Submission No: 116
Supp to Sub:
AUTHORISED: KS
9/5/07

SUBMISSION TO

HOUSE OF REPRESENTATIVES
STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES

INQUIRY INTO THE IMPACT OF ILLICIT DRUG USE ON FAMILIES

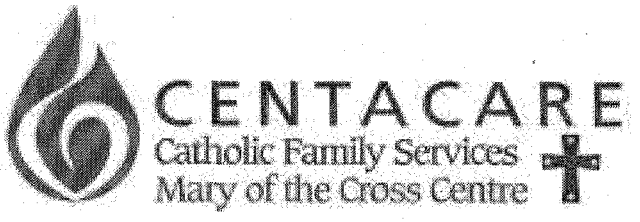
By

Jenny Blakey
Manager, Mary of the Cross Centre

Nina Gee
Project Officer, Centacare Catholic Family Services

CENTACARE CATHOLIC FAMILY SERVICES

MARY OF THE CROSS CENTRE



23 MARCH 2007

HOUSE OF REPRESENTATTIVES
STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES

The Impact of Illicit Drug Use on Families

Introduction:
A family member's drug use invariably impacts upon family life and the individual relationships that exist within it.

Traditionally in Australia and overseas, the focus has been solely on supporting people using drugs, providing drug treatment services, detox and rehabilitation. Mary of the Cross Centre, as part of Centacare Catholic Family Services, challenges this practice by providing a service that is focussed on assisting families of alcohol and other drug (AOD) users, recognising that drug use usually occurs within some kind of familial setting.

There is a strong connection between healthy and positive relationships within a family and family members' health and wellbeing. It is incumbent upon government and community to act to strengthen families. However, it is also important to note that drug abuse can strike any family for a variety of reasons. In this time of crisis and stress, all families need extra support and information.

In this submission the concept of family is defined broadly. When considering the impact of illicit drug use on families we need to acknowledge the different forms and diversity of families. Drug use can affect immediate and extended family members equally. The majority of our clients are parents trying to cope but we also see other family members such as:

- siblings who, as a result of another family members drug use, are affected and can be exposed to familial conflict and neglect
- grandparents looking after their grandchildren, as the parents are unable to do so due to their drug use
- adult children still dealing with the effects of their parents drug use
- extended families living in one household particularly from different cultural backgrounds.

It is also important to recognise that the most significant relationships of the person using drugs, which support a healthier life, may be with an extended family member.

Through our unique experience over many years of working with families of drug users we have critically identified two independent but equally important approaches to service delivery:

1. We recognise families as clients in their own right so that they can seek a service specifically for them and separate from their drug using member.

2. We provide treatment services for the individual drug user, which are family sensitive and family inclusive. This involves seeing individuals in the context of their significant relationships with their family members and community.

When working with families there is not a distinction between licit and illicit drugs. Whilst the terms of reference specify illicit drugs, the huge impact of licit drugs, particularly alcohol, upon families cannot be excluded. The abuse and problems arising from all drugs is concerning to families. Our experience is that the majority of people who have problems with drug use ingest a variety of drugs. This may depend on their availability and cost. People who are poly drug users often include alcohol as one of their drugs. Alcohol can be more problematic because of the culture of acceptance of excessive drinking. This culture of tolerance means that families and people will put up with more problems from alcohol than other illicit drug use. In this submission, our use of the term "drug" will therefore refer to licit and illicit drugs.

Who we are:

Centacare Catholic Family Services began over seventy years ago as one of the first agencies to provide professional social services in Australia. Centacare offers responsive, professional family relationship counselling services, community development and education programs for families, children and individuals. We focus on the needs of the most vulnerable and disadvantaged in society, in particular children. We work to prevent further social need through advocacy for greater opportunity and fairer social structures.

Centacare employs specialists in the areas of psychology, social work, counselling mediation, conciliation and education. Our staff comes from the community we serve, enabling us to provide multi-lingual and culturally sensitive services.

Mary of the Cross Centre is a service of Centacare. The Centre was established in 2000 by the Catholic Archdiocese of Melbourne to assist the community in dealing with the harmful effects of drug and alcohol abuse. Our mission is to specifically work with and care for families, in all their diversity, who are affected by licit and illicit drug use. We acknowledge that the effects of drug and alcohol abuse can lead to people losing hope in themselves and the world around them. Therefore our vision is 'Hope of a world made new'. This is the hope of families affected by alcohol and other drug use for a better future.

The Centre has three units, counselling, education and community development. Over the past seven years these services have been delivered from various locations including our main office in the inner city suburb of Fitzroy, Noble Park in the south east of Melbourne, and Yarraville, Footscray and Hoppers Crossing in the western region of Melbourne. The geographical spread of our sites enables clients from both urban and rural Melbourne to access our services. We have ten staff, three of whom are counsellors.

The legitimacy of our comments arises from our extensive experience in counselling families, from our work with culturally and linguistically diverse (CALD) communities and through the implementation of our education and community development programs. The Centre's work covers the spectrum of prevention, early intervention and counselling.

In the last financial year we saw 430 clients through our small counselling and outreach service. We had 3,413 contacts with clients and achieved 519 significant treatment goals, such as improved emotional and psychological well being and

increased knowledge and skills for functional family living. Some 4,146 participants attended our 99 information or training sessions. Topics included information about drugs, communication and setting boundaries, parenting adolescents, and cultural awareness training for agencies.

We facilitated three ongoing parent support programs and the New Hope playgroup for Vietnamese parents who had a child under the age of 5 years. We completed evaluations of these projects while also undertaking research of client satisfaction of our counselling service. From these assessments we are able to draw upon the views and experiences of families for this submission.

A particular focus of our work is with families from different cultural backgrounds. We have extensive experience with Vietnamese families and we are currently making contact with newly arrived African families through projects of consultation and delivery of education sessions. It is important to consider the particular requirements and approaches of these culturally and linguistically diverse (CALD) families.

Much has already been reported upon the impact on Indigenous families of alcohol and other drug use. Whilst we do not specialise in providing services for this community, we wish to note the significance of this for inclusion in the Committee's findings.

Terms of reference:

- **The financial, social and personal cost to families who have a member(s) using illicit drugs, including the impact of drug induced psychoses or other mental disorders.**

Financial

Families often find themselves in difficult financial situations due to the direct and indirect costs associated with having a member use illicit drugs. They often have to make difficult decisions about the level of financial support they give to their using member. The family may continue to support the person who is unemployed or unable to retain their earnings from work. Families may pay debts to try to prevent the stress of worsening problems or to avoid violence from other parties. However there are times when this risk cannot be averted and families are subjected to the violence and crime associated with drug debt recovery. They may find their belongings sold, with or without their permission. We have had instances where the family has returned home to find household furniture, cash and jewellery gone. Families have also borne the cost of theft and fraud as result of their member's problem with drug use.

The financial support given to the using member may prevent the family from affording clothing, household amenities and necessities for themselves and their other children. These factors can isolate and stigmatise the family and lead children to withdraw from normal childhood development and activities. Families make complex decisions when trying to balance self protection and family support with the risks of future outcomes. They face the very difficult decision of when, and to what extent, should they withdraw financial support, and will limiting or completely removing this assistance lead to a positive change.

Social

Social stigma is great due to the common negative stereotypes of people who use drugs and assumptions about dysfunctional families as the cause. Families can incorrectly be regarded with blame, with parents being held accountable for their children's drug use.

These negative responses add to the stress of coping. Families become isolated from support or obtaining information and implementing strategies for change. When families seek assistance, they find it difficult to obtain family inclusive counselling, which emphasises harm minimisation and self care. Many families have recounted their repeated efforts to find an agency that can offer them support and information as a family unit. Mary of the Cross Centre aims to provide the core conditions of empathy, positive regard and congruence to help support and counsel family members.

Social and financial costs are heavily related. Families will try to hide the drug use from relatives, friends and neighbours. Children are unable to have their friends visit the family home due to the unpredictability of the using member's behaviour. Families cannot afford to take part in social occasions where an expense is necessary. Moreover, as family life can be chaotic and unorganised it can be difficult to participate in a social activity even when no expense is involved.

Our work with the Vietnamese community has taught us that impact of shame and isolation is particularly so for the families from a Vietnamese background. This highlights the relevance of culture in the impact of drug use upon families. Due to the fear of losing face many Vietnamese families try to manage in isolation. Findings from our Link Hands Together Group, an outcome of the New Belief Project targeted to older Vietnamese families, indicated that respondents felt uncomfortable at the thought of sharing their personal family problems with others. The respondents experienced exclusion and negativity from their community once they had revealed their children were using drugs. Consequently many reported purposefully withdrawing from regular social activities to avoid further stigmatisation.

These findings are indicative of the experiences of all families.

Families who are included in police investigations report the social impact of guilt by association. Families experience harassment, police raids and face charges as a result of the using member's criminal activity. This may occur when illegal drugs are found in their home, whether they were aware of their presence or not, and regardless of their power to keep their home free of illicit drugs.

Personal

There is a common, negative view that the person who is using drugs is without positive features; is a person without humanity, intellect, talent or endearing personality and incapable of having normal, loving and caring relationships. The family may well know the abilities and positive characteristics of the person who is using and have a more complete picture. However the loss of the person they knew or the impact of seeing the person they know experience such pain, obsession, despair and chaos can make those memories seem distant.

Another personal cost is the distancing, or loss of a relationship with the family member. The loss may be due to the person moving away, cutting contact or even dying. Children may lose a parent. A parent may lose an adolescent or adult child. The member may be missing and the family not know if the person is alive or dead. The consequence of the family protecting itself may result in the using member moving into a more addictive environment and incarceration, homelessness or sexual exploitation. These situations mean families deal with guilt, grief, anxiety, fear and many other strong emotions. (See attachments of case stories.1.)

These incidents can initiate or exacerbate mental health problems in non-using family members. Many families experience great anxiety and depression due to the strain and breakdown of family relationships. However, results from our counselling unit evaluation reveal that the non-judgemental, emphatic and respectful counselling environment can validate and normalise their feelings of desperation and grief. Counselling can provide a space in which to reflect upon rather than react to the family members drug use. The aim is to empower the client to access his/her own problem-solving ability and strengths, not to dictate solutions.

• The impact of harm minimisation programs on families.

Our experience with families endorses the approach of harm minimisation, which is to reduce the supply, demand and harm caused by drug use. We consider reduction of harm in the broader sense. For example, harm reduction for families is the provision of support and services for families.

Whilst the using family member does not or cannot cease their problematic use, families still want them to be as safe and healthy as possible. Therefore, when the problematic use does cease, the user will have suffered the least emotional, psychological and physical damage, standing them in better stead to maintain their rehabilitation. It is important that there are choices in the treatment type that suits the person who is using.

Families may be advised that they should disown or cut off contact with the person using drugs. For some families this is the difficult choice they have had to make. However one solution does not fit all as each family situation and circumstances are different. The concept of parenting training and support is one approach allowing parents to be supported and empowered, thereby becoming more effective in dealing with the family members drug use. We know that the ability to work with families leads to changes, even if this does not include the person who is using. Families need to be recognised as clients in their own right and models of service delivery need to be both effective and efficient in responding to family dynamics.

Recommendation:

1. *That the concept of harm minimisation be reinforced and that it be enhanced to include strategies to minimise harm to families through counselling, support, education and information.*

- **Ways to strengthen families who are coping with a member(s) using illicit drugs.**

The rationale for strengthening families is that relationships between members, particularly parents and their young people, which reflect warmth and attachment; concern and interest; positive authority and control; involvement in shared activities; and mutually satisfying interaction are more likely to correlate with control over the development of problematic substance abuse (***Involving families in alcohol and drug treatment DHS 2000, pg5***)

Our extensive experience in strengthening families leads to the number of recommendations under this term of reference.

Families affected by drug use can be strengthened by:

- **Early intervention through education:** Federal and State governments need to support and resource training and information programs which have a strong evidence base of success. The ABCD programs – *About Better Communication about Drugs* – funded by the Department of Health and Ageing, helped to inform and raise the consciousness of parents with adolescents yet this program is no longer funded. Education and information on parenting and relationship training, childhood and adolescent development, conflict resolution and boundary setting are significant ways to strengthen families. Programs such as the Behaviour Exchange Systems Training BEST and BEST Plus that were developed by the Centre for Adolescent Health, University of Melbourne, have been evaluated and have evidence for their success. These are just some examples of education and group programs. We have good knowledge about what education and early intervention works to strengthen families and what does not. We have delivered education programs and information sessions to parents, schools, students and community members.

  Recommendation:

  2. *That evidenced based education and group training programs are funded by State and Federal government for delivery by professional family trained staff.*

- **Early intervention through community support and positive connections to families:** This is particularly significant for CALD families. A celebration and understanding of their culture by the wider community affirms the background and traditions of their parenting style. We have organised events, such as a Vietnamese Peace Concert where several groups of school children and adult groups performed modern and traditional songs and dances to an audience of 400. We worked with an inner city primary school to increase the involvement of the Vietnamese parents at the school. We assisted the parents to organise a Lunar New Year festival, which involved over a hundred students. As a result of the development of the positive relationship with the parents, we were then able to run parent education programs including information about drugs.

  A greater ease of access to English language courses and the provision of training in parenting and cultural differences will facilitate the family relationships. The latter affords an opportunity to explore and accommodate the differences between

culture of origin and contemporary Australian culture, particularly in relation to parental and family roles. We have run many cultural awareness sessions with parents to inform and discuss parenting styles of different cultures and the Australian cultural influences upon their children.

Recommendation:

3. *As part of its strategy to minimise problematic drug use the Departments of Family and Community Services, and Health and Ageing should provide resources for programs developed to strengthen families through their positive connections and engagement to their communities and schools.*
4. *That programs are provided to parents with different linguistic and cultural backgrounds by skilled and culturally appropriate staff in cultural awareness in relation to parenting and childhood development.*
5. *That the Commonwealth department of Immigration and Citizenship increase and make available free or low cost English language classes.*

- **Counselling which concentrates on families as the client distinct from the person who is using:** All families require information about drug use and support in dealing with the difficulties they face and the emotions they experience. Some families may require long term counselling due to other significant issues associated with the drug use such as family violence, grief and loss. The extent and intensity of the counselling would need to be responsive to the length of dependence, as a family may experience several years of problematic drug use. (See attached information as an example of our counselling work in strengthening families.2.)

Recommendation:

6. *That state and commonwealth drug counselling funding be expanded to specifically include specialist family alcohol and other drug counselling, family support and peer support services for metropolitan and rural regions*

- **Treatment services for the drug user that are family inclusive and family sensitive:** This would require employing staff that are specifically trained in family therapy and family support as well as adapting system responses such as intake.

Recommendation:

7. *That funding is allocated by Commonwealth and State governments to employ staff skilled in family therapy and family support in treatment services*
8. *That agencies implement referral protocols to refer families of people who are using to services specialising in family therapy, family support and peer support groups.*

- **Intensive support from professionally skilled workers with the language and cultural knowledge to work with CALD families:** Our extensive experience with the Vietnamese community confirms that a 'missing link' exists between drug prevention and early intervention schemes aimed at Vietnamese-Australians. This also appears to be apparent from our early work with the emerging Horn of Africa communities. CALD workers are able to engage and connect with the family members to enable them to access appropriate agencies for early drug intervention, treatment and information. We have facilitated parent support groups

which have been of great benefit to the participants. (See attachment with extracts from the evaluation of the "Link Hands Together Group".3.)

Recommendation:

9. That Commonwealth and State Government programs resource parent support groups with staffing and costs associated with running a group

- **Those with young children are in need of extra intensive support**: We have identified a need for professional counselling staff skilled in working with young families and family support workers skilled in childhood development and community development. In addition, the availability of therapeutic and non-therapeutic playgroups helps to build on the strengths and motivation of parents to provide a positive relationship, healthy development and future for their children. The groups can foster a sense of belonging and support in the community and have the potential to reduce social isolation by sharing information and experiences. Through the groups it is possible to foster leadership and connections with mainstream services. (See attachment of extracts from the evaluation by the Australian Catholic University of the New Hope project which included the Raising Hope Playgroup.4.)

Recommendation:

10. That the Commonwealth Department of Family and Community Services have a dedicated program resourcing counsellors and family support workers to work with families with young children in a preventative and supportive way

- **Self help peer groups such as Family Drug Help and support groups facilitated by professionals:** These groups provide opportunities to share common issues and concerns. The sharing of stories can give a family power and relief over their situation whilst giving others the permission to do the same. Evaluations of our group programs consistently report the value of discovering that families are not alone, can share the emotions of their situation and learn from each other.

Recommendation:

11. That State government programs for peer support groups are expanded

- **Improved continuity of service so that families are not left alone to support the using family member between service types.**

Recommendation:

12. That places in detox and rehabilitation are increased and where there is a gap between services the person receives intensive support

- **Dedicated and funded treatment places for families**: Many facilities are not able to take children. They do not have the physical facilities, the appropriate staff and organisational structure. This is a barrier for parents and can further fragment family ties.

Recommendation:
13. That Commonwealth and State government resource treatment facilities to include families with children

- **Free pharmacotherapy as this becomes another cost to families that may well be financially stretched**

  Recommendation:
  14. That the Commonwealth Government subsidise pharmacotherapy to reduce the financial barrier to families

- **Family support during and post incarceration and during diversion programs**: The impact upon families when a member is released from prison or during diversion programs can be onerous. There is an expectation that families will take care of the member, but they are not provided with the support they need. Families need targeted support during these situations.

  Recommendation:
  15. That the State Government provide extra support to families whilst a member is in the criminal justice system and on their release.

- **That various Commonwealth and State Departments overcome their silo approach to initiatives regarding resourcing work with families affected by alcohol and other drugs:** The resources available to work with families affected by alcohol and other drug use are limited. Frequently the feedback we receive from State and Federal government to our grant applications is positive but that we do not fit the right funding box. When we seek assistance from a generalist family program, we are referred to an AOD program and on other occasions the reverse occurs. This response has occurred to clients with co morbidity problems in that they were excluded from AOD services and Mental Health services. The combination of working with AOD and families means exclusion from existing programs. Some funding rounds targeted at AOD and families but they are few and have limited funds. (E.g. some 2 year NIDS (National Illicit Drug Strategy grants)

  Recommendation:
  16. That funding from programs for families does not exclude projects that work with AOD affected families and that programs funding AOD projects do not exclude proposals that work with families.

  17. That the Commonwealth fully fund long term work with families affected by alcohol and other drugs, rather than a limited two year period.

Conclusion

As a specialist service provider for families affected by problematic drug use we welcome the Committee's inquiry. We would like to thank the Committee for taking the time to review our comments and consider our recommendations. The staff of

Centacare and Mary of the Cross are available to provide additional information in support of our position and would welcome any feedback from the Committee.

Attachments

1 – 4: Case studies

5: How Counselling helps Strengthen Families

6: New Belief – Link Hands Together excerpts from the evaluation

7: New Hope – evaluation excerpts

Contact details:

Centacare Catholic Family Services
Cardinal Knox Centre
383 Albert Street, East Melbourne 3002
Ph. 9287-5555
Fax. 9287-5599

Mary of the Cross Centre
7 Brunswick Street, Fitzroy 3065
Ph. 9495-6144
Fax. 9495-6166

CASE STUDY ATTACHMENT 1:

Term of reference 1: ***Financial, social and personal cost to families with a member using illicit drugs.***

I write these comments from a very broad frame of reference and information.

Firstly, I am person who has experienced illicit drug use in my own family and from this perspective I shall begin by describing some of the personal costs that I experienced as a result. These were largely emotional costs and took many forms. I should add that my own experience centers around the short time I had to cope with the crisis of discovering my daughter's drug use and my own attempts to come to grips with it. This occurred ten years ago for me, at a time when there was no useful information or support available for families, no one to put me onto the path of thinking "harm minimization" and "self care", no one to counter the prevailing horrible advice given to parents – to turn ones back, to shut the door until they had stopped using. How utterly useless that directiveness was, telling me to do what I had never done or could contemplate doing, to walk away from my daughter because she had developed a drug problem. I should stress that the personal costs I experienced relate to those commonly experienced by parents in the early stages of their journey of coping.

The costs to me ....firstly, an overwhelming fear, terror more like it, that she could die, the fear that she could never get over this. This fear leads to anxiety and a constant sense of dread. There was the fear that I would say the wrong thing, make the wrong decision, take the wrong path. In hindsight, when I did just follow my heart and do what seemed natural, this worked out well, but it was not always easy to do.

And there was anger somewhere in all this, an irrational anger that she had taken this path, anger at what we all had to go through, anger that she could not stop using. I should add that I knew practically nothing about the process of change at this time I am ashamed to say that I knew nothing about the physiological process of addiction – despite having parental alcohol use in my own childhood and having been addicted to nicotine myself for 30 years and having worked in secondary and tertiary education for most of my working life. My anger came largely out this profound ignorance, out of the naïve belief that many parents have in the early stages of coping that this problem should just go away.

And then there was the aloneness, the feeling of terrifying isolation, that I and my family were alone with this problem, there was no one to help and no one could understand. At the time, certainly there was no-one to put me in touch with other parents who I could talk to, apart from a 12 step group I attended once and found confronting and blaming.

And there was guilt, not about blaming myself for my daughters drug use, because I knew I had been the best mother I could be to her. But my guilt was about my inadequacy, how hopeless I seemed to be at managing, how utterly lost and confused I felt. As a person who had previously managed large classes in schools, who had managed a residential college of the university with fifty staff and two hundred students, suddenly I was clueless and pathetic and I felt ashamed. Somehow, all the directiveness of the services I had contacted served to make me even more confused

and feeling inadequate. Somehow, I lost my internal wisdom, my inner frame of reference, I could not centre myself. All I needed, in hindsight, was someone to help me to look into my own heart, to focus back on my existing relationship with my daughter and find my own way of coping, not an ideologically based formula presented to me by someone who just did not understand.

And then there was shame. Not my shame, because I never felt it, not for a minute. Why should I be ashamed that my daughter was using a drug, even it is was illicit? Maybe because I did not blame myself as a parent, I did not feel the shame that may parents feel. But it was her shame, the terrible shame that my daughter experienced – this is what was so painful to me. And how absurd that this stigma exists around injecting drugs, when so many people self- medicate to deal with their emotional pain or loss in more socially acceptable ways, with alcohol or nicotine for instance.

And finally, the terrible grief and sense of loss, the perceived loss of the path I had perceived my daughter to be on, a path of tertiary study leading to a career in psychology. Grief and sorrow over the pain she was experiencing in trying to cope with and master the compulsive urge to use the drug. Just plain grief over the fact that I loved her so much and she was suffering.

How could I begin to describe the grief when we lost my beautiful daughter, the shining light of our lives. Yet this grief, this terrible crushing bereavement that one never recovers from, is part of the personal cost for many parents in this situation. I should add that this is a grief that I would never want to fully recover from, this deep sorrow is part of my relationship with my daughter now, along with the joy and bliss of having her in my life for 24 years. I have re-organized my whole life, retrained in my professional life, experienced new joys with my three beautiful grandsons, but I still and will always burst into tears without warning when I think of her. It could be something I have read, a person walking by who reminds me of her, kind and loving words about my daughter from a friend, a song she loved, photos, reading her copious volume of writing, looking at her paintings and photography, reminiscing with friends and family.

In amongst my grief that rendered me powerless and paralysed for a long time, there stirred eventually in me a kind of anger, an anger that society treats people with drug use issues as pariahs, or they did then. Hundred of young people died in the 1990's from heroin overdose in what I describe as a heroin epidemic. Yet what was there to help the families, how many families were out there struggling and desperate, just as I had been? And if families were not getting support, then what help could the family offer to the person with drug use problems?

In July 1998, I started a group for parents, kindly helped by Vera Boston, CEO of North Yarra Community Health Service, by Michelle Keenan, founder of the Yarra Drug and Heath Forum, by my sister Christine, by Jane Worrall and eventually assisted by a wealth of professional speakers. These included Dr. David Jacka, a GP specializing in drug and alcohol patients who became a drawcard speaker for the partents, because he told them all the things they had been too afraid to ask and because he deeply respected them.

Term of reference 3: ***Ways strengthen families who are coping with a member(s) using illicit drugs***

I learnt about the process of coping, about the nature of the coping journey that family members can embark upon in dealing with drug use in the family. I realized that I had been pretty much at Stage 1 with my daughter, that the personal costs I was experiencing related a lot to my attempts to control, to influence events, to change the behaviour of another person, to my lack of information. I myself learnt much from co-ordinating this hugely successful group that operated for four years and which I reluctantly had to close due to other commitments.

- I witnessed parents shift and change in how they approached things, as they learnt more, listened to each other and were themselves heard.
- I learnt that people can move beyond the overwhelming emotions I had gone through, provided their child remained alive.
- I learnt that anger and fear can be used to energise, to demand better services and information.
- I learnt that sharing your story gives you power and relief.
- I learnt that sharing your story gives permission to others to do the same, that stigma and shame fly out the window at that moment.
- I learnt that listening to the stories of others puts an end to that horrid feeling of isolation.
- I learnt that knowledge is power, that obtaining accurate and up to date information about drugs and their effects, about drug treatments, about withdrawal, about legal issues, about the history of drug prohibition, about agencies.....all this learning is a vital ingredient in helping parents in their coping journey.
- I learnt that expressing emotions in a healthy way was better than holding them in or directing or projecting them onto others.
- I learnt that the only way through this journey was to get into the "grey" areas, the messy in- between, difficult muddling through, with no way being the right way. I learnt that "black and white" polarized positions served little purpose, that over- rescuing and over-controlling were both positions from which people needed to shift, to either harden a little or soften a little in a shift towards a healthier balance. Yet this need to shift had to be experienced by the person, not imposed by an outside professional. In the group, the range of personal experiences on show helped others get a sense of where they needed to move.

All of this I learnt from leading and being part of a peer group process which was both structured yet flexible, which respected each family member for the stage of this journey they were at and validated the steps they wanted to take at this point in time.

In summary, one of the most powerful ways of helping families is through the peer self- help process. Parents can listen to how others cope, realize they are not alone, possibly hold their heads up with pride again as they see other "normal" parents in the same position, understand more about what their child is dealing with, pick and choose from approaches they hear in the group to suit their own situation. They need the input of professional information along the way, so that the choices they make are based on knowledge, not rumour or mis-information as is common in the drug field.

They see other parents at all stages in the process, from early crisis to later acceptance, have a sense of where they have come from and where they may be heading.

The Family Drug Helpline and the Family Drug Help service in Victoria was the brainchild of this writer and supported and fought for by herself and members of her group. Peer family volunteers trained in basic counsellng take calls from the public, providing support and understanding and referral. They do not provide direction or advice. The model of the group just described became the model on which the Family Drug Help service is based, with groups across the state.

I now work as a professional counsellor with family members of people with drug use issues. In my own journey, I have moved from secondary school teacher, to Deputy Head of a tertiary residential College, from bereaved parent, from social justice activist in starting my group, to retraining as a counsellor.
Counselling which is based upon a humanistic, respectful approach to such clients is another most powerful tool in strengthening families. Meeting clients at different stages of this coping journey, assisting them in their own exploration of how best to manage, helping them access their own strengths which many feel have deserted them, helping them search their own hearts for where they need to go and the goals they wish to set.

Counselling, peer support and proper information are to me the the three key areas for strengthening families. I should add that one of the most useful pieces of information for families to learnt relates to the theory of the Stages of Change as described by Prochaska and di Clemente. Once a parent or family member understands this concept and can apply it to both the drug user and to themselves, they can get a sense of something not set in stone, something fluid and changeable. It can give them hope. Hope is the key vital experience for families in their coping, the sense of possibility for the future.

CASE STUDY ATTACHEMENT 2:

Carina has been a client at Mary of the Cross Centre since 2004. Originally she attended the Centre because she was not coping well in her life, largely as a consequence of growing up in a household where her father was an alcoholic.

Carina is the eldest of three sisters. Her mother came from Denmark and her father from Spain. Over time it became apparent that she had growing concerns about the welfare of her youngest sister, Alicia, who was in a relationship where she was subject to domestic violence. In the family story it is said that when the fair-haired Alicia was born her father asked "where did she come from?" and three months later he left the family home and had no further contact with his daughters until they were adolescents and his physical and mental health had deteriorated considerably.

In late 2005 a pregnant Alicia had left her marriage and moved into their mother's housing commission home together her other four children under 10 years of age. In January 2006 syringes and other drug using paraphanalia were found in Alicia's bedroom and this confirmed fears that she had been using drugs, probably heroin given the description of her behaviour.

Through counseling Carina had been learning a range of skills to help her cope with the stress within her family. She now understands the limits of her responsibility and how to maintain healthy boundaries for her own well-being and how to focus on the relationship rather than on the drug use. These skills helped Carina maintain a relationship with her youngest sister and by mid-2006 Alicia had seemed to have reduced her drug use and obtained her own accommodation even though she relied heavily on her mother for help with babysitting.

However in November 2006 Alicia's behaviour took a turn for the worse. She moved back into mother's house but has paid nothing towards rent or utilities. She has been having violent mood swings and is verbally abusive towards mother and has hidden knives at various points throughout the house. Her thinking seems to be irrational and bizarre and probably the result of continued drug use however this has not been confirmed because of the secretive nature of her drug use. She has been known to leave the house in the early hours of the morning, taking several of her children and not returning for days and giving her mother no indication of what she is doing or when she will be back. The older children have been imitating their mother by being verbally abusive to their grandmother. Alicia blames her mother for all the things that have gone wrong in her life. The Department of Human Services are maintaining a watch on the welfare of the children but Carina wonders how bad the situation has to be for the children to be taken into care. When Department workers visited the house Alicia laid the blame for the filth in the house on her mother. Carina is deeply concerned for her mother's welfare and the security of her housing given that her sister has taken to collecting 'junk' that is now piled up in the backyard and front yard of the house, damp clothing (washed but never hung out to dry) piled up in the house, personal papers belonging to mother being destroyed, jewellery belonging to other family members being pawned, etc.

This case highlights that one of the anxieties family members have to cope with is not knowing the truth about a person's illicit drug use and the fears that suspicion can engender. It also illustrates how all members of a family can be impacted through

their love for a family and concern for her well-being and that of her children. This story is ongoing and is already damaging the lives of another generation of children.

March2007

CASE STUDY ATTACHMENT 3:

Tony, a successful businessman, first came to Mary of the Cross Centre as a participant in a BEST (Behaviour Exchange Strategic Training) program for parents. His 33 year old son, Peter, had a long history of drug abuse, violence, and other illegal activities. Peter has participated in many drug rehabilitation programs but, because he has learning difficulties, the results of these programs are generally short lived and he reverts to drug using within a very short time of leaving a rehabilitation centre. These programs have cost the family many thousands of dollars.

Some of Peter's activities have been directed at his father, for example using his father's identity and selling property belonging to his father and intimidating his father with threats of violence.

A factor that makes Tony's situation particularly painful is that his wife fully colludes with her son and does not seem to be able to believe that he does anything wrong and continually makes excuses for Peter's behaviour, gives him money, and undermines Tony's attempts to set healthy boundaries. Tony says that he stays with his wife because he understands her vulnerabilities as the daughter of Holocaust survivors even though her behaviour makes him feel frustrated and angry and very lonely.

Tony says that counselling provides him with an opportunity to have his experience validated and to be understood, to have permission to live his life without constantly being drawn back into the web of addiction, and as the only place in his life where someone is willing to listen to him and believe him because of the shame of letting people outside his family become aware of the extent of his son's behaviour.

CASE STUDY ATTACHMENT 4:

Always be aware-even the simplest every day acceptances give a devious effected person an unwanted opportunity-for example:

Do you hide your valuables in your own house, your purse, your bag, credit cards, credit card slips, cheque books, bank statements - all these provide information for him/her to use. Even your frequent flyer number should be kept secret, the dependant user is clever and can clean out your account.

If you pay rent, debts, doctors for the drug dependant son/daughter don't give them cash or cheques to pay with as they can't resist the opportunity to use the money for themselves.

If you pay the above by credit card don't have the receiver give the credit card receipt to your dependant son/daughter as it has your credit card number and often your signature on the slip and they can't resist the opportunity to use the information to turn the chance into money for themselves. Frauds are easy to commit when the dependant user has the information at hand.

Do you lie to your partner/spouse about your son/daughter's drug use problems. "He/she has a problem, it's only a little bit of money to help" this is not helping it is actually furthering the problem. All problems related to drugs have consequences, hiding the user from consequences is not "helping" it is furthering the problem.

I hope this little information is of help. All these things have happened to me.

ATTACHMENT 5: How counselling can help family members in a range of ways:

With parents, counseling can:

- Provide a safe space for emotions to expressed. Family drug use can lead to some profoundly disturbing and difficult emotions, ranging from grief, anger, fear, guilt, shame to feelings of alienation. Because many people feel stigmatized by illicit drug use in the family, it is not always safe to express these emotions in public or even within the family.

- The very release of emotions and the validation and normalization of these by the counsellor, can help the client feel relief and know that they are not going mad.

- Provide a safe place for the story to be told and be heard in a compassionate and non judgemental way, bearing in mind that the outside world if often full of judgment and bias over this issue. This can begin the process of restoring the clients self esteem, which may have been at a low ebb. This is a step on the way towards strengthening the whole family.

- Help the client start of focus more clearly on the issues they face, help begin a process of reflection and thinking, which can start reducing feelings of being overwhelmed and out of control. A thoughtful and mindful approach by the parent can benefit the whole family.

- Assist clients in their exploration of the painfully difficult dilemmas that can arise. For instance, how long their child can stay in the home, whether to allow drug use in the home, whether to keep financially supporting their child, whether to notify police if items have been stolen, whether to hide the facts of drug use from other family members, whether to keep trying to save their child from their own behavioural consequences and so on. It must be stressed that for most parents, this is the first time they have had to contemplate such challenging and threatening dilemmas, as illicit drug use can put the whole family on a new and unpredictable and unknown path.

- Counselling can help clients explore what they need to try at this point in time, bearing in mind that the journey of coping is a long and difficult one for many, and characterized by trial and error. Counselling can assist the client by validating the steps they wish to take at any given point and support the client if that approach needs to change – coping cannot be imposed, it must be learnt along the way. However, the counsellor bears in mind that balance is important in peoples lives and can gently suggest steps towards redressing that balance if needed. Balance can mean bringing focus back onto other family members, it can mean bringing focus back onto self care, it can mean working on conflict that may have arisen in marriage due to family drug use, it can mean starting to think more and stress less…

- In this journey towards balance and a reflective attitude, some clients may wish to explore boundary issues – situations where they feel invaded,

threatened, unsafe, used and exploited. Counsellor can help clients move towards their own resolution of these issues, which are individual and unique for each client and family. Counsellor should understand that most parents are conflicted around boundary setting because of love for their child and fear of consequences of firmer stance. Counselling does not direct or impose, it works with that love and acknowledges it, which is important before any change can take place. Counsellor can help client understand that setting boundaries is not a betrayal of love or abandonment, rather it can be a loving thing to do as it models a healthy process that the drug user perhaps is struggling with internally. It also models self love and self care, which are good for the rest of the family.

- Provide the client with valuable information on the Stages of Change that the drug user can go through, this providing hope and a realistic appraisal of what point the drug user is currently at along this continuum and the best ways of supporting them given this situation. It can also alert parents to the fact that they too are in a process of change, that they too can move to a more resilient and accepting space of the fact of drug use, even if they cannot condone it.

- Help client notice and reflect upon their interpersonal relationship with family members, including the person using drugs. Provide suggestions about ways of communicating in a non blaming or accusing way, if that is what client feels they need.

- Help with referral to peer support groups, which are known to provide strengthening to family through the normalization and validation of the shared experiences in the group.

- Provide client with drug and alcohol information which is relevant to their needs.

- Provide a respectful and compassionate space for the client to be heard, thus reflecting back a valuable and precious self to the client, whose inner sense of dignity may be compromised by having illict drug use in the family.

In summary, if the parents start to feel stronger within as a result of counselling, this change can flow on the rest of the family. Support the parent and he or she is better placed to focus back on other children and on the parents own relationship. Even more, they are better placed to survive this crisis and to help the drug user so the same.

ATTACHMENT 6: Excerpts from New Belief Project Final Report 2006

Mary of the Cross Centre's work with the Vietnamese community is entirely aimed at building upon these pre-existing strengths from within the Vietnamese community, whilst at the same time providing assistance to overcome some of the above-mentioned impediments. Staff of the Centre are involved in a number of drug prevention, community development and casework management functions relating to Melbourne's Vietnamese community. However, we have also come to acknowledge that there are some significant gaps in the service system which the 'Niem Tin Moi' project sought to overcome. These include:

- Too little assistance to Vietnamese-Australian families, with almost the entire emphasis being on reaching Vietnamese-Australian drug users, viewing them in isolation rather than in their socio-familial context
- A 'missing link' between drug prevention and early intervention schemes aimed at Vietnamese Australians, and the drug treatment sector. This disconnectedness means that the benefit of the prevention programs is largely lost. For example, when prevention programs provide information and incentives for families to refer drug-affected members to treatment, they find the sector non-responsive. Moreover, Vietnamese-Australian clients are then compelled to make new relationships with unfamiliar workers, perhaps lacking in linguistic skills and cultural competence. This results in many subsidiary problems such as Vietnamese clients failing to attend appointments, withdrawing early from treatment schemes, etc.

In 2001 – 02 staff of Mary of the Cross Centre conducted a weekly program for Vietnamese families on SBS Radio's Vietnamese service. This program had very broad reach to parent-age Vietnamese Australians, and provoked discussion on the many issues concerning family relationships and their implications for drug abuse among young Vietnamese-Australians. This led to many requests for help from callers and listeners. However, the unfamiliarity of those people with a non-inculturated drug service system, and the lack of available outreach worker resources, meant that those queries often went unanswered.

Three case studies have been selected to provide some detail of the nature of the issues affecting Niem Tin Moi clients and the role the worker played in providing assistance. Any identifying information has been changed.

Case studies

Mai-Lien

Mai-Lien, a single mother, came to Australia in 1983 with two children – a son and daughter. When her daughter was thirteen Mai-Lien paired up with a new partner. Her daughter felt unwanted and started using drugs. She ran away from home to live with a group of friends. In that time her mother went to great lengths to try and find her and keep in touch, but the daughter moved around a lot and rejected her mother. Mai-Lien tried many things to encourage her daughter to come home to live, including enrolling her at an expensive private school.

At the age of 17 years Mai-Lien's daughter partnered up with another drug user and had two children. When they were homeless Mai-Lien took the two of them into her home and helped to care for the two children. This was difficult because of the lack of hygiene practised by the children's parents and her daughter's partner was dealing drugs from Mai-Lien her home, making it unbearable to live there. Mai-Lien asked her daughter's partner to leave, which he did.

Her daughter went to see a drug and alcohol worker at a local community health centre and he referred Mai Lien to Hue, the New Belief worker. With Hue's support Mai Lien came to see one of the counsellor's at Mary of the Cross Centre and this helped her to recognise the boundaries for her as a grandmother and her daughter as a parent. The counsellor and outreach worker worked closely together to provide holistic support for Mai Lien. She joined in the Link Hands Together group and found the support of workers and other clients a great help.

With renewed confidence and her daughter's steady recovery Mai-Lien bought a new house in a different area of Melbourne with the aim of giving everyone a fresh start. Her daughter is on a methadone program and life has improved for all.

Huy

When Huy's son was studying year 9 his father had very high expectations of him. Huy was very strict and demanded that his son obey him without question and spend inordinate amounts of time studying. His son could not cope with this discipline and ran away from home. He stayed with friends, started smoking marijuana heavily and went out to clubs where he was introduced to ecstasy use. He got into a fight and seriously injured one of his friends. As a result he was investigated by the police. Huy was very distressed about this and worried greatly about his son. A friend knew of his situation and gave him the Niem Tin Moi (Vietnamese newsletter) suggesting Mary of the Cross Centre may be able to help. The New Belief worker visited his family and listened to the story from both the father and the son.

Huy joined the Link Hands Together Group where he participated in the anger management sessions. He saw for the first time how his behaviour had contributed to the problems with his son and made significant changes at home. His son returned home permanently and gave up drug use. He was charged with assault by the police and went to court. The New Belief worker arranged for the family to have legal aid and supported them through the court hearing, writing a letter on behalf of the young boy to the magistrate and attending court sessions. Huy's son received a good behaviour bond and asked the outreach worker to help him find employment. She contacted CRS on his behalf and he is attending their services.

Thu

Thu is a single mother with four children, two daughters and two sons. Her oldest son and her son-in-law have been involved in drug use for many years. Her youngest son has a disability and lives at home with her. She loves all her children very much, including the one who uses drugs, but he has treated her with great disrespect and caused lots of trouble for her.

Because of the crime he committed in the neighbourhoods where they lived and the violence threatened by his associates she has moved house 27 times since coming to Australia in the early eighties. Because she feels so ashamed about his behaviour she

has cut herself off from friends and family and is very lonely. Thu has attempted suicide on four occasions.

She heard about Mary of the Cross Centre from the Vietnamese education worker who referred her to the project outreach worker. Hue has visited Thu on many occasions. One day when she called, Thu was sitting in her house with all the furniture gone – stolen by her son while she was out shopping! A relief voucher was arranged through VCAVic and new locks were fitted. Thu is a regular attendee at the Link Hands Together group and says she could not live without the friendship and support provided by the group. Over the past year her mental health has improved so much that she now acts as a welcomer for new participants in the Link Hands Together group.

Outcomes (from Casework section of New Belief Project Final Report)
Clients were generally in a crisis situation and highly anxious when they made initial contact with the project worker. For some of them the trigger point for seeking help was family violence or an impending court case. Occasionally someone has rung in fear for their life such have been the threats from a drug-using family member or one of his/her associates. As they explained their circumstances to a calm non-judgemental worker and knew that they were being listened to, their level of anxiety usually dropped. Arrangements by the worker to make a home visit or meet the client at a place where they felt safe often brought a level of relief and a sense that they could cope until that time. A few clients chose not to have face-to-face contact with the worker but were satisfied to call in and discuss their situation over the phone.

For most clients talking through their situation and setting some goals, no matter how small, gave them a sense of control over their lives again. Some of the parents amongst the client group came to understand that they cannot force their son or daughter to stop using drugs but they can make changes in their own lives to improve their own health and wellbeing. In talking with the outreach worker some realized that instead of helping their son or daughter to face the consequences of their own drug use they were actually enabling drug use to continue by paying fines, providing money, etc. They were very pleased to see that once they changed the way they related to the drug user, his or her response often lead to greater harmony in the home, better communication and a renewed respect for the parents.

Some parents believe that if they send their drug-using child back to Vietnam the influence of the extended family and culture and the perceived lack of availability of illicit drugs will 'fix the problem'. Unfortunately this is rarely the case. When the worker encountered this belief amongst her clients, with some making great sacrifices to save money for this, she countered it with evidence to the contrary. With her support they investigated local treatment services and encouraged their children to access pharmacotherapy.

A number of the casework clients who were parents of drug users had been clinically diagnosed with depression and two of them were regularly attending mental health services for more severe psychiatric conditions. Over many years they have lived with the worry of injecting drug use, criminal activity, incarceration, broken promises and threats of violence. They have sometimes had their home virtually taken over by a son and his drug-using peers; negotiated with Child Protection Services to care for their

daughter's children; waited hours and hours in court for their son's case; plotted and pleaded to try to stop the drug use; come home to find their furniture gone; gone without food after giving in to demands for money.

Some mothers and fathers had more than one drug user in the family and lived in fear that younger non-using children would follow into the lifestyle. The most extreme situation is that of a mother with five sons, four of whom are or have been injecting drug users. The years of drug use have taken its toll and most of the parents came to Niem Tin Moi with a sense of hopelessness.

As a result of the support provided through the Niem Tin Moi project many clients experienced better mental health and one of them, fewer psychotic episodes. The project worker had accompanied this particular client to the emergency department of a major hospital on one occasion and to the mental health service on another. The psychiatrist responsible for the client's health care liaised with the project worker at these crisis points and over time the client's condition improved with regular medication and ongoing visits. Her son was in prison for drug related crime.

The worker reported improvements in living standards as a result of her intervention on behalf of clients needing material assistance. She also worked with Centrelink to ensure that clients received the social security benefits for which they were entitled. For one grandmother caring for young children in the absence of drug using parents this made significant improvements in their circumstances and quality of life.

Some of the children had insight into the pain their drug use had caused family members and were in the process of change, but found it very difficult to remain drug-free. The project worker often met them by chance when visiting parents and sometimes arranged to talk with them separately if they expressed a desire to do so. While the worker could listen to their concerns and provide a number of avenues of support, it was often more appropriate that they be referred for pharmacotherapy treatment and/or to a drug and alcohol counsellor. While many of the Niem Tin Moi clients were non-English speaking, most of the drug-using clients could access support from mainstream services.

As with most illicit drug users, the Vietnamese drug using clients were very negative about their prospects of ever remaining drug free and finding suitable employment. Using a contact within CRS the outreach worker successfully supported three young men into a methadone program and regular employment.

Outcomes (from Support Group section of New Belief Project Final Report)

Parents who overcome their initial apprehension to attend these group programs are most appreciative of the benefits received … and these are significant. Some of them find it a great relief to know that they are not the only ones experiencing the problems associated with a family member's drug use. They listen to each other, cry and laugh together, ring each other up between programs and say they look forward to their time together each week. For one or two of them it is what "keeps them going". The workers all report improved mental health amongst participants (see Evaluation Report)

The educational input gave them insight into aspects of drug use and different ways of addressing it within their families. They have taken home and shared with drug-using family members information about methadone, buprenorphine, blood borne viruses, legal aid, anger management, etc. In 2006 the facilitators invited a Vietnamese-speaking drug and alcohol worker from Odyssey Victoria to talk to the Link Hands Together group about drug rehabilitation and they were so interested he arranged for an excursion to Odyssey's Therapeutic Community in Lower Plenty. Long term rehabilitation was an unfamiliar concept for group members and they were excited by what they saw – returning to Mary of the Cross Centre to ask if the agency could set up such a service for Vietnamese-speaking people! The visit reinforced the knowledge that recovery usually takes a long time.

Outsiders may think it inefficient to have four workers involved in running a parent support group, but the needs of this group are so great and the benefits of working together so evident that it is justified.

ATTACHMENT 7:

Excerpts from New Hope project
Family Outreach

Background

It was expected that the parents, including mothers with young infants, seeking help would themselves have drug and alcohol problems, it was therefore a surprise to find that there were a number of first generation migrant Vietnamese women living in Australia, particularly in areas such as Springvale, Victoria, who have come to Australia as sponsored brides. Many of them had met their Vietnamese Australian husbands in Vietnam. One of the reasons for sending young Vietnamese Australian men back to Vietnam is in the hope of getting them off drugs, usually heroin. Their drug use often resumes when they return to Australia. Previous drug use is rarely known to the wives, who often become pregnant in the first year of marriage. They are unprepared for the isolation and stigma that attaches to new arrivals, particularly if drugs are a common practice within the family. The new arrivals often live with the husband's family and as sponsored brides are required to be fully supported by their husband and/or family for two years and, even in the face of horrendous circumstances, are unable to receive Centre link payments within this time period. Their stories are often heartbreaking. The women recount struggling to survive birth and child rearing in an alien culture with no knowledge of English, often very little family support and limited knowledge of how to deal with the drug use within the family.

The other group of women who have a demonstrated need are young mothers of Vietnamese origin who have substance abuse problems and are referred by chemical dependency clinics for pregnant women operating at major obstetric hospitals.

Case Study 1

An excerpt from the one woman's story, was as follows:

> In the first few years I encountered a lot of difficulties.....My husband was a drug addict, upon knowing I was pregnant I was completely bewildered. My life was hard... I must look after not only my parents in law, but all my husband's siblings. ... I was so frustrated and very down, I was thinking of taking my own life. However the baby I was carrying gave me strength. After the baby was born I met a girlfriend, she introduced me to the workers at the Centre. They helped me get a refuge, so I could look after my child and assisted me to get financial support from the government

This young woman had considered all options before she left her husband. She finally made the decision to leave to protect her child and was only able to do so with the help of the program. She required assistance with housing, setting up a house with furniture and equipment and gaining access to Centre Link payments once established in a home.

Playgroup

Analysis of the focus group interview carried out after the women had been involved in the program for seven months and the mother's playgroup for six months found

that the women had formed new friendships, shared experiences, learnt new skills, and had been given opportunities to meet Australians and learn about Australian culture. All wanted the mother's playgroup to continue. They also identified the need for more classes on childrearing and appropriate ways to discipline children. Several mentioned they had heard it was against the law in Australia to smack your child. Those who were coping with addiction within the family wanted more information about addiction in relation to family members so they could "manage within the family." All agreed that the formal help they received through the program had made an enormous difference in their lives and was assisting them to integrate into Australian culture.