part of the 'treatment team', rather than external to the treatment process
- The family is a source of strength, competency and hope that, when mobilized in a safe environment, can diminish the influence of the problem.
- The family is a significant (and sometimes the only resource) for people looking to make positive changes.



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4. Foundation level skills / knowledge

Types of work & desired outcomes.

Adapted from Copello et al 2005

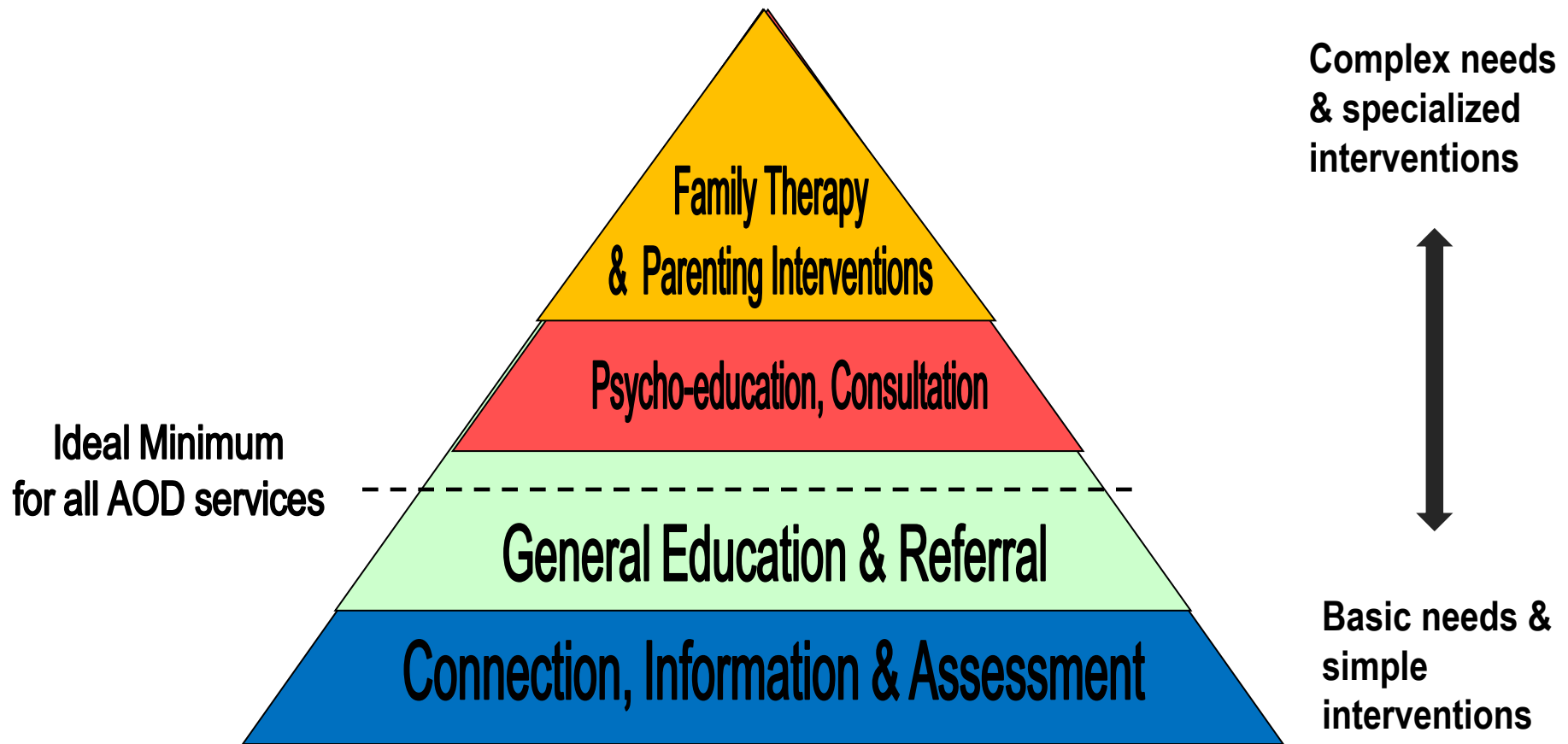


Work may be:

1. predominantly with family members / significant others to support / encourage problematic user to access treatment
2. with the whole family (including problematic user) to improve treatment outcomes for the user
3. predominantly with family members / significant others to support them in their own right
4. with the whole family (including problematic user) to meet all members needs

Pyramid of Family Care

Adapted from Mottaghipour & Bickerton, 2005



Core Skills & Knowledge



- child and family screening & assessment
- attitudes, engagement & facilitation micro skills
- responding to identified needs through information and education AND / OR referral
- understanding of:
 - relevant child and family / CP services
 - privacy-confidentiality issues
 - worker obligations under local legislation
 - indigenous, CALD & GLBT contexts

Tips for new workers



- Expect trauma history, and evasive and erratic behaviour, but don't make assumptions. Ensure family members feel SAFE.
- If unsure about anything, just ask!
- Maximise decision making by family members
- Speak about drug use in a matter of fact way
- Check if body language matches words. If not raise it
- Be clear about your role, limits, how info is used

Traps for new workers



- Forgetting the family will be “checking you out” and testing you out. *Be mindful of your reactions.*
- Expecting instant engagement. *It takes time.*
- Expecting too much or too little. *Be careful of superficial or compliance based responses.*
- Moving quickly to solutions (especially your own). *Problems are likely to be complex.*
- Interrogating children or speaking down to them. *Be genuine.*



5. Investment

some resources needed to establish service policies, practices, appropriate environments & provide supervision

Who feels Welcome at your service?

“Front Door”

“Soft Entry”

“Open Door”

“No Wrong Door”

“Men’s Shed”

“Playgroup”

“Skate Park”

“Coffee Shop”

“Treatment Zone”



Summary of Benefits and Costs (2003 Dollars)

Estimates as of September 17, 2004

Washington State Institute for Public Policy, 2004

Measured Benefits and Costs Per Youth

Benefits	Costs	Benefits per Dollar of Cost	Benefits Minus Costs
(1)	(2)	(3)	(4)

Pre-Kindergarten Education Programs

Early Childhood Education for Low Income 3- and 4-Year-Olds*	\$17,202	\$7,301	\$2.36	\$9,901
HIPPY (Home Instruction Program for Preschool Youngsters)	\$3,313	\$1,837	\$1.80	\$1,476
Parents as Teachers	\$4,300	\$3,500	\$1.23	\$800
Parent-Child Home Program	\$0	\$3,890	\$0.00	-\$3,890
Even Start	\$0	\$4,863	\$0.00	-\$4,863
Early Head Start	\$4,768	\$20,972	\$0.23	-\$16,203

Child Welfare / Home Visitation Programs

Nurse Family Partnership for Low Income Women	\$26,298	\$9,118	\$2.88	\$17,180
Home Visiting Programs for At-risk Mothers and Children*	\$10,969	\$4,892	\$2.24	\$6,077
Parent-Child Interaction Therapy	\$4,724	\$1,296	\$3.64	\$3,427
Healthy Families America	\$2,052	\$3,314	\$0.62	-\$1,263
Systems of Care/Wraparound Programs*	\$0	\$1,914	\$0.00	-\$1,914
Family Preservation Services (excluding Washington)*	\$0	\$2,531	\$0.00	-\$2,531
Comprehensive Child Development Program	-\$9	\$37,388	\$0.00	-\$37,397
The Infant Health and Development Program	\$0	\$49,021	\$0.00	-\$49,021

Worker self care, supervision and professional development



- Long-term work, often with slow progress
- Chaotic presentations, difficulty in regulation of emotions, interpersonal conflict, and histories of trauma can take a heavy toll on workers
- Be honest about own vulnerabilities / feelings
- Supervision/reflective practice is critical
- Multi-disciplinary training across a range of domains where possible

6. Standardized Screening and Assessment tools

Screening & Assessment



Which tools?

- NADA Tools for Change
- Parenting Support Toolkit – updated soon
- Turning Point Clinical Guidelines
- NCETA Resource – soon to be released
- PUP – measures
- EDAS Toolkit

What's important to know? (screening and assessment)



- The type, level and immediacy of risks to infant or child
- Parental willingness to address risks and motivation to change
- The worker / services capacity to manage / continually re-assess risks
- Families resources, strengths, goals, values

Tips for new workers



- Multiple sources of information are better than one
- Ask for details/clarification when a parent says “not very often” or “not much”
- Respect the views of others, but don’t blindly accept their assessments
- Be confident in questioning suspicious or contradictory behaviour in a sensitive but direct way
- Build a safety net around the child and their parents by finding out about and then enlisting others/extended family/neighbours to monitor and support the family. Ensure all know their roles, and know what plan B is.

Traps for new workers



- Making anxiety driven or reactive notifications
- Not acting through fear of losing parent's engagement
- Forgetting to examine family strengths, long-term goals, and noticing the positives
- Failing to persist in contacting parents when evasive, intimidating, relapsing...

Practice Issues & Guide

Odyssey House Victoria, 2010

(working with Substance Dependent Parents and their Kids)



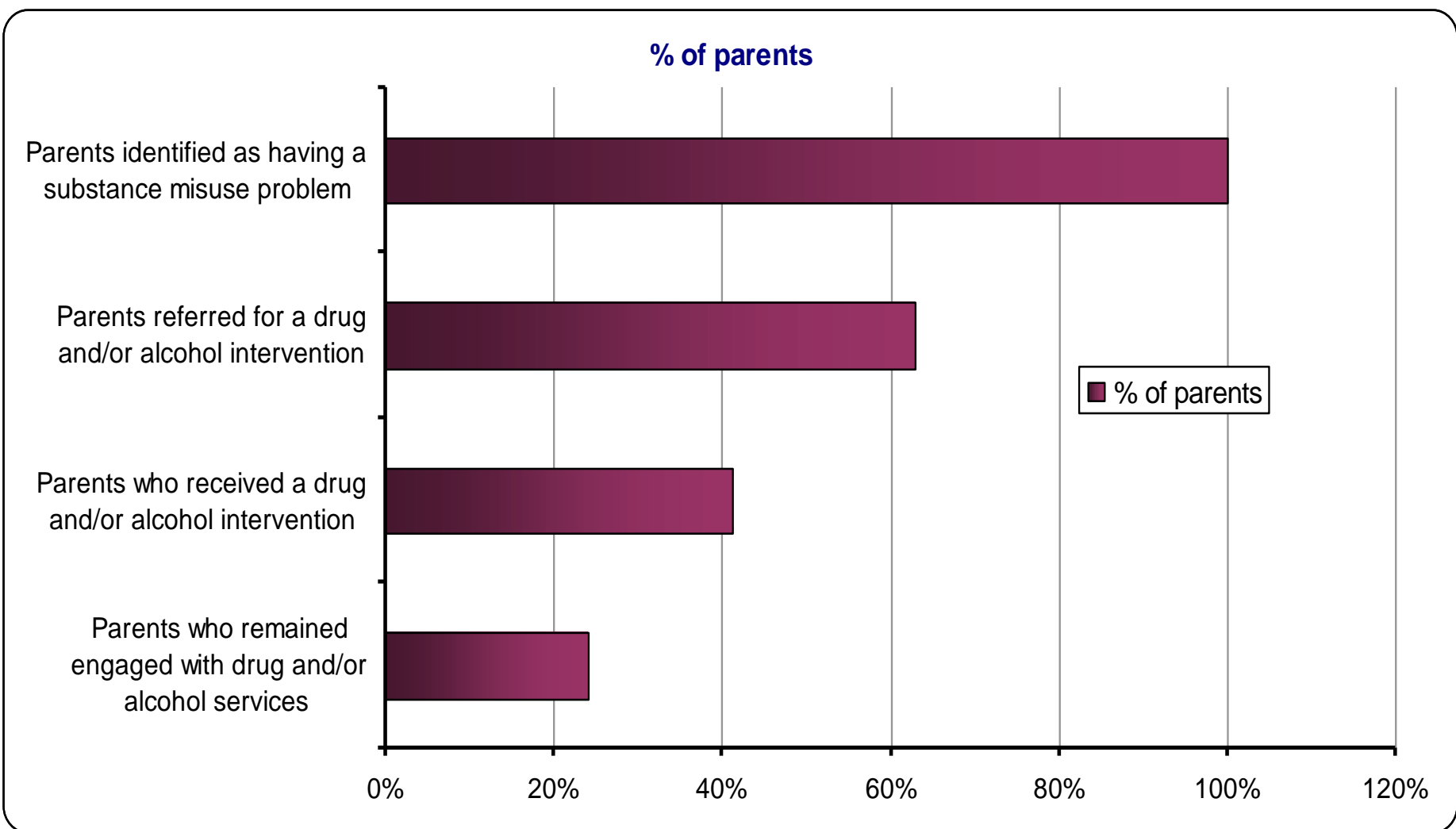
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1. Engagement
2. Keeping the Child in mind
3. What's important to know
4. Meeting the needs of the whole family
5. Staying Goal focused
6. Managing Risk
7. Providing support when Kids don't live at home
8. Collaboration between services
9. Worker self care and development

7. communication / collaboration with other sectors

Parental uptake of AOD interventions referred from Child Protection

(South Australian Department of Families & Communities: (Jeffreys et al., 2008))



AOD Sector

Drug and alcohol workers:

- Skilled in engaging substance-dependent parents
- Uniquely placed to consider the needs of clients' children
- Do not easily engage with child and family welfare sector
- Reluctant to notify child protection services

Reasons for reticence include:

- Threat to the therapeutic relationship
- Confidentiality / Privacy
- Conflicting policies on parental substance use (harm min vs abstinence)
- Definitions of 'the client'
- The belief that notification is punitive to parents
- Lack of feedback from child protection services
- Loss of control over the intervention

Managing & Sharing Risk



- Traditionally the adult AOD/MH sectors ignored child concerns or just reported them to Child Protection
- Now some adult AOD/MH services are:
 - Referring to Family Support services / co-working
 - Carrying some risk by: assessing, intervening, monitoring, communicating, organizing respite care, including children in relapse plans
- Practicing Integrated Governance
 - Requires understanding and clarity of each other's role

In their words



“The less you know about risk,
the more anxious you are about it.”

Child Protection Worker

Sometimes....

- “Well meaning people who focus on children and see children in compromised situations feel the need to rescue. They think if they pick up the ‘phone, fairies will come and take the child to a cozy nest somewhere” (out-of-home care worker).
- “We need to sit with some risk; to remove the child from home may not be in the child’s best interests” (out-of-home care worker).

Dealing with Risk



Risk Management Approach

Therapeutic Approach

Focus on risks

Focus on needs

Focus on symptoms (child abuse and neglect)

Focus on causes (holistic approach to family)

Short term

Long term

Deficit focus

Strengths focus

Adversarial

Empowerment/supportive

Crisis response (tertiary)

Preventative (secondary)

Documentation

Engagement

Case management

Case work

Building Bridges



- Some baggage / tensions to deal with
 - May be value, attitude and language differences
 - Short term goals may seem contradictory
- BUT
- Share long term goals
 - Many examples of collaborative practice
 - Move beyond personal relationships to protocols
 - Respect for each others' expertise

In Summary



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1) Thinking Families – tips & strategies



- All clients have families /significant others (of all shapes & sizes)
- Family members have their own Needs
- Happiness and wellbeing is most usually connected to our relationships
- Addressing family / parenting issues are critical to sustainable solutions: Improves outcomes
- Non blaming attitude – build strengths and resources rather than pathologize
- Requires Organisational Policy / Leadership

2) Engaging Families – tips & strategies



- Don't need to be an expert in Family Therapy or Child / Parenting work to have family conversations or be family sensitive / inclusive
- Ensure the environment is family friendly
- Ask simple questions at the front door
- Treat “the family” as the client in their community
- Engagement is critical - focus on all members' goals, strengths, resources
- Requires Organisational Systems & Committed staff

3) Working with Families – tips & strategies



- Staff activities & organisational policies and procedures need to be in balance
- Build staff confidence and skill over time
- Simple responses initially, access to secondary consultation, supervision, training, interventions.
- Brief communications can be very helpful
- Brief interventions can be very effective
- Requires Organisational Partnerships, Resources & Competent and Confident staff

Primary care giving Dads



Jade(7)

Jeff(42)

Sam(5)

Tracy (deceased)
drug overdose

Fathers



- Around 65% of adults accessing drug treatment are **men**
- A high proportion of these men are **fathers**, although few actively parent
- Most other sectors struggle to **engage** with dads (DV, FS, CP, MCH)
- Drug Treatment provides a **unique** and privileged **opportunity** to work with fathers

Why Dads matter?



- Aus teenagers – 15 min/day with dad (Coleman, 1996)
- Abusive fathering or lack of fathering related to negative outcomes such as AOD problems, crime, poor education, depression etc. (Marsiglio et al, 2000)
- Positive fathering contributes to achievement and well-being (Gruenert, 2003; Lamb, 1997; Marsiglio et al, 2000; Russell, 1999)

The link to alcohol & other drugs



- Fathers often experience guilt, shame & grief about their fathering
- Many have had abusive fathers themselves, become authoritarian themselves / overcompensate
- These issues can contribute to relapse or maintenance of alcohol or drug use
- Children are one of the biggest motivators for parents to stop using drugs and to seek AOD treatment (Eg. Motivation Enhancement)
- Its good drug treatment ...

Memories of Dad

(Gruenert, 2004)



- “My father getting me to jerk him off while looking at a porno. As he “taught” me how to masturbate at 11 years old. I felt disgusted, shamed, degraded, revolted.”
- “I’m back in Ballarat, I’m 8, and I’m waiting for dad to come and pick me up so we can go and stay at his place (Melbourne). All fucking day I waited for the prick. Not the last time that’s for sure. I hate thinking back to that kid waiting for something that would never arrive. I guess I learnt that trusting people is a big ask for me.”
- “I remember when I was terrified every evening because when he got home, I would get beaten for what I had done wrong during the day.”

Workers need to...

- Ask men if they are fathers
- Ask fathers about their kids
 - Do they see them, how often, are they close?
 - How were they fathered, what kind of Dad have they been / do they want to be?
 - What skills, supports, services do they need to achieve their parenting goals?
- Liaise with and encourage other services to be more father friendly

Use Snakes



And finally.....



In the words of Samuel:

“Stop drinking and smoking
tell mum these for me.”

Acknowledgements



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- Nobody's Clients Project
 - The RE Ross Trust
 - Menka Tsantefski & Samantha Ratnam
- Parenting Support Toolkit for AOD workers
 - Victorian Department of Human Services & Victorian Parenting Centre
 - Kylie Burke
 - www.health.vic.gov.au/drugservices/pubs/parenting-support.



Thanks