EVALUATING THE EFFECTIVENESS OF SUPPORT PROGRAMS FOR FAMILY MEMBERS AFFECTED BY A RELATIVE’S SUBSTANCE USE

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## ABBREVIATIONS & GLOSSARY OF TERMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AOD</td>
<td>Alcohol and other Drugs</td>
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<tr>
<td>ARC</td>
<td>Action for Recovery Course</td>
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<tr>
<td>DoH</td>
<td>The Commonwealth Department of Health formerly known as Department of Health and Ageing (DoHA)</td>
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<tr>
<td>EOC</td>
<td>Episode Of Care is a completed course of treatment which achieves significant treatment goals</td>
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<tr>
<td>Family member</td>
<td>Anyone who is impacted by a family member’s drug use</td>
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<td>FDH</td>
<td>Family Drug Help</td>
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<tr>
<td>Mutual aid</td>
<td>The process of giving and receiving non-clinical, non-professional help from peers, i.e. people who share the same experience</td>
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<tr>
<td>Mutual aid groups</td>
<td>Self-organising groups that provide mutual aid to their members to address a shared a health or social issue, also known as self-help groups</td>
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<tr>
<td>Peers</td>
<td>People who share the same lived experience.</td>
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<tr>
<td>Peer-led</td>
<td>Describes programs designed, managed and led by peers of the participants of the programs</td>
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<tr>
<td>Problematic use</td>
<td>Any substance use that causes problems for the individual and/or others</td>
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<tr>
<td>Relative</td>
<td>Refers to the person whose substance use is causing concern or disruption for their family members</td>
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<tr>
<td>Self-help</td>
<td>Synonymous with mutual-aid</td>
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<tr>
<td>SHARC</td>
<td>Self Help Addiction Resource Centre</td>
</tr>
</tbody>
</table>
Contents

ABBREVIATIONS & GLOSSARY OF TERMS................................................................. 5
ACKNOWLEDGEMENTS ............................................................................................... 7
EXECUTIVE SUMMARY ............................................................................................... 8
1. INTRODUCTION ......................................................................................................... 15
2. EVALUATION DESIGN ............................................................................................... 21
3. LITERATURE REVIEW ............................................................................................... 25
   Impact on families ........................................................................................................ 25
   Recognition by academics and policy makers ............................................................. 26
   Family interventions ................................................................................................... 27
   The Stress-Strain-Coping-Support (SSCS) model ...................................................... 28
   Community Reinforcement and Family Training (CRAFT) ....................................... 29
4. EVALUATION OF FAMILY DRUG HELP PROGRAMS ............................................ 30
   Action for Recovery Course (ARC) ............................................................................ 30
   FDH Support Groups .................................................................................................. 42
   Family Counselling Service ....................................................................................... 55
   Family Drug Helpline & Volunteer Program ............................................................ 58
5. SUMMARY & CONCLUSIONS ................................................................................... 62
REFERENCES .................................................................................................................. 66
Appendix 1 – Outcome Measures .................................................................................. 69
Appendix 2 – Detailed description of the ARC program content .................................... 70
ACKNOWLEDGEMENTS

We are pleased to have been given the opportunity to conduct this evaluation and thereby contribute to greater understanding of peer-based recovery oriented support for families impacted by addiction.

We would like to acknowledge the generosity, honesty and patience of the management, staff and participants of the FDH programs. They all engaged willingly in what was an intensive evaluation at a time of great change both inside and outside SHARC.
EXECUTIVE SUMMARY

Self Help Addiction Resource Centre (SHARC) is a Victorian community based, not-for-profit organization established to promote and provide peer-led, mutual-aid approaches to recovery from severe substance related issues for individuals and families.

SHARC provides a range of services including Family Drug Help (including Family Drug Helpline and Volunteer Program, Action for Recovery Course, Family Drug Help Support Groups, and Family Counselling Service), Recovery Support Service (RSS), and the Association of Participating Service Users (APSU), a Victorian consumer representative body for alcohol and other drug (AOD) service users.

In 2012, Turning Point was commissioned to undertake a process and outcome evaluation of four programs sitting within Family Drug Help. This evaluation was funded by the federal Non-Government Organisation Treatment Grants Program (NGOTGP) as part of SHARC’s service development work. The evaluation team also conducted a parallel evaluation of SHARC’s Recovery Support Service (RSS) which is documented in a separate report.

The aim of this evaluation was to determine the extent to which Family Drug Helpline and Volunteer Program, Action for Recovery Course, Family Drug Help Support Groups, and Family Counselling Service were delivered as described and in line with best practice, and to assess the outcomes (that is, improvements in health and wellbeing) for participants in the programs.

Findings

The Family Drug Help services provided by SHARC fill an important community need, ensuring that the families of those with substance misuse problems have access to professional and peer support. These services are provided by a dedicated pool of paid and volunteer staff who are committed to the values of SHARC and to supporting their community. The four programs under evaluation form a pathway of support for families of those with substance misuse problems, and a vital peer network that enables participants to both gain and provide support at the level that best suits their needs. Dedicated staff and management are committed to ensuring that the programs are tailored to participant need and are delivered in line with best practice. Together this suite of programs provides a valuable service to the community and SHARC is to be commended for the ongoing delivery of these quality programs.

Action for Recovery Course (ARC)

The ARC is a facilitated education course for family and friends on how to best cope with a family member’s addiction, held one evening a week for six weeks. Five courses were run in 2013. Participants are mainly referred from the FDH Helpline. Facilitators are trained professionals with a lived experience of addiction. ARC facilitators were well informed by research evidence and good practice for family support programs.

Program delivery and review practices show a commitment to quality improvement and evidence informed practice. The course aligns with best practice for peer-based support programs, providing relevant information, exploring ways of coping, discussing social support and establishing the need for further help.

- Snapshot of participant demographics (from participant survey; N=28)
  - Profile:
    - Primarily aged over 45 years, with 50% aged 55-64 years.
    - Majority were married (65%).
A significant proportion was female (71%).
Many in the group were engaged in professional or semi-professional occupations (64%), with 78% currently employed and 22% recently retired.
89% of participants were parents of the ‘substance using relative’. The ‘substance using relative’ was generally a son (71%) aged 18-34 (77%).

- Drugs of concern:
  - Participants reported the primary drugs of concern were 1) methamphetamine (42%) and 2) cannabis (28%).
  - When asked to list all of the drugs of concern, cannabis was the most frequently mentioned (78%) with methamphetamine (57%) the second most frequently cited.
  - When collated, analysis showed that substance using had been a concern for an average of 10 years (with a range from 2-35 years).

- Primary reason for attending ARC was to gather information related to treatment/intervention (71%).

- Summary of program outcomes (from participant survey; N=42)
  - Improved overall personal wellbeing for family members who had graduated from the program across personal relationships, feeling part of a community and perceived future security.
  - Family members who had completed and/or graduated from the program identified fewer negative physical and psychological symptoms than those who had recently commenced in the program.
  - Family members participating in the program demonstrated an acceptance of new coping behaviours.
  - Family members who had graduated the program were more likely to credit involvement in ARC for changes they made in their life.

- Summary of program experiences (from qualitative interviews, n=7)
  - Participants’ experiences of ARC were overwhelmingly positive.
  - Facilitators with lived experience were central to many people’s positive experiences of ARC, with many commenting on how they were able to create safe, supportive and empathic environments for people to learn. Their lived experience also gave them extra credibility in the eyes of participants, who also reported learning from fellow participants’ experiences.
  - Many people liked that ARC focussed on participants’ wellbeing. It provided participants with the opportunity, often for the first time, to reflect on their own experiences, needs and lives – not just their loved ones’.
  - Participants also reported that they were able to implement the practical coping strategies they learnt about in the course and in their workbooks in their own lives. The fact that participants reported that they referred back to these materials after they had completed the course was a testament to their perceived value.
  - Participants had very few negative experiences or perceptions about ARC. One of the few challenging aspects identified pertained to the appropriateness of ARC for people in crisis-type situations, who some thought might struggle with the demands of the course when they are looking for immediate support. As was the
case with most of the participants we talked to, attending support groups prior to participating in ARC may be a useful pathway.

- Participants reported numerous wellbeing benefits, which they attributed to their participation in ARC. These included increased hope for what the future could offer, better self-care through setting boundaries and subsequently reduced worry, and improved relationships with their AOD using loved one and others.

- The contribution of ARC to SHARC’s goal of building a legacy of ongoing peer support can be seen in the influence and leadership that ARC graduates showed in other FDH programs such as the FDH Support Groups and Helpline.

**Family Drug Help Support Groups**

Family Drug Help Support Groups are monthly/fortnightly mutual aid groups, facilitated by trained volunteers and supported by group co-ordinators (FDH staff). Their role is to help foster a group interaction that welcomes and encourages people to support each other by sharing their experiences and how they are dealing with them. Ten support groups were funded through this program, and operated in the Melbourne metropolitan area at Balwyn, Carnegie (2 groups), Cranbourne, Dandenong, Ringwood, Sunshine, Frankston, Healesville and Watsonia and two in regional Victoria at Bacchus Marsh and Warragul.

- **Snapshot of participant feedback** (N=51):
  - The median length of attendance was 7 months.
  - Most participants reported that the impact on their overall family dynamic was positive:
    - They reported a calmer more settled home environment
    - Spouses reported their relationships were stronger, more supportive and less conflicted as their children’s problems dominated their lives less.
    - Members generally reported better communication, more honesty and less conflict.
  - Members gave strong endorsement for the idea that the support groups were the reasons behind the changes they had made in their life.
  - A small number said they could cope without the support groups either because they had gained so much knowledge from the groups or they had made friends through the groups they could access. The majority said they would have difficulty coping without the groups.

- **Summary of program experiences** (from qualitative interviews, n=7)
  - Similar to the experiences of ARC participants, participants in Family Support Groups reported overwhelmingly positive experiences of the program.
  - Facilitators who were able to encourage sharing, turn-taking and active listening were considered important to the running of the group, and the cultivation of a supportive, safe and non-judgemental environment.
  - Sharing experiences and strategies for coping amongst people going through similar issues was considered a key ingredient in the success of groups – as was active listening.
  - Other positive aspects reported by participants included the ability to give back to the group by sharing, providing advice or by becoming a facilitator, as well as the range of guest speakers and learning materials that were made available.
Family Drug Help Evaluation 2014

- Very few negative experiences or aspects of the program were reported. Group dynamics and catering to the needs of people at different points in their journeys was the main issue that people reported. For instance, new people who were distressed or in crisis-type situations may feel the need to share, without being ready or able to engage in active listening. This sometimes placed the onus of emotional work and active listening on people who had been attending for a longer.
- Added emphasis on strategies for managing high need participants in facilitator training may be a way of improving group dynamics. Similarly, those experiencing very high distress, could be offered the opportunity of undertaking individual counselling until they are ready to participate in groups.
- Participants discussed the positive impact the program had on their wellbeing and coping skills in conjunction with ARC and other activities people were involved in.
- One of the main ways support groups were able to help participants was to enable them to disentangle their own wellbeing from the wellbeing of their AOD-using loved ones. In so doing participants were able to worry about their AOD-using loved one less, focus on their own self-care and life, and cultivate resilience.
- Participants reported that drawing on the strategies they had learnt during support groups, they were able to improve their communication and relationships with AOD-using loved ones and other family members.
- Similarly, as well as receiving support, participants also discussed their sense of fulfilment in being able to contribute to groups and in helping others. For some participants, contribution to helping others with similar issues extended beyond support groups to other volunteer roles.

**Family Counselling service**

The Family Counselling service provides face-to-face counselling for individuals and family groups. It is offered as a single session or up to twelve sessions and is delivered by a qualified family counsellor. The service has an allocated quota of 110 episodes of care per annum. It consistently meets this demand and has a number of people waiting for up to a month to access the service.

Feedback, for the purposes of this evaluation, was received from 18 people who had accessed the Family Counselling Service (including current and former clients). Their experience of the service was resoundingly positive, with many benefits cited relating to their ability to cope with their situation, greater self-awareness and confidence to deal with their substance using relative and more productive communication within their family unit. Feedback was particularly supportive of the counselling framework and engagement approach.

**Family Drug Helpline**

The Family Drug Helpline is available 24 hours a day, 7 days a week. Between 9am and 5pm, Monday-Friday, it is staffed primarily by volunteers who have a personal experience of family substance misuse. Outside of business hours it is diverted to Directline (an external service provider). Helpline volunteers are not required to have any formal training or qualification, but
are provided with an extensive induction program, including three-day training upon commencement. Quality controls included monitoring of calls during the induction period, ongoing supervision, regular debriefing and access to professional development and training. The Helpline had 80% volunteer retention for the period of July-December 2013.

- Snapshot of call activity and profile (July – Dec 2013)
  - 1,675 calls, with a median of 14 calls per day.
  - Call profile:
    - 85% by family members, with remainder from external agencies or internal queries.
    - 79% of callers were female.
    - 58% of callers were parents (aged 40-60) and 14% were partners (aged 25-40).
    - 56% of parents who called were living with their ‘substance using relative’ and 80% of partners who called were living with their ‘substance using relative’.
    - 70% of ‘substance using relatives’ were male and aged under 40, the largest group of whom were sons aged under 40 (40%).
  - Primary drugs of concern:
    - Across the 1,675 calls, the top three primary drugs of concern were (in order) methamphetamine (39%), cannabis (23%) and alcohol (20%).
    - Where callers were parents, the top two primary drugs of concern were methamphetamine (42%) and cannabis (23%).
    - Where callers were partners, the top two primary drugs of concern were alcohol (37%) and methamphetamine (34%).
  - Referral:
    - 42% of callers were referred to other FDH services.
    - 23% of callers were referred to external services including AOD services (51%), MH services (23%), crisis services (e.g. emergency services or suicide lines, psychiatric triage; 14%), housing (2%) and child welfare (2%).
    - 39% of callers were sent resources and 47% were offered information.

The Helpline and Volunteer program aligns well with the SHARC Mission and Vision, fulfils the Program Objectives and is informed by best practice for peer-based support programs.

The high level of training, monitoring, development and support for the volunteers shows a commitment to quality improvement. The volunteers gave evidence of reduced harm, and improved health, well-being and connectedness for both themselves and the callers they helped. The Helpline and Volunteer program are an example of how SHARC and FDH are able to build a legacy of ongoing and sustained peer support for affected family members. Many of the volunteers are former clients of the services and several staff members previously worked on the Helpline.

**Next Steps**

On the whole, the evaluation identified that Family Drug Helpline and Volunteer Program, Action for Recovery Course, Family Drug Help Support Groups, and Family Counselling Service are delivered in line with their stated objectives, and to the satisfaction of participants. A few small areas for attention, including both challenges and opportunities were identified.
Challenges
At the time of the evaluation the Family Drug Help Counsellor role was completed full time by a single counsellor. This was identified as a key challenge for the organisation. SHARC responded quickly to restructure their program model to employ two part-time family counsellors (the equivalent of 1FTE), implementing an effective strategy to mitigate the risks to service continuity posed by a single counsellor.

Whilst the outcome data is limited, findings from this evaluation, particularly the rich and in-depth qualitative data, suggest that family support services are effective in improving the wellbeing of the family members who use FDH services. In addition, FDH services facilitate access to treatment by providing education and advice to families, and increasing their skills in motivational encouragement. Participants reported improvement in mental health, physical health and well-being over time. The qualitative data suggests that one of the main ways in which they were able to do this was by disentangling their own wellbeing from the wellbeing of their AOD-using loved ones’. Good outcomes were attributed to participation in ARC and support groups by family members.

The breadth and diversity of FDH’s programs is a real strength, which enables FDH to meet the needs of a range of clients. In order to fully capitalise on this strength, more data is needed to understand the pathways between FDH programs and what might be ideal pathways for different types of clients.

Improving existing routine data collection would support a more robust evaluation and process of continuous improvement. Increased capture of information relating to participation in Support Groups (e.g. number attending, number per session) would assist with this, as would routine analysis and use of participant & staff perception of care surveys and health and wellbeing surveys (staff). Similarly qualitative focus groups could be conducted with participants of ARC and support group programs to get an in-depth snap shot of experiences of the program and areas for improvement.

Recommendation: Improve data capture to support evaluation and continuous improvement processes

Opportunities
Current policy and practice for AOD treatment highlights the importance of the involvement of families in that treatment (Roozen et al, 2010; NDS, 2011). There is also an increased awareness of the need for specific family counselling and support services. Particularly, programs need to address four key areas in which families are affected by and respond to a relative’s problematic substance use, including the stress of worry and active disturbance to family life; the resulting strain on physical and mental health; their ways of coping; and, the social support they receive from others (Orford et al, 2010).

The FDH program is ideally placed to capitalise on this increased focus on the role of the family in substance use treatment, and in addressing the needs of the family members of a substance using individual. The utilisation of the support groups has been consistent over a number of years. The absence of support groups may result in greater impost on other services and increased isolation for current and potential participants.
Recommendation: Investigate opportunities to continue providing support groups, and/or strategies to address participant needs through other FDH programs.

FDH has the potential to inform the evidence base in family support practice in such areas as the place of mutual aid services as a social network replacement, the impact of the provision of support to families on treatment outcomes, and the impact of funding family support independently from treatment on family functioning, social functioning, social connectedness and treatment outcomes.
1. INTRODUCTION

This report documents a process and outcome evaluation of Family Drug Help (FDH) at Self Help Addiction Resource Centre (SHARC) conducted by Turning Point from September 2012 to December 2014. This evaluation was funded by the federal Non-Government Organisation Treatment Grants Program (NGOTGP) as part of SHARC’s service development work. The evaluation team also conducted a parallel evaluation of SHARC’s Recovery Support Service (RSS) which is documented in a separate report.

The process evaluation asked “Does each FDH program deliver what is claimed and how do these activities match best practice?”

This was achieved with a desktop review of key documentation and a literature review to describe the evidence base and best practice for the four FDH programs evaluated.

The programs were reviewed to 1) assess fidelity of practice by comparing program goals with actual delivery and 2) to assess whether these activities represent best practice, as much as could be assessed within the resource limitations of the study. This was achieved by reviewing routine data, clinical documents and program resources and observing and interviewing staff, volunteers and managers.

The outcomes evaluation helped assess the impact of program delivery by surveying program participants using a set of outcome measures that both satisfied the funding requirements and reflected the peer-based, recovery-oriented nature of the FDH programs.

This report provides a description of the background and context of the FDH programs including an overview of the FDH philosophy; a description and analysis of each program based on evaluation activities; and, presents and discusses key findings with recommendations for service improvement.

This evaluation was conducted during a challenging time for SHARC. The CEO, in an initial interview, described how the FDH programs were going through a period of change regarding new management and quality review in programs. This was occurring in an unusually unstable environment of funding at both state and commonwealth level with concern about the future funding of the FDH Support Groups by the Victorian state government due to the sector reform process.

Self Help Addiction Resource Centre (SHARC)

Self Help Addiction Resource Centre (SHARC) is a Victorian community based, not-for-profit organization established to promote and provide peer-led, mutual-aid approaches to recovery from severe substance related issues for individuals and families.

SHARC provides a range of services including Family Drug Help (FDH); Recovery Support Service (RSS) a therapeutic day program for young people aged between 16-25 years experiencing problems relating to their use of alcohol and other drugs; and the Association of Participating Service Users (APSU), a Victorian consumer representative body for AOD service users.

SHARC’s Vision, Mission and Values statement provides an overview of the ethos of SHARC and its programs.
Vision

“We envision a world where all people affected by the impact of addiction can proudly and openly seek help, help each other and demonstrate the living proof that recovery is possible.”

Mission

“To provide opportunities for individuals, families and communities affected by addiction and related problems to recover and achieve meaningful, satisfying and contributing lives.”

Values

- PEOPLE: People who ask for help have our respect and admiration.
- INSIGHT: We believe that people are the experts in their own life.
- SELF HELP: We believe in Self Help as mutual healing, passing on the knowledge and skills acquired as we give and receive help.
- LEADERSHIP: We believe in Leadership that is born from direct experience and has the spirit to inspire and advance the wellbeing of all.
- COMMUNITY: We believe in Community that includes all members as equal and necessary participants.
- ADVOCACY: We believe in Advocacy as a means offered to people to take an essential and active role in a democratic community.

Family Drug Help (FDH)

While the impact of substance use on families is increasingly recognised by researchers and policy makers, few services target the needs of affected family members independently of their relative’s needs.

FDH offers a range of programs and services aimed at families impacted by addiction and related problems and who are struggling to care for themselves and their family. These services provide family members with practical support, information and education as well as hope, inspiration and the encouragement to look after their own health and well-being; and to develop better relations with their relative whether they continue to use or not.

All FDH programs are delivered by health professionals supported by trained volunteers with a lived experience of recovery from the impact of a relative’s substance use.

FDH programs all share a similar philosophy and peer-based ethos, staff from each program work closely together and mutually support each other personally and professionally, and all programs are overseen by the one Programs Manager.

The FDH programs under evaluation:

- ARCl is a six week facilitated education course aimed at providing family members with knowledge and skills to improve self-care, ways of coping and better communication and relationships with their relative.
Family Drug Help Evaluation 2014

- FDH Support Groups offer a professionally supervised, volunteer facilitated mutual aid group that offers social and emotional support along with practical information and ongoing education.
- Family Counselling is delivered by two part time qualified family counsellors who provide counselling and mediation to family members referred from other FDH and SHARC programs and externally. At the time of this evaluation a single full time counsellor was employed. The change to a shared role was in part a result of early reflections from this evaluation.
- Family Drug Helpline is a confidential telephone information, referral and support service provided by trained volunteers with lived experience.

Family Drug Help Model and Philosophy

History and development

FDH and its programs developed as a response to the pressing needs of family members dealing with escalating heroin use in Victoria in the late 1990’s which resulted in a steep rises in overdose deaths (Degenhardt, Day, Gilmour and Hall, 2006). A key informant described how she and other family members in Melbourne wanted an alternative to existing peer oriented support groups such as Alanon and the lack of professional services available for families.

With the support and advice of Tony Trimmingham from Family Drug Support (FDS) based in Sydney NSW, they approached the precursor organisation to SHARC (The US Society) for help and in 2000 FDH was funded by State government at the newly established SHARC.

Peer-based professionalism

FDH is a professional, peer-based, family recovery support service (P-BRSS; White, 2009: p36). Not only does a peer-based model allow volunteers and staff to explicitly use and share their own lived experience but is designed to make people seeking help feel more accepted and engaged than may be the case with professional services. The peer based nature of FDH is described further in discussion of the Helpline and Volunteer Program.

While there is no universally accepted definition of peer support, Mead, Hilton & Curtis (2001) offer the following description which is endorsed by FDH.

"Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another’s situation empathically through the shared experience of emotional and psychological pain. When people find affiliation with others they feel are 'like' them, they feel a connection. This connection, or affiliation, is a deep, holistic understanding based on mutual experience where people are able to 'be' with each other without the constraints of traditional (expert/patient) relationships."

It should be noted that all FDH staff are trained health professionals and FDH does not believe lived experience can take the place of formal training and qualifications.
Family Drug Help Evaluation 2014

FDH volunteers include Family Drug Helpline volunteers, Family Support Group facilitators and co-facilitators and Family Support Group Administration. While FDH volunteers are not required to have professional health qualifications, they are recruited, trained, managed and supported by staff who do have such qualifications. A large number of volunteers participate in FDH, and other SHARC programs, and many are former clients/participants in FDH programs. From July 2012 to June 2014, 27 FDH participants became SHARC volunteers, and 60 new volunteers received induction training. During that time, approximately 405 volunteers attended community engagement and forum activities, providing 12,000 hours of support. In 2012-14 FDH had an 80 - 87% retention rate of volunteers.

Recovery orientation

The underpinning concept of all SHARC’s programs including FDH is a recovery model which emphasises the wholeness, wellness and connectedness of the individual within their community (White, 2004). The FDH manager stated that FDH did not explicitly endorse any model of addiction as the focus of FDH was not on the relative or their addiction. He suggested the model that was most used at FDH was the Stage of Change model of Prochaska and diClemente (1986).

Non-intervention

Unlike other drug and alcohol programs aimed at families, FDH is not primarily focussed on helping the family to motivate the substance using relative to seek treatment or to overtly try to change their relative’s behaviour. However, many families who approach FDH are attempting to do just that.

“I was so very desperate to get help primarily for (my son) and did not believe that there would be help and advice for myself. At the time I did not realise how very tired and desperate I had become. I was given an invitation to get support for both my family and self. I did not really think this was what I was looking for and really wanted a “magic pill” to get my son back again.” (FDH Support Group participant)

It is important to note that one of the key challenges for ARC and other FDH programs is that they do not offer what most family member are initially seeking - knowledge and support on how to change their relative’s behaviour.

“They rarely get what they initially come for, they want to fix the problem, they want advice and solutions. They are usually obsessed with their relative’s drug use which has crowded out the rest of their life, sapping the energy to look after themselves and other family members.” (ARC Facilitator)

“They usually come to FDH as a last resort and are often in a state of distress and, I suspect, have high levels of anxiety and depression. The more they are lost in the problems the worst their outcomes – conflict, divorce, illness, use of medications and other substances, especially tobacco.” (ARC Facilitator)

Family focus

The primary goal of FDH is addressing the direct needs of affected family members by helping them change their own behaviour in service of their own needs and those of other affected family members.

“I have already gained so much help, advice and support that I think I would struggle without it. Other help I get is via people who are helping my son but he is the main focus.
At FDH, the focus is on us – my husband and I, and how life can be improved etc. despite our sons problems. (FDH Support Group Member)

The FDH manager emphasised that the family member is the client of FDH and they work with their individual needs. There may be beneficial flow-on effects to the relative in terms of behaviour change but this is not the immediate goal. For example, family members are taught to put boundaries in place to protect themselves and others from the relative’s behaviour and not necessarily to influence the relative’s behaviour.

“The first thing they are taught is that they can’t control someone else’s behaviour, for example, you can’t force them into treatment. It then gives them the space to find the strength to change what they can - that although their situation may seem hopeless, there is hope that circumstances can change even if the person using doesn’t necessarily change.” (Programs Manager)

Evidence Informed vs Evidence Based

NGOTGP funded programs are required to “be informed by evidence and good practice” as opposed to being “evidence based”. Evidence based practice refers to practice confirmed by scientific evidence such as clinical trials. Evidence-informed practice (EIP) allows room for clinical experience and judgements of practitioners in interaction and dialogue with each another and their clients, (Nevo & Slonim-Nevo, 2011). Under the EIP model, practitioners are required to be knowledgeable of a wide range of sources such as empirical studies, case studies and clinical insights and use these in creative in their practice.

Peer-based services have traditionally been developed based on personal experience of addiction and recovery rather than evidence based in academic research. In the context of recovery-oriented peer-based services it is important to understand the different sources of evidence which includes addiction professionals, lived experiences of addiction and recovery (Novotná et al, 2012).

For an extensive review of the evidence for peer-based recovery support services and an analysis of their contrasting and complimentary relationship to professional services, readers are encouraged to read William White’s (2009) Peer-based addiction recovery support: History, theory, practice, and scientific evaluation.

Family Drug Help Program Objectives

A key stakeholder to the evaluation is the Commonwealth Department of Health (DoH) who part-funds FDH through the Non-Government Organisation Treatment Grants Program (NGOTGP).

We designed the evaluation and chose outcome measures based on the program objectives for FDH as outlined in the NGOTGP Project Plans as summarised below.

All NGOTGP funded programs must demonstrate that they:

- a) Reduce and treat illicit drug use
- b) Be informed by evidence and good practice
- c) Improve mental health, physical health and social functioning

For FDH, these requirements were negotiated as six specific program objectives:
1. Deliver project outcomes:
   i) Facilitate and deliver the ARC across Victoria and
   ii) Provide family counselling and mediation to RSS residents and families and referrals from FDH and external sources.
2. Adopt an integrated approach to service delivery
3. Manage services within a Quality Improvement Framework
4. Reduce use and harm
5. Improve health, well-being and connectedness
6. Build a legacy of ongoing peer support

The first three of these program objectives focus on service delivery and were assessed by the process evaluation. The following two program objectives (4. Reduce use and harm and 5. Improve health, well-being and connectedness) are the focus of outcomes evaluation. It is important to reiterate that the outcomes relate to the family member seeking help from FDH and not their substance using relative.

The final objective (6. Build a legacy of ongoing peer support) highlights the distinctive contribution that SHARC offers in helping build and lead a self-sustaining community of peer support. The evaluation design based on these program objectives is described in the next chapter.
2. EVALUATION DESIGN

This chapter outlines the evaluation methodology and design, and a description of the data sets.

Methodology

Pragmatism is a worldview that is associated with mixed methods research and health service evaluation and places primary importance on the problem at hand and using “what works” rather than on rigid allegiance to methodology or discipline, (Creswell & Plano Clarke, 2008).

Following this pragmatic approach, we chose a framework called Utilisation-Focused Evaluation that follows a stepped participatory process with the stakeholders to ensure the evaluation was a useful and valid exercise (Patton, 2008). This required a considerable degree of initial consultation with program management and staff prior to finalisation and ethical review of the study design, as well as throughout the project. For example, we worked closely with FDH management and staff to choose and design outcome measures that would best fit the FDH philosophy and contribute to building capacity for ongoing program evaluation.

The programs are well established, thus an outcomes evaluation was the primary focus. However due to the changing political environment and the participatory nature of the evaluation, a process evaluation was also appropriate focusing on active engagement and participation with staff and management aimed at recommendations for program improvement, sustainability and ongoing program evaluation.

Aim and scope

The aim was to evaluate whether the four FDH programs were delivered as described, determine how well they matched best practice and to assess the outcomes for the participants for each program.

Only two of these programs, namely ARC and the Family Counselling Service, are funded by the NGOTGP. However this evaluation included the two other major programs of FDH, namely Family Drug Helpline and FDH Support Groups which were funded by the Victorian State Government.*

The rationale for including these later programs is to demonstrate how SHARC adopts an integrated approach to service delivery. The evaluation describes the component programs of FDH as an interacting whole, reflecting how clients tend to pass through the FDH programs in a continuum rather than as clients of discrete programs. For example, a caller to the Helpline may be referred to the ARC course and the Family Counsellor, start attending the Support Groups, become part of the SHARC community and go on to volunteer with the Helpline.

* Support groups are no longer funded by Victorian State Government, but five support groups have received continued funding through state consortiums.
**Design**

The process evaluation comprised three activities.

a) A desktop review asked “*What are the programs supposed to deliver?*” based on a review of key documentation such as the project plans negotiated with funders (Commonwealth and Victorian Departments of Health, Victoria), the procedures relating to client pathways and the marketing materials such as the website and pamphlets.

b) A literature review asked “*What is best practice for these kinds of programs?*”

c) The program review asked “*Do the programs deliver what they are supposed to and does this represent best practice?*” based observation and interviews with staff and program participants, and assessment of clinical materials and documents.

The following process data was collected and analysed:

1. **ARC**
   - Numbers of ARC applicants screened, accepted and referred
   - Review of courses delivered each year
   - Review program content for best practice
   - In-depth interview with ARC facilitators (n=2)
   - Interviews with former participants in the program (n=7)

2. **FDH Support Group**
   - Number of meetings held and estimated number of attendees
   - Number of facilitators trained
   - In-depth interview with support group co-ordinator (n=1)
   - Interviews with current and former participants (n=7)

3. **Family Counselling**
   - Numbers screened, accepted and referred
   - Confirmation of Episodes of Care
   - In-depth interview with family counsellor (n=1)

4. **Helpline**
   - Number of calls answered
   - Number of volunteers trained
   - Interview with Helpline manager (n=1)
   - Interviews with Helpline volunteers (n=2)
   - Analysis of in-house data

In addition to this, in-depth interviews were completed with the Programs Manager, the SHARC CEO and a staff member who had participated in various FDH programs and had volunteered with FDH prior to their employment with FDH, to gain a broader perspective of how the FDH programs are delivered.

The outcomes evaluation asked the following questions.

a) Do participants show improved outcomes associated with participating in FDH programs?

b) Does participating in FDH programs contribute to these outcomes, if so how?
c) What impact does a family member’s participation in the FDH programs have on their substance using relative and overall family dynamic?

The outcomes evaluation component of the project focused on the ARC, Support Groups and Family Counselling programs. Data was drawn primarily from the participant survey, which collected:

- Demographic information,
- Family Member Questionnaire (FMQ)
- Personal Wellbeing Index (PWI)
- Contemplation Ladder (CL)
- Client Satisfaction Questionnaire (CSQ)
- Open-ended questions about their experience of the programs and the impact of participation

Open-ended questions included:

1. How has the (FDH program) helped you make changes in your life?
2. Would you credit the (FDH program) for the changes you have made to your life?
3. What impact has your participation in the (FDH program) had on your overall family dynamic?
4. What impact has your participation in the (FDH program) had on your relative?
5. Do you have any comments or suggestions about how the (FDH program) could be improved?

While the focus of the FDH programs is on the needs of the affected family member it is still important to assess what impact does participation in FDH have on the relative and the wider family dynamic. If there is a positive ‘ripple effect’ it provides evidence of added benefit of the FDH programs to the wider community. However evidence of harmful effects would be a cause for concern in that the net effect of the FDH programs to the community may be neutral or even harmful. See Appendix 1 for a description each of the above outcome measures and Appendix 2 for a detailed description of each service.

**Recruitment**

*Interviews*

Convenience sampling techniques were employed to recruit staff and current or former program participants for interviews. In total, ten interviews with SHARC staff were completed. In addition, 14 interviews with current or former program participants were undertaken, with seven interviews conducted with former participants of the ARC program and seven current/former participants in the Support Groups.

*Surveys*

A total of 107 surveys were completed by participants across the three FDH programs:

- **ARC**
  
  Forty-two participants from the ARC completed surveys; 14 participants in the first week of the course (Starters) and a different 14 participants in the last week (Completers). Follow-up surveys were conducted with 14 participants (Graduates) recruited by FDH’s email database who had completed the course on average six months prior to data
collection. We collected demographics from the 28 ARC Starters and Graduates, but not from the Completers (due to an oversight).

- **FDH Support Group**
  
  Facilitators at support group meetings distributed 200 paper surveys and 51 were completed and returned by support group members.

- **Family Counselling**
  
  The family counsellor distributed paper surveys to her current clients of which 15 completed and returned. Twelve past clients were approached by mail and invited to complete and return surveys however only three were received.

**Survey Participants**

The participants were 80% female with the most common age group being 55-64, (40%) followed by 65-74 (25%). Most were married (63%) or separated/divorced (22%) and half were working full or part-time and a quarter of them were retired. Their relatives were 74% males, a quarter were aged under 25 (26%), just under half were between 25 and 34 (45%) and a third were living at home.

**Ethics approval**

The Eastern Health Human Research Ethics Committee Science approved this study named LR100/1213 – *Evaluating the effectiveness of support programs for family members affected by a relative’s substance use* on 26 June 2013.
3. LITERATURE REVIEW

This chapter starts with a review of the literature on the impact on families of problematic drug use and recognition of such impact by researchers and policy makers. We then look at the various models and services for families and identify best practice for family specific interventions.

Impact on families

The UK-based Alcohol, Drugs and the Family research group (ADF; Orford, Velleman, Copello, Templeton & Ibanga, 2010) found that, across cultures, family members report remarkably similar experiences of what it is like to live with a relative with a serious substance use problem. They describe four areas in which families are affected by and respond to a relative’s problematic substance use. These areas are 1) stress of worry and active disturbance to family life, 2) the resulting strain on physical and mental health, 3) their ways of coping and 4) the social support they receive from others (Orford et al, 2010).

Stress and strain

Orford and colleagues (2010) found that family members worry about their relative’s health and welfare, their own and that of other family members especially young children. They report active disturbance to family life such as trying to deal with changeable, uncertain and disagreeable relationships with their relative, enduring verbal and physical aggression and violence, coping with disruption and damage to family life, finances and employment.

These stresses lead to physical strain such as panic attacks, chest and stomach pains, poor sleeping, high blood pressure, and exhaustion. Mental strain was reported in the form of anxiety, depression, hopelessness, anger and resentment, social isolation and perceptions and experience of stigma.

Ways of coping

Family members struggle with recurring and confusing dilemmas about what to do and they try many different ways of coping, often with little success. Family members’ attempts to cope with the situation can be maladaptive or even damaging to themselves and other family members including the relative of concern. Orford and colleagues (2010) found that families cope in three distinct but overlapping patterns, namely engaged, tolerant and withdrawal coping.

Engaged coping is focused on emotional, assertive and controlling ways of trying to change a relative’s behaviour. This included arguing or nagging, throwing away their drugs or telling the user that their behaviour was having a negative effect on the family.

Tolerant coping meant passively putting up with the relative’s using, covering up or making excuses for them, making sacrifices in the face of it or even encouraging it. This toleration stemmed from feeling the situation was hopeless and that they could not do anything about it. Orford and colleagues (2010) found this style of coping was associated with the highest levels of poor health in the family.

Withdrawal coping involved neither trying to change nor trying to cover up for them. Family members tried to distance themselves by engaging in activities independently of their relative and their using, getting on with their life and leaving them to their own devices. This style of coping was associated with better health in the family.

Social support
Orford and colleagues (2010) found that the quality of support from other people greatly affects how well family members cope with their situation. Family members find themselves feeling a loss of control over their lives which is often made worse by lack of understanding, blame and criticism from others.

While family members were not usually socially isolated, their existing social networks were often unsupportive or unhelpful. People either did not want to get involved or tried to support in ways that were unwelcome such as unwanted and unsympathetic advice. Many families hide the problem due to feelings of shame or disloyalty and fear of criticism and gossip. Sometimes the relative pressures other family members not to seek outside support. Conflict within the affected family about what to do undermines their support for each other.

Most valuable to them was emotional support from someone who listened and allowed them to talk openly about the problem in an atmosphere of acceptance and support. They appreciated non-judgemental support for their coping efforts and were gratified when others treated their relative as someone who deserved help and support and who potentially could change.

People who had ‘been through it themselves’ were regarded as particularly effective sources of support. This was because they recognized the nature of the stresses, the dilemmas of coping, the competing needs and obligations and the ambivalent feelings towards their relative.

Recognition by academics and policy makers

Affected family members have been referred to as the “silent majority” in the addiction and recovery literature (Ligon, 2013). Historically, when families were mentioned in the literature they were characterized as the cause or part of the problem and rarely seen as needing help or assistance in their own right (Copello, Templeton & Velleman, 2006).

Only in recent decades has it been recognised that adult family members can provide valuable support to their substance using relative by 1) influencing the course of the problem, 2) by promoting positive outcomes such as reduced use and better engagement with treatment services and 3) by helping to reduce the negative effects of the problem on other family members, (Roozen et al, 2010).

The concerns and needs of families seem to be well recognised at a national policy level. Australia’s National Drug Strategy 2010–2015 contains specific objectives of “promoting social inclusion and resilient individuals, families and communities” and “reducing harms to families”. A key harm mentioned is the reinforcement of social disadvantage through family breakdown and job loss which is described as both as a cause and a result of substance use.

Families are identified as one of the priority settings for preventive interventions and the document urges “closer integration with child and family services ...to more effectively recognise and manage the impacts of drug use on families and children.” (NDS, 2011: p7)

Under the Harm Reduction Pillar sits Objective 2: Reduce harms to families which recognises that “families of people using drugs often suffer significant impacts from their drug use” and that “support needs to be available to families to help them manage the stresses they may be experiencing from a family member’s drug use and help engage them in managing the individual’s drug-related problem.”

A specific recommendation is to “Enhance child and family sensitive practice in alcohol and other drug treatment services and build links and integrated approaches with community, family and child welfare services.”
Since FDH is not focused on reducing demand but on addressing the harm to families, FDH can be seen as sitting under the Harm Reduction pillar of the National Drug Strategy.

**Family interventions**

General clinical practice is centred on behaviour change of the substance using relative and their family members’ needs tend to be routinely included only as a result of child protection or domestic violence concerns. The impact of parents’ problematic use on young children rightly generates much concern and attention, however the impact on adult family members such as spouses, partners, parents, grandparents, siblings and adult children is far less prominent in policy and research. Similarly, the pressing needs of this hidden population have been largely unmet by professional services (Copello, Templeton & Powell, 2010).

In recent years, engagement with families at a clinical service level has been formally recognised in models such as Family Inclusive Practice (ReGen, 2013). However these models still tend to regard families as additional treatment engagement and support resources for their relative and offer nothing for families whose relative is not seeking treatment.

**Types of family models**

There have historically been three kinds of approaches to addiction in the family. All three family based perspectives see the problem located as much within the family as the individual.

The first approach, peer-based community support groups such as Al-Anon, have until recently been the only support for affected family members. These mutual aid groups follow a 12-step approach that views addiction as a disease and family members as being ‘co-dependent’ meaning that they become preoccupied with controlling the substance use and its consequences. Al-Anon encourages members to admit that attempts to intervene are futile and to instead to ‘detach with love’ and focus on addressing their own emotional distress and to increase their coping skills. The theory underpinning this approach posits that as family members learn to assign responsibility for family problems to the disease rather than to themselves, they begin to forgive themselves, accept that they have been adversely affected by the addicted individual’s shortcomings, and begin to improve their functioning (Timko, Young & Moos, 2012).

The second approach, the family systems approach applies general systems theory to highlight how substance use serves a functional role in the family dynamic. The goal of therapy is to change the family dynamic so that the substance use no longer serves its former function (Rowe, 2012).

Finally, behavioural approaches assume family interactions reinforce the problematic behaviour and aim to directly change behaviour in the family to reinforce positive behaviour in the individual (Grant, Potenza, Weinstein & Gorelick, 2010).

**Types of family services**

Family services can be categorized into three types based on their goals.

**Unilateral interventions** work with families and social networks to engage unmotivated relatives to make changes such as reduce use or seek treatment. The goal is behaviour change of the relative and to a lesser extent the family members. Examples are Pressures to Change (Barber and Chrisp, 1995), Unilateral Family Therapy (Thomas & Ager, 1993), Johnson’s Institute Intervention (Johnson, 1986) and CRAFT (Roozen, de Waart, & van der Kroft, 2010).
Collaborative Interventions jointly work with family members and their relative to engage and maintain treatment and recovery such as Social Behaviour Network Therapy (SBN; Copello, Orford, Hodgson, Tober and Barrett, 2002) and Behavioural Couples Therapy (BCT, O’Farrell & Fals-Stewart, 2008). The goal is behaviour change of both the relative and family members.

Family Specific Interventions work with affected family members as clients independently of whether their relative is making changes or not. The goal is behaviour change of the family member and not the relative. Family members are seen as people under stress and at risk of developing health problems in their own right. These approaches emphasise different ways of coping and thus general improvement in health and functioning without directly trying to control or influence their relatives behaviour.

FDH programs are not focussed on behaviour change in the relative and thus FDH programs fall into the last category of family specific inventions. Two models of family specific interventions are described below.

The Stress-Strain-Coping-Support (SSCS) model

The family specific intervention that appears to have the most empirical support is a strengths-based model of families affected by addiction (Orford et al, 2010), known as the Stress-Strain-Coping-Support (SSCS) model. The model arguably represents current best practice in family interventions, and provides a benchmark for assessing whether FDH programs are evidence informed. The ARC facilitator claimed that this model had been influential in the development of the FDH programs.

This model explicitly rejects the notion of family dysfunction or deficiency in favour of a view of normal people facing stressful life circumstances that puts them at risk of physical and psychological ill health (Copello, Templeton, Orford & Velleman, 2010). A key assumption is that, as difficult as coping can be, family members need not be powerless in helping others and maintaining their own health. Addiction within the family is seen as no different to any other complex task and not a sign of dysfunction or pathology within the family itself.

The 5-step method

Based on the SSCS model, the ARC team developed a treatment modality called the 5-step method.

The five steps are:

1) listening nonjudgmentally;
2) providing relevant information;
3) exploring ways of coping;
4) discussing social support; and,
5) establishing the need for further help.

The model is designed to be adaptable to a range of settings and circumstances delivered by a range of helpers without the need for lengthy training. Of key importance is the style and orientation of the helper which should be non-judgemental, curious and solution focussed. The orientation is not that of an expert but someone who works within a collaborative framework and thus the model and method are well suited to peer support services (Copello, Templeton, Orford & Velleman, 2010).
The model encourages people to be active in the face of adversity, to seek effective problem solving strategies, to be an agent in one’s destiny and not succumb to feelings of powerlessness. The model is supported by increasingly robust evidence showing improvements in a broad set of outcomes for both relatives and their family members beyond simply making an impact on substance use. Participants reported improved physical and psychological well-being, enhanced understanding about the problem and its impact, increased focus on their self and their own needs, and felt more support (Copello, Templeton, Orford & Velleman, 2010).

Given the substantial evidence base behind the SSCS model, the 5-step method may represent best practice in family specific support in addiction (Velleman, 2010). Thus this will be used as the benchmark model for the FDH programs.

**Community Reinforcement and Family Training (CRAFT)**

The other well established model that was reported by the ARC facilitator as influential in the development of the course was Community Reinforcement And Family Training (CRAFT). While FDH eschews the explicit focus on behaviour change in the relative, it aims to incorporate many of the self-care aspects of the CRAFT program. CRAFT is a professionally delivered intervention that aims to engage resistant substance abusing relatives into treatment and reduce the physical and psychological distress of family members and improve their wellbeing.

The CRAFT model aims to steer a middle course between the powerless, hands off, “detach with love” model of Al-Anon and the confrontational “tough love” interventions pioneered by the Johnson Institute (Liepman, Nirenberg & Begin, 1989). CRAFT is designed to engage resistant substance users into treatment by working with intimate partners, family members and close friends to actively restructure an individual’s “community” to make it clear to the relative that a sober lifestyle will be more rewarding than one dominated by substance use.

The CRAFT components related to self-care that can serve as secondary benchmarks for evidence informed practice are:

1. Learning specific strategies for preventing and managing dangerous situations
2. Social skill training to improve communication and problem-solving skills
3. Teaching adaptive skills to improve the life quality of the family member.
4. EVALUATION OF FAMILY DRUG HELP PROGRAMS

This section of the report provides a detailed description of the evaluation outcomes for each of the four FDH programs. Quotes from the free text responses of participants are used throughout this section to illustrate points of discussion.

Action for Recovery Course (ARC)

Program Overview

ARC is a FDH staff facilitated education course held one evening a week over six weeks. ARC aims to provide family members with knowledge and skills to:

- Better understand the complexities of addiction;
- Explore ways of improving relationships;
- Learn skills and strategies for coping with anxiety and depression; and,
- Help participants gain greater self-awareness look after themselves and plan a positive future.

Program Rationale

The philosophy and approach of ARC closely matches that of the Family Drug Helpline and Volunteer program, with the same focus on behaviour change of the participant not the relative and a similar emphasis on empowering participants to discover their own solutions.

However, the ARC program is designed to provide education and skills to assist people to deal with their situation rather than the social and emotional support provided by FDH support groups and Helpline. The ARC program is not group therapy.

Delivery

Fives courses were held across Victoria in 2013, funded by the NGOTGP program, and a further five courses delivered at Carnegie, funded by the Victoria State Government. Participants contribute $60 towards the costs of workbooks and catering. Additional fee-for-services ARC courses are run at other AOD services such as ReGen Uniting Care and St John of God Pinelodge Clinic.

Intake

The course is promoted through the SHARC website, presentations to AOD services and VAADA, and demand is such that a wait list is maintained for the program. Potential participants are referred to the ARC facilitators who brief them on the content and aims of the course. Family Drug Helpline provides a central referral point for many participants.

Staffing

ARC facilitators are trained professionals with a family lived experience of addiction. Hiring practice supports the FDH program objective of “building a legacy of ongoing peer support”, and is illustrated in the anecdote below.

Gloria (pseudonym) started as a concerned mother who found marijuana in her teenage son’s room. She rang the Family Drug Helpline and received some useful information and support, and she continued to use the service over the next few years whenever she was struggling to cope with his behaviour.
She started going to a FDH Support Group, which helped her feel less alone and ashamed, and after a few years she attended an ARC course. She discovered at ARC what she could and could not control and she decided to stop trying to fix her son and instead give back to FDH by joining the Helpline as a volunteer. She was later invited to facilitate a support group and at the same time she started studying counselling.

During this time she continued to struggle with her son’s drug use and addiction as he progressed to heroin and cycled in and out of pharmacotherapy programs. Once she completed her certificate in counselling and psychotherapy she was employed by FDH to facilitate the ARC course.

**Lived Experience**

ARC participants seemed to place great value in having someone with lived experience rather than just professional knowledge. Not only did they get a sense of empathy, compassion and identification but practical advice about what is possible and what is not. They expressed satisfaction with the course and the facilitator who one participant described as “professional, friendly, organised, compassionate as well as tough on some issues when it was needed.”

**Governance and Quality Control**

SHARC has accredited governance practices, protocols and systems in place for all its programs. Each SHARC program has an advisory group made up of people with lived experience and professionals. The Family Advisory Group meets every six weeks to advise on issues of program development and participant feedback. The ARC course content and workbook are reviewed annually and the current (2013) edition of the workbook was substantially revised based on participant feedback and ideas gained through further professional training.

**Evidence Informed Practice**

ARC was not explicitly developed on a research evidence base rather it was an adaptation of existing family support programs. The content was augmented by the personal needs of participants and experience of FDH staff members.

As FDH staff gained more professional experience and training, considerable content was added from an eclectic range of evidence based family models such as the SCSS model of Orford and colleagues (2011) and the self-care components of Community Reinforcement and Family Therapy (CRAFT; Roozen, De Waart, and Van Der Kroft, 2010).

The ARC handbook references a variety of popular self-help books. These resources cover assertiveness (Ury, 2007), Cognitive Behavioural Therapy (Bailey & Black, 2014; Burns, 1999; Ellis & Harper, 1997), Positive Psychology (Goleman, 2000; Jeffers, 2006; Seligman, 2004; Sharp, 2005) and mindfulness based approaches (Dowrick, 1997; Siegel, 2007) including Acceptance and Commitment Therapy (ACT; Harris, 2008).
Participant Experience of the Program

Qualitative interviews were conducted with eight former participants of ARC and family support groups in order to examine perceptions and experiences of the respective programs, their impacts and how it could be improved. Interviews were conducted over the phone and took between 22 and 75 minutes. As illustrated in Table 1, the participants were mostly female, parents to a son/daughter who experienced AOD problems, particularly with methamphetamines.

Table 1: Characteristics of participants interviewed

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Statistic</th>
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</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Female: 6 (75%)</td>
</tr>
<tr>
<td></td>
<td>Male: 2 (25%)</td>
</tr>
<tr>
<td>Age</td>
<td>Ranged from 44-68</td>
</tr>
<tr>
<td>Relationship to user</td>
<td>Parent: 7 (87.5%)</td>
</tr>
<tr>
<td></td>
<td>Partner: 1 (12.5%)</td>
</tr>
<tr>
<td>Primary drug of concern of the user</td>
<td>Methamphetamines: 6 (75%)</td>
</tr>
<tr>
<td></td>
<td>Opioids: 1 (12.5%)</td>
</tr>
<tr>
<td></td>
<td>Alcohol: 1 (12.5%)</td>
</tr>
<tr>
<td>When completed ARC</td>
<td>Less than 1 year ago: 5 (62.5%)</td>
</tr>
<tr>
<td></td>
<td>1-2 years ago: 2 (25%)</td>
</tr>
<tr>
<td></td>
<td>Only completed support groups: 1 (12.5%)</td>
</tr>
<tr>
<td>Also participates or has participated in family</td>
<td>6 (75%)</td>
</tr>
<tr>
<td>support groups</td>
<td></td>
</tr>
<tr>
<td>Length of time since starting family support groups</td>
<td>Less than 1 year ago: 1 (12.5%)</td>
</tr>
<tr>
<td></td>
<td>1-2 years ago: 6 (75%)</td>
</tr>
<tr>
<td></td>
<td>Only completed ARC: 1 (12.5%)</td>
</tr>
</tbody>
</table>

The data was analysed using thematic analysis and four key themes were identified: positive aspects of the program, challenging aspects of the program and suggestions for improving the program, and impacts of the program. Pseudonyms are used where participants are quoted.

Positive aspects

Participants’ experiences of ARC were overwhelmingly positive. Particular aspects that participants identified as positive included facilitators, peer support and learning, focus on family/friends, and practical strategies and workbook.

Facilitators

Many participants commented on the positive experiences with ARC facilitators. Facilitators were pivotal in cultivating a supportive and safe space in which participants could share their experiences, and this is reflected in Michaela’s comments:

"...the provider at the ARC program was absolutely brilliant. She was just so supportive and so wise."

Many participants attributed the “wisdom” of facilitators to the fact that they had lived experience of having a loved one with AOD issues. Not only did this enhance the credibility of
facilitators in the eyes of participants, it was also perceived of enabling facilitators to empathise with and validate participants’ experiences:

   When the facilitator started talking about the guilt and the worry and the manipulation it was honestly like a light bulb went off and we weren’t the only ones was my first impression and I can’t wait to go back and learn some more. (Anna)

Other participants also talked about similar moments of insight and relief at knowing that they are not alone. These “light bulb moments” were often provoked by the shared experiences of facilitators and peers. Anna goes on to describe the degree to which facilitators understood what she had been going through:

   The facilitator who ran our ARC program... I felt like she had been living in my house and that feeling... was so liberating and made me feel safe where we were. (Anna)

Anna’s metaphor of the facilitator living in her home – a private space usually inhabited by family and loved ones – speaks to the degree to which facilitators were perceived to have an intimate awareness and understanding of the issues faced by participants, by virtue of having experienced similar things themselves. As Anna and others’ reported, this shared understanding helped to cultivate a safe, empathic and non-judgemental space in which people were able to learn and share.

Peer support and learning through shared experiences

Having peers in the room, who were experiencing similar things also added to the empathic environment, and also enabled participants to learn from the experiences of others. As well as the structured component of the course, participants also valued the discussion that ensued, and Dean’s comments reflected this:

   It was very structured, we worked through a workbook and there were different topics. There was quite a bit of discussion, some of the people were in tears virtually every time we went there, there were quite a lot of tissues being passed, it was very cathartic.

Focus on family/friends

For many participants, the fact that that ARC existed to support them, rather than their AOD using loved one, was also therapeutic and highly valued. For instance, Isabella, whose son experienced problems with methamphetamine and alcohol, said:

   I went in expecting strategies on how to help my son but the program made me realise that what I’ve been doing hasn’t helped, paying his debts, giving him money just being a door mat. It was good because it made us think about ourselves and our lives.

ARC provided the opportunity for Isabella and others, often for the first time, to reflect on their own experiences, needs and lives – not just their loved ones’. As with most other participants Dean expressed his relief at learning about the need to draw boundaries and take care of himself:

   I was still thinking every night did he (his son) go back to drugs, asking “are you still clean” and stuff like that, but they taught us that what’s on his side of the street and what’s on our side of the street, what the things I can’t change to let them be and focus on the things
I can change and how I react to things and also looking after myself and not letting the drug thing be the main topic of our conversation.

In this way, Dean and other ARC participants were not only able to look after better themselves but re-define relationships with their loved ones beyond a narrow focus on AOD.

**Practical strategies & workbook**

The other aspect of ARC that participants found helpful was a focus on practical strategies that could be implemented to help people cope and take care of themselves. The workbook that participants completed throughout the course became a resource that many referred to after they had completed the ARC program as they experienced challenges in the real world. As Anna said:

*Whilst your loved one is in the phase where everything’s going along alright it’s easy to keep the boundaries, but when they relapse you relapse to a certain extent too and you have to go back to your tutorial, so that has been helpful to have those resources available to you.*

That the workbook became an active resource, instead of something that was never referred to after the end of the course, is a testament to the value participants placed on it. Dean also talked about other exercises that were done in the course that were helpful:

*Also other things he got us to do a little diary that we write three things that we are thankful for, that was actually very helpful as it showed me day after day that there are actually good things going on in my life and focusing on some of the good things rather than the negative things all the time so I found that very helpful.*

**Challenging aspects & suggestions for improvement**

Participants had very few negative experiences or perceptions about ARC. The few challenging aspects we could identify pertained to the appropriateness of ARC for people in crisis-type situations, and a few instances where a facilitator was overly academic. These are possibly areas that could be improved.

**Appropriateness of ARC**

The course was viewed as possibly being a bit intense for people who are in crisis type situations or for people who had not received any other support from a service before. While this was not an experience that participants had personally experienced, Tyson’s remarks highlight the possibility that the course may be too demanding for some:

*I think doing the other program (support group) before ARC at least showed you what should happen, just leads you in whether you really want to do it, while going straight into ARC might have been tough. Having a taste then going in seriously with ARC program is the way to do it.*

Given this, Tyson’s suggestion of participating in support groups before attempting ARC might be useful for prospective participants and is reflective of the order in which most participants engaged in the programs. Providing participants with clear information about the demands of
ARC and what is expected may help potential participants decide whether ARC is the best option. If it is not, then support groups may be a good way of engaging people in some form of support until they are ready to do ARC. At the same time many participants continued to attend support groups while and after completing ARC, suggesting that support groups are potentially useful at any stage.

Facilitators who were overly academic

Some participants reported instances where they had difficulty connecting with some facilitators who employed an overly academic style. Anna, for instance, talked about a fill-in facilitator saying:

A guy (facilitator) came into a couple of classes. I found him to be the opposite of our regular facilitator in that he had lots of big words and lots of ideas about things but most of the parents sitting around the table were eye balling each other. That part was not very helpful, but I don’t really know who he was, it was a one off.

Given the value that participants placed in clear and practical strategies, Anna’s sentiment is not surprising. However, it does reinforce the need for an emphasis on practical and clear strategies, and the avoidance of jargon in the training, mentoring and supervision of facilitators.

Impacts

Participants reported numerous wellbeing benefits, which they attributed to their participation in ARC. These included increased hope, better self-care, reduced worry and improved relationships with their AOD using loved one and others.

Hope

Many people felt that ARC highlighted possibilities and positive aspects of their life that were previously obscured by their pre-occupation and worry about their AOD-using loved one. As Isabella points out, this led to increased hope and optimism about life:

I’m more hopeful for my own life. I was just obsessed with him, trying not to think about him all the time. I believe we’re sort of recovering. It highlighted the 9 areas of your life, so it was really good to see where you were lacking to have a full life and the areas you could work on, the satisfaction.

Like Isabella, many participants viewed themselves as being in their own kind of ‘recovery’ from the impacts of their loved ones AOD problems. Participants had come to different understandings of what this meant to them personally. However, most talked about this in terms of an ongoing process of self-improvement, of which participants had the power to maintain but that ARC had helped to facilitate.

Better self-care

Prior to beginning ARC participants reported that they were so bound up in helping and worrying about their AOD-using loved one that they had neglected themselves and their own wellbeing. All
commented that ARC had provided them with skills to take better care of themselves. One of the main ways it did this was by encouraging participants to establish boundaries with their AOD-using loved ones’ problems, as Anna explains:

*The best thing I took away was the boundaries, my husband and I had no boundaries and enabled rather than helped. We learnt by paying her bills and giving her money is enabling. It ARC just gave you a sense of direction and hope.*

These boundaries enabled participants more time and space to care for themselves.

**Reduced worry**

The development of boundaries also enabled participants to reduce the amount of time they spent worrying about their AOD loved one, which as Dean suggested, could be quite debilitating:

*I used to lie awake at night and used to worry myself absolutely sick and I just don’t do that anymore. I’ve moved to a better place.*

Many people attributed their reduced worry and movement to a better place to their work in the program.

**Improved relationships with loved one and others**

While the ARC course focuses on the family member or friend of the AOD-using loved one, participants also reported benefits in terms of their relationships with their AOD-using loved one. Some participants were able to stop ‘interrogating’ their loved ones about their AOD use, which in the past had alienated some loved ones. This helped to re-orient relationships such that AOD use was peripheral rather than central to interactions. At the same time, some participants also talked about the changes that were occurring to them as “rubbing off on others”.

Improvements noted were not limited to relationships with AOD-using loved ones, but also were discussed in relation to participants’ relationships with other family members and friends. For instance, one participant said:

*Without ARC I think my marriage would have ended, it helped my husband and I to get on the same page because once we went there and learnt what we did we learned what we were both doing was sabotaging. It gave us permission to stand back and take a deep breath, look after ourselves, put some boundaries in place, recognise that we still have worry and we still have guilt but that was okay. Beforehand life was out of control and I was walking away from the marriage. (Anna)*

**Quantifiable outcomes**

The following section provides the results from the 42 survey responses received from ARC participants. This segment of the research endeavoured to quantify whether participants who completed ARC showed better health and well-being outcomes than those who had just started and whether participating in ARC contributed to these outcomes. Given the small number of
survey responses, results are indicative only, and should not be viewed in isolation from the other evaluation results.

The analysis segments the 42 survey responses into three groups: 14 ‘Starters’ (participants in the first week of the course), 14 ‘Completers’ (participants in the last week), and 14 ‘Graduates’ (completed the course on average six months prior to data collection – unconnected to ‘Starters’ or ‘Completers’). We compared outcomes between Starters, Completers and Graduates with one-way ANOVAs and conducted post hoc comparisons using the Tukey HSD test. Due to the small sample size, differences are hard to detect at p < 0.05, and as such, results that are p < 0.1 are considered notable.

Higher scores in each of the fields indicate higher levels of that type of behaviour. Analysis was designed to reflect achievement in relation to the ARC program objectives. As such, it is hypothesised that there will be reductions in stress (worry and disturbance), physical symptoms, psychological symptoms, and coping (engaged, tolerant), and increases in coping (withdrawal) and social support.

**Demographics**

Demographic information was collected for Starters and Graduates only (n=28).

Starters and Graduates were generally aged over 45, with approximately 50% in the age bracket 55-64. Most were married (65%) and most were female (71%). All were either working (78%) or retired (22%), most worked in professional or semi-professional occupations (64%) and all those not retired earned above $30,000 and some (28%) earned more than $60,000. This suggests the respondents were mostly of an above average socio-economic status which was broadly consistent with their residential postcodes centred in Melbourne’s eastern suburbs.

Eighty-nine percent of the 28 Starters or Graduates were parents, generally of a son (71%) aged either 18-24 (35%) or 25-34 (42%). Half of the relatives lived with their parents. Of all substances causing problems, respondents most often nominated cannabis (78%) and methamphetamine (57%) but when asked to nominate the primary substance of concern they most often nominated methamphetamine (42%) and cannabis (28%).

Participants indicated that their relative’s substance use had been causing the family problems for an average of ten years, with a range from two to thirty-five years. This suggests that about half of the relative’s substance use had been impacting the family since they were teenagers, and that most families have been struggling for years before they come to the ARC program. Most relatives (71%) were seeking information or support relating to detoxification, rehabilitation, counselling or mutual aid.

**Family Member Impact**

In line with the approach and goals of the ARC program, it was hypothesised that there would be less strain in the form of psychological (S-PSYCH) and physical (S-PHYS) symptoms as participants learn to practise better self-care and protect themselves from their situation using strategies such as boundary setting. The analysis indicated that Completers (M=2.64, SD=1.99) and Graduates (M=2.31, SD=1.84) reported significantly fewer physical symptoms than Starters (M=4.50, SD=1.698), F(2,38)=5.62, p=0.007.

There was a significant difference in psychological symptoms with Starters (M=4.14, SD=1.14) reporting significantly higher levels of psychological symptoms than Completers (M=3.29, SD=1.38) but not Graduates (M=3.70, SD=1.80, F(2,38)=4.82, p=0.014). Unexpectedly only
Completers reported fewer psychological symptoms, but again it is important to note that sampling limitations mean these results must be treated with caution.

We hypothesised that there would be a reduction in the engaged and tolerant coping behaviours discouraged by ARC and increase in withdrawal-independent coping behaviour style which is encouraged. Our analysis indicates that Completers & Graduates (M=7.85, SD=1.91) reported significantly more withdrawal-independent coping behaviour (C-WI) than Starters (M=5.43, SD=2.56, F(2,37)=4.08, p=0.025).

There was a notable but not significant reduction in tolerant/accepting coping behaviour but no change in engaged coping behaviour. This suggests that participants are able to adopt new coping behaviours that were more consistent with ARC suggestions but they also found it difficult to let go of those coping behaviours ARC suggest were less helpful.

Overall, given the small sample size, the analysis suggests positive impact of the ARC course particularly around increases in coping, and reductions in physical and psychological symptoms.

**Figure 1: Comparison of psychological wellbeing and coping between three populations in ARC**

**Personal Wellbeing Index (PWI) - Satisfaction with Life**

It was hypothesised that ARC participants would show improved personal wellbeing as measured by the Personal Well-being Index (PWI). For this analysis we compared five groups:

- ARC starters, completers and graduates
- Australian population norms for this scale
Our analysis indicated that, across the eight standard PWI domains, there was little difference between Starters and Completers. In contrast, ARC Graduates show notably higher sense of wellbeing across these domains with the exception of health (PWI 2) as shown in Figure 2 Personal Wellbeing - ARC vs Aust Norm & IDRS.

This difference had near statistical significance (p < 0.1) in three domains, Personal relationships (PWI-4) F(2,38)=2.64, p=0.085, Feeling part of a community (PWI-6), F(2,38)=3.16, p=0.054 and Future Security (PWI-7), F(2,38)=2.56, p=0.091. The Overall PWI score which is an average of the eight standard domains was also near significance F(2,38)=2.57, p=0.09.

These results suggest that ARC participants experienced an increased sense of wellbeing as a result of implementing the skills they had learned through the ARC program. The graduates reported overall wellbeing at least the equivalent of the general population and markedly higher than both the drug user group and both the starting and completing groups.
Awareness

Participants reported that ARC had helped them gain a greater awareness of their situations and how their own behaviour contributed to the status quo. Survey respondents reported better acceptance of their situation through realising that change can only come from the person in question and cannot be imposed. Similarly they gained an ability to separate their own journey and associated challenges from their relatives.

“ARC showed me that the drug taking of my relative was something I should not feel any guilt about. I should take more care of my own health and come to terms with the fact drug taking is their choice and it has to be their choice to change the lifestyle they are currently living. I found the course empowering whereas before I felt frustrated and depressed.”

Behaviour Change

Survey respondents reported a key learning from the ARC involved strategies to set boundaries on unacceptable behaviour and how to follow through on them as well setting boundaries on their own behaviour especially in regard to enabling. Participants realised that much of their old behaviour was holding their relative back and disempowering the relative from taking responsibility for their own life. They reported receiving practical support in the form of information on pragmatic strategies in terms of self-care and avoiding becoming re-entangled in their relative’s problems.

Causal Contribution

On a scale of 0 to 10, participants were asked to indicate the extent they would credit ARC for the changes they made to their life (perceived causal contribution). Participants gave the ARC a mean score of 6.4 (SD 2.5) with Completers somewhat less ready to credit life changes made to the groups 6.2 (SD 2.2) than Graduates 7.0 (SD 2.9). Thus the participants gave a moderate-high level of endorsement for the idea that participation in ARC contributed to the changes they made in their life.

Suggestions for Improvement

The participants offered the following as suggestions for improvement.

- Follow up session or course to reinforce leanings.
- More information on dual diagnosis and mental health issues
- More guidelines on how to “lead loved one to” treatment
- A clearer structure in the course book with homework to do listed at the end of each week
- More concrete strategies on difficult issues like asking their relative to leave the house.

Conclusions

FDH delivers the ARC as negotiated in the Project Plans and is broadly informed by evidence. The ARC course successfully achieves each of the four specific program goals.
Participants reported improved mental health, physical health and well-being once time had passed. They attributed their good outcomes to participating in the program and applying what they had learnt to their lives. Our additional questions did not show significant quantitative reporting of improvement, and this is likely to be a consequence of the small sample size. However, the qualitative data did suggest significant gains. Impacts identified included increased hope, better self-care, reduced worry and improved relationships with their AOD using loved one and others.

The way ARC was delivered and managed and the ongoing development and review of course content shows a commitment to quality improvement and evidence informed practice. We found that the ARC facilitators were well informed by research evidence and good practice for family support programs. The course aligns with best practice for peer-based support programs, providing relevant information, exploring ways of coping, discussing social support and establishing the need for further help. This is also reflected in participants’ overwhelmingly positive experiences of the program, as indicated in qualitative data.

In addition, two of the three self-care elements of the CRAFT program that we used as a secondary benchmark for evidence based practice were present. Namely (2) social skill training to improve communication and problem-solving skills, and (3) teaching adaptive skills to improve the life quality of the family member.

The contribution of ARC to SHARC’s goal of building a legacy of ongoing peer support can be seen in the influence and leadership that ARC graduates showed in other FDH programs such as the FDH Support Groups and Helpline.
**FDH Support Groups**

NOTE: During the course of this evaluation the funding model for the Family Support Program was significantly changed as a result of the Victorian State Government’s reform of the AOD sector.

**Program Overview**

FDH Support Groups offer a monthly/fortnightly mutual aid group facilitated by trained volunteers with a lived experience and supported by group co-ordinators who are FDH staff members. The FDH Support groups are a form of mutual aid group where people come together to address a shared health or social issue through mutual support (Seebohm, Chaudhary, Boyce, Elkan, Avis & Munn-Giddings, 2013).

The aim of the support groups is to provide family members with practical support in the form of education, resources and information as well as emotional and social support through providing a safe space for members to share their experiences and help each other.

*Seeing other people who are living the same nightmare as I am. And hearing their conversations gives me strength & hope for my future. Group speaking is very uplifting when life is difficult.* (FDH Support Group Member)

FDH Support Groups are offered as a place to be “amongst people who understand and who have travelled a similar journey” and “through sharing our stories and listening to each other’s experiences that we gain insight into how to take care of ourselves as we live through these challenging times” (FDH Website).

*Some members are in a really bad way emotionally and generally fear for their safety, however shame and embarrassment prevents them from seeking help within their own networks, leaving their FDH support group the only outlet they have to share their experiences and seek solace without the fear of being judged.* (FDH Support Group Member)

FDH states that by “attending groups regularly (one) can reduce feelings of fear, anxiety, depression, helplessness and shame” (FDH Website).

**Program Rationale**

The philosophy and approach of the Support Groups matches that of the other FDH programs with a focus on the needs and behaviour of the participant not the substance using relative. The groups provide education and information, however their primary role is to provide social and emotional support, develop a sense of hope and reduce feelings of isolation, stigma and powerlessness.

When asked how the groups help people, the Support Groups Coordinator described a sense of relief from stigma and shame and misplaced responsibility.

*They say things like “It is such a relief to not feel so isolated and alone, I cannot burden my family and friends with this anymore, they keep offering advice that is not suitable, making me feel bad as a parent, that I haven’t done the right thing, until I came here I had nowhere to go.”*
When asked what the underlying message of the groups she described it as follows:

“Remaining connected and supportive of others in recovery, not allowing people to take advantage and walk over you and take from you – and it can take people a long time to learn and put into practice. Any change they make often is met with resistance and the resulting conflict means members will step back and return to old habits - but they can come back to the group where they can get support and understanding. From this they may gain strength and awareness to make another move.”

Demand, Intake and Delivery

The groups are promoted through the SHARC website and presentations to AOD services and most referrals come from the Helpline or word of mouth. Potential members are encouraged speak with the Group Coordinators before attending.

As of the end of 2013, FDH was running 12 support groups, 10 in the Melbourne metropolitan area at Balwyn, Frankston, Healesville, Carnegie (2 groups), Cranbourne, Dandenong, Ringwood, Sunshine and Watsonia and two in regional Victoria at Bacchus Marsh and Warragul. The number of participants in each session ranges from 10 to 30, however due to the groups being anonymous, attendance records are not kept.

The Programs Manager spoke of considerable unmet demand for Support Groups in regional areas which FDH did not have the resources to support.

Activity

The format of the meeting is one hour of education followed by one hour of sharing. Facilitators use manuals which provide the standard format, meeting guidelines, suggested topics for discussion and other resources.

The combination of education, discussion and sharing of the way we and others are handling the challenges experienced is amazingly effective in empowering us.

The education hour features a video or speaker from SHARC, FDH or an external agency. FDH speakers could be ARC facilitators talking about boundaries, communication and coping skills, the Family Counsellor talking about self-care strategies or a Recovery Support Service resident talking about their recovery journey. External speakers talk about topics such as drugs, addiction and treatment, mental health and dual diagnosis information, or legal matters such as writing wills, how to apply for intervention orders and dealing with police.

Every meeting I learn something new. I come away with hand written notes and literature that has helped us individually in our day to day lives both with the addict and me personally.

In the sharing hour, members take turns to focus on what they are feeling. While they do share their experiences so others can relate, the focus is on the present, what has worked, what has not and where they are at.

Meeting guidelines are read out at the start of each meeting and are designed to protect the safety of members and provide a climate that supports sharing, fellowship, authenticity and change. The guidelines ask members to, 1) observe and protect the confidentiality of other members, 2) treat all members with respect, 3) refrain from talking when someone else is speaking and 4) share your experiences without telling others what to do.
Similar to the Helpline and ARC program there is a gentle proscription against giving and seeking advice.

*We recognise that every member has a unique story and no-one else can know what is best for you, or give you definite answers to your problems.* (FDH Website)

When members share, others are not allowed to interrupt or offer advice but are allowed to ask questions and interactive dialogue is encouraged. If members are confronted with something they find difficult to deal with in the group, they are encouraged to speak with the support group coordinators or ring the Helpline and talk it over with a peer.

**Governance and Quality Control**

SHARC has accredited governance practices, protocols and systems in place for all its programs. Each SHARC program has an advisory group made up of people with lived experience and professionals. The Family Advisory Group meets every six weeks to advise on issues of program development, consumer feedback and review of the support groups program material. A key role for the Group Coordinators is to observe the health of the groups and gain staff support to intervene if necessary.

**Staffing**

**Facilitators**

The support groups are facilitated by trained volunteers with a lived experience of substance use in the family. Their role is to help foster a group interaction that welcomes and encourages people to support each other by sharing their experiences and how they are dealing with them. The facilitators manage the progress of each meeting to ensure discussions are not dominated by particular members. The facilitator’s role is not to provide advice or solutions to individual members however they may freely share their own situation both as a peer and a role model.

Usually the facilitators are members of the group in question and ideally several facilitators will rotate the role each meeting. Occasionally experienced facilitators from other groups may assist.

**Coordinators**

The FDH Support Group Coordinator’s primary role is to provide training and education, support and supervision to the group facilitators. The FDH Support Group Coordinator will facilitate groups that are new or struggling with group dynamics. A Group Coordinator reported that over the time they have been in the role, members have taken more ownership of the groups and larger groups have become more self-sufficient in generating facilitators from their ranks.

**Value of Peer Facilitation**

Members seemed to greatly value having facilitators and staff who could bring their own lived experience. There were repeated phrases such as – “they’ve been there”, “we’re all on the same level” and “they’ve walked in our shoes”.

*“Their willingness to share their experience, to acknowledge that they too stumble sometimes, gives them credibility, reduces the fear of being judged, and provides a model of how to live with a chronic illness situation.”*

They felt a peer can better empathise with and understand their problems and can offer credible advice drawing from similar experiences.
“It makes all the difference. The facilitator who has experienced these problems can empathize with us and recount personal stories to provide real examples of what to do and what not to do.”

Family members value lived experience. A shared experience seemed to allow facilitators to engage quickly and deeply as equals in a relationship free of the fear of judgement.

“If you want to learn basketball and 2 people are offering to help, do you pick the one who reads books about it or Michael Jordan? “

“It’s THE ingredient needed, it is only with great difficulty that an outsider can fully understand the trauma of the drug addict’s family.

Possibly the most important thing they got from the facilitator and their peers was practical information such as how to support their relative in ways that are beneficial yet often very difficult.

“Their advice is often more helpful as they have lived the nightmare.”

“They can explain being strong is not being cruel as this is hard to understand “

Evidence Informed Practice

The evidence for mutual aid groups show strong associations along with a range of health and social benefits including enhanced mental well-being. Seebohm and colleagues (2013) found that such groups lift members’ self-esteem, knowledge and confidence through the exchange of emotional and practical support. This support enhances a sense of control over their situation and therefore increases resilience and increased participation in the wider community.

Participant Experience of the Program

Telephone interviews were conducted with participants of support groups and were designed to examine perceptions, experiences and impacts of the program, as well as how the program could be improved. Seven interviews were undertaken, and the characteristics of participants have been described earlier (see Table 1, p32). Interviews were analysed using thematic analysis and three key themes were identified: positive aspects of the program, challenging aspects and suggestions for improvement, and impacts of the program

Positive aspects of the program

Participants in Family Support Groups reported overwhelmingly positive experiences of the program. Key themes that we identified included facilitators, people with similar experiences, sharing experiences and strategies for coping, giving back to the group, active listening, guest speakers and learning tasks.

Facilitators

Participants stressed the importance of good facilitators who could encourage turn taking and sharing. For this to occur, facilitators needed to perform a delicate balancing act to ensure individual participants were able to tell their story and feel heard while also ensuring that everyone in the group had ample time and opportunity to contribute. Participants thought that many facilitators did this well:
I was just amazed at the professionalism of this group, they watch the time, they are on time, really beautifully run, I’ve never seen anyone get angry because they’ve felt they were cut off, it’s never happened. (Elsa)

As Elsa’s comments suggest, facilitators were generally thought to be organised and professional, which contributed to the smooth running of the groups. As with ARC, facilitators of support groups were also thought to be influential in cultivating a supportive and non-judgemental environment. One of the ways they did this was to share their own experiences of living with an AOD-using loved one. Not only did facilitators have first-hand experiences of living with an AOD-using loved one but they had also experienced what it was like to attend the group for the first time and how scary sharing can initially feel. They were able to draw on this experience to ease new participants into the group and let them participate at their own pace rather than bombarding them with questions or putting them on the spot.

People with similar experiences

The fact that groups consisted of people going through similar experiences also contributed to a supportive, non-judgemental and empathic environment. This was critical because many participants talked about feeling judged or blamed by others because they had a loved with AOD issues:

When I first started I was just a bumbling mess and found it difficult to talk without crying and I just wanted to be around people who had similar problems and would understand and wouldn’t judge me or criticise me or I didn’t feel assaulted by lots of questions. (Bernadette)

Participants felt that the support group was a safe space in which people were free from stigma and could share their experiences without judgement – in contrast to how they felt in their non-FDH community environments. This was essential in enabling the sharing of experiences and strategies for coping, and was something that all participants thought was helpful.

Sharing experiences and strategies for coping

Sharing experiences and strategies for coping was one of the mechanisms through which positive impacts of the program were achieved. Interviews revealed that sharing experiences had the dual purpose of facilitating social support as well as yielding practical strategies that participants could use to cope with challenges in their life. This dual purpose is evident in Bernadette’s account of how she got through a terrible experience that happened to her AOD using son:

What I heard that night (about my son) was the most frightening horrible thing but I could handle it because I had the group to get me through it, I’d learnt a lot of strategies and had time to work out what I’d do.

The group was able to support Bernadette through a crisis-type situation, but she was also able to employ the strategies she had learnt over the course of 12 months of participating in the group. Participants discussed the role of group members who had been in the group longer than others, as being particularly helpful in sharing experiences of ways they had coped with particular
situations. Sharing experiences was also viewed as a way of contributing and “giving back” to the group.

**Giving back to the group**

Given the skills, support, information and connection that the group had given participants, many also liked the opportunity that support groups provided for them to give back. As well as sharing experiences and suggestions and providing support to others, one of the main ways people did this was by becoming a facilitator:

> I’ve done the facilitator role once. I can’t say I liked it or didn’t like it. I went to a facilitator’s course because I wanted to learn it, it was really good and I want to do it well because it’s part of being in the group and giving. Part of being a team and group and I will learn other skills. (Elsa)

The fact that the program affords people with the opportunity to undertake facilitator training and serve in a facilitator role also allows people to develop new skills.

**Active listening**

To get the most out of participating in the group many participants commented that active listening as well as sharing was important. Bernadette suggests that active listening is not always an easy task when you are going through a tough time yourself:

> There’s an understanding that you have to share and that you can’t be talking all the time and be prepared to listen to others which is helping yourself which is very hard to learn when you are at crisis point. It took a lot for me to do that, had to learn some new skills and some sharing.

As Bernadette suggests, with time she had come to learn that listening to others is about helping herself learn new strategies, which can be as important as sharing experiences.

**Guest speakers**

Active listening was also important when it came to guest speakers, which came from a range of backgrounds as Marie explained:

> Guest speaker - sometimes it’s the director of alcohol, the detox nurse or someone from a drug and alcohol service, the drug & alcohol doctor, various speakers, even a policeman talking what they do about the drug problem.

Many participants commented that they liked the variety and range of guest speakers, and found the information they provided really useful.

**Learning tasks**
Similarly, many found the learning tasks that often preceded sharing time, were relevant and useful. Some talked about the readings as documents that people could refer back to and that reinforced what they discussed and learnt in the group.

**Challenging aspects and suggestions for improvement**

Like ARC, participants of support groups reported very few negative experiences or aspects of the program. However, when probed by the interviewer, a few challenges and suggestions for improvement emerged. Other than possibly improving the range of topics discussed, utilising more Australian content in readings and learning tasks, and having more guest speakers, group dynamics was the main issue that participants talked about.

**Group dynamics and catering to the needs of people at different points in their journeys**

One of the challenges noted by a couple of participants was how the group responds to the needs of participants at different stages in their journeys, and with different needs and expectations. Overly large groups were viewed as not being conducive to sharing and discussion.

The group was also the first source of formal support that many people had sought. This meant that people who had just started may be more likely to be in crisis type situations and want to talk about their experience, may be quite emotional and may find it hard to engage in active listening. Dean talked about a couple of people who were in crisis-type situation and who had unrealistic expectations of the program saying:

*I noticed that there were a couple of people there that didn’t get the same result from the program. They were still freaked out, as they had only just discovered their child had a drug problem and they came looking for a fix, a cure for the problem. I thought the program made it quite clear you can’t cure the addict, you can only help yourself. That wasn’t a problem with the facilitator it was a problem with the place in their heads, and the facilitator wouldn’t tell them what to do with their child so they would be cured for life.*

On the other hand, people who have been attending for a while might be beyond this point and thus may be doing a lot more active listening and emotion work, which might place an added burden on them. Bernadette, who was a relatively experienced group member and keen to help newer members of the group, found this hard to deal with sometimes:

*I understand but dislike that there are members of the group who are so needy, some have been coming as long as I have or longer but with their neediness have not yet reached a point I have. I understand but the group may need a little more guidance in that area, maybe facilitators need more. Probably from SHARC, how do we help those people?*

Perhaps as Bernadette suggests, facilitator training courses need to incorporate more content related to dealing with challenging group dynamics and high-need group members. Ongoing mentorship is likely to help in this regard. Similarly offering high-need clients the opportunity for individual counselling may enable them to work through crisis-type situations before starting support groups.

**Impacts of the program**
Participants discussed the positive impact the program had on their wellbeing and coping skills in conjunction with ARC and other activities people were involved in. While a range of positive impacts were reported, these included disentangling participants wellbeing from the wellbeing of their loved ones, improved relationships, and a sense of fulfilment from helping others.

Disentangling participants wellbeing from the wellbeing of their loved ones

Many participants reported that the program helped them to disentangle their own wellbeing from the wellbeing of their AOD-using loved ones, which reduced how much time and energy they spent worrying. This was the case for Dean, who talked about his new perspective on his son’s drug use:

Now when he has a relapse which could happen every couple of months I say to myself that it’s his problem I can’t make him stop taking drugs, he has had all the lectures and knows all the dangers and I know he wants to stop but if he has a relapse I will support him if he comes to me for advice but I can’t change his life for him, so instead of focusing on that I focus on other things.

The group had helped Dean to come to terms with the limits of the agency he has over his son’s drug use and enabled him to focus on things beyond his son’s drug use. Tyson and others talked about this in terms of recovery:

It is recovery for us because you thought 24 hours a day for him, but none for yourself, but now you still think of him but we have our own life. We can go away, we cannot think of him 24 hours a day. (Tyson)

Here recovery is about reclaiming time for thoughts that were not about a loved one’s AOD-use and problems. Marie’s comments also resonate with this:

I get a lot out of life, it’s made me stronger and a bit tougher and not as anxious as I was. I’ve learnt to turn off a bit because I was reacting to him.

Through the support group she had learnt to “turn off”, worry less, and became more resilient. Similarly, others talked about having developed the strength to not experiencing their AOD-using loved ones problems on as their own:

I know that if I’m coming from a place of strength, of acceptance and have my boundaries in place I just know that if I change the other person will change. My daughter is like a walking miracle, now she drinks a bit so the addiction is not gone, but at least it’s more visible. (Elsa)

Elsa’s comments also illustrate how the changes she had made also encouraged her daughter to change.

Improved relationships

Like ARC participants, support group participants also thought that their participation had resulted in better relationships with their AOD-using loved one and others. Many participants
discussed their past inability to talk with other people about their loved ones AOD use and the challenges they’ve faced as a result. For example, Bernadette said:

Keeping things from people – I think I haven’t been truthful from myself and now share feelings with my family. I can now say I don’t feel great if I don’t feel great, I’m much more truthful out loud. Group has helped me face these issues much more easily. A counsellor tells you what to do... A member of the group... says how she dealt with something.

According to Bernadette, learning from the experiences of other support group members has been more valuable than being told what to do by a counsellor. It has enabled her to articulate her feelings – both good and bad – to her family and other people, and not feel guilty about keeping things from people. Bernadette also discussed how her work in the group had enabled her to accept her son’s AOD problems, and how this had enabled her to support him:

I can now move forward as I now accept my son has life style choices that I don’t agree with but I still love him. He has a right to choose the way he lives, but I understand if he doesn’t want to see me. I can put that worry about the drug addiction out there, I’m not addicted and I’m not the addict, but I’m there. Now move forward and be cheerful as I’m not taking it on.

Sense of fulfilment from helping others

Not only did participants report a sense of fulfilment at helping others as facilitators and fellow group members, they also discussed how they became motivated to attempt to contribute beyond groups. Inspired by her experiences in the group, Anna started volunteering on a telephone helpline for family members trying to cope with their loved ones AOD problems:

I volunteer on the helpline... I felt like I’d like to help people in the same situation as I am.

(Anna)

Elsa discussed how learning about AOD use in support groups sparked a greater interest in AOD treatment, which has manifested in her starting an AOD counselling course. Another person mentioned their desire to develop a training program about AOD. In this way the support groups impacts are likely to extend beyond participants and their families and into the broader community.

Outcomes

The following section provides the results from the outcome evaluation component of this project. Specifically, our analysis explored whether members who had participated in the support groups for more than seven months showed better health and well-being than those who had participated less than seven months; and whether participating in the support groups contributed to these outcomes. Data is drawn from the participant survey (as completed by FDH Support Group members; N=51). The demographics of FDH Support Group members closely matched that of the total FDH sample (see page 18-19).

Outcome data from 51 respondents were sorted into length of attendance and split into two even groups and compared. The median length of attendance was 7 months and thus the two groups were 1) less than 7 months and 2) 7 months or more. There was no difference in any measure
between each group. This may suggest that the members do not improve with time in the groups. However, as the FDH Website suggests, results may be slow to come. “The real value of a support group is not always immediately apparent and we may experience a gradual change in how we see and react to problems.”

The free text answers were highly positive about the value of the groups to the member’s well-being.

**Impact on other Family Members**

Most participants reported that the impact on their overall family dynamic was positive.

“We are happier as a family because we are not continually focusing on my loved one. I have a better relationship with my other children now.”

“I am able to release my GRRR!!! in a supportive environment so I’m not releasing it on my family.”

“They have learned a little bit about enabling and so we are armed together to tackle some of the obstacles to help our loved one.”

They reported a calmer more settled home environment.

“I come home stronger, peaceful and focused. My children are glad I go, it is a great stabilizer for our family in a chaotic situation.”

“They can see the change in me. I think with me much calmer it flows through the household which makes us all cope better with this awful problem.”

Spouses reported their relationships were stronger more supportive and less conflicted as their children’s problems dominated their lives less.

“We reclaimed our lives as members of a community. Instead of feeling guilty, embarrassed and that we were ‘bad’ parents.”

They focussed more on other family members who had been neglected, especially the relative’s siblings. Other non-attending family members gained more insight into their own struggles with the relative as they spoke more, shared information and supported each other.

**What impact on your relative?**

Some relatives were threatened by the member’s participation; others were relieved to be given the space to do what they wanted. Some resented boundaries being implemented, whereas others respected them and the relationship benefited from the clarity about what was acceptable or not.

*My son (although still using) respects me more and understands I am not responsible for his problems. Thus we get along so much better than before I attended groups.*

*I set clear boundaries and say what I am prepared to accept so there are no grey areas for my relative. I think he even appreciates the changes at times.*

*They are still using but now know asking me for money won’t work. I’ve made it clear I won’t help them use but will do anything to help them change and get better*

Members generally reported better communication, more honesty and less conflict.
“I’m able to express my concerns in a much calmer and positive way, asking questions rather than lecturing.”

“My approach towards my son has changed and he does not intimidate me as easily as before and I am stronger with my decisions towards him.”

“My son is still using but now admits he has a problem. He also will talk to me more about his problems, because my attitude has changed, thanks to all I have learned through FDH & Support Groups.”

“Extremely positive. By learning to let go of the need to know my son’s every move, it has enabled me to have a positive relationship with him which does not focus on drugs all the time. I have stopped making myself sick over what may or may not happen next which in turn has improved my relationships with my husband and other children.”

Some reported their relative taking more responsibility for themselves

“Probably has made me stronger so he can’t co-depend on me. Makes him responsible for himself, not me. Which is good for him, but it’s not why I do it!”

On a scale of 0 to 10, the members were asked to indicate the extent to which they would credit the Support Program for the changes they made to their life. The respondents gave the support groups a mean score of 7.9 (SD 1.9) with newer members (<7 months) slightly less ready to credit life changes made to the groups 7.5 (SD 2.4) than older members 8.1 (SD 1.4). Thus the members gave strong endorsement for the idea that the support groups were the reasons behind the changes they had made in their life.

**How would you cope with your situation if the FDH Support Groups were no longer available?**

News of the threat to funding of the Family Support Groups was received just before the data collection from members. This provided an opportunity to ask, “How would you cope with your situation if the FDH Support Groups were no longer available?”

A small number said they could cope without the support groups either because they had gained so much knowledge from the groups or they had made friends through the groups they could access. The majority said they would have difficulty coping without the groups.

*I don’t know if I would cope, I think I would fall into the vicious cycle of blaming, arguing, violence, etc.*

*Without my group meetings ... I really think I would sink. Without Family Drug Help and my group, my life would be a total mess.*

*I truly believe finding this group may have saved my life. It has given me a strength that I thought I had lost. It would be a disaster for others not to be able to find a group like this.*

Many feared the isolation they may again face.

*I would feel deserted and terribly unhappy as I would have no one I could talk to who would understand. It would be like losing a 'life jacket' on a sinking boat.*

Some even said their own mental health could be at risk.

*I don’t believe I would cope at all. This is a hugely stressful time and without support, I believe I would suffer from acute anxiety and depression.*
I would be devastated as I was so impressed and felt as though it was the first and only time anyone has helped ME. I didn’t realise such help was available and although I have superb assistance from my sister we didn’t know where to go next as nothing is working.

Some mentioned the support they received in dealing with the treatment system and with social stigma and judgement from others.

Before attending this group I was always extremely reluctant to speak about my problems in public.

I’m not quite sure there is already so much red tape to go through to get ANYONE to help you + your loved one e.g. waiting lists, wrong assessments, police restrictions, DHS services. The group has helped me through a system that is failing our addicted loved ones.

It would be more difficult. The support group is vital and people from all walks of life need this help to identify with others. It is a taboo subject unfortunately and most people who are unaffected are usually too judgemental or don’t want to know.

Two final responses point to the change in identity and self-esteem they experienced as being part of the supports groups.

I hate to think this (support groups not being available) will ever happen. I was not coping at all before I attended my group. I merely existed and held everything inside, praying that my son would wake up one day and everything would be gone, he would be drug free. It still hasn’t happened, however through my group I learned it is possible for me to lead my life and I now see myself fit and entitled to as much as possible.

“Honestly I don’t feel I would be able to cope and would go back to square one. I always blamed myself for things that have gone wrong. The support group has taught me to look and deal with things differently and that when things (are) out of my control (they) are not my fault. They have given me strength and understanding and support I have never had before. They understand my needs and my pain and they help me get through troublesome times. I think I would feel lost and abandoned as well as helpless if it no longer available to me.”

Conclusions

We found that the Support Group program is delivered successfully and fulfils its tasks – although we found no objective variations in wellbeing between older and newer members, the overall ratings are extremely positive as is indicated in the quotations above. There is both a demand for the groups and a high degree of reported satisfaction with them. Participation in the groups helped respondents cope with their situation and improved their lives and they enthusiastically attributed their good outcomes to participating in the support groups.

Their descriptions of their experience closely matched the process described by Seebohm and colleagues (2013). Namely participation lifted self-esteem, knowledge and confidence through the exchange of emotional and practical support. This support enhanced a sense of acceptance of their situation and control over their lives which led to increased resilience and participation in the wider community.

There is good evidence that the Support Groups help build a legacy of ongoing peer support for affected family members. Indeed the Support Groups seem to be SHARC’s primary vehicle for
achieving this goal. Many members had been attending for years and the coordinator described how longer term members help newer members learn new ways to live with their situation.

The impact on other family members including their relative seems positive through better communication and clarity about boundaries and responsibilities. While some relatives seemed to resent their lost ability to manipulate and intimidate their family, most seemed to respond well to the changes in their family.
**Family Counselling Service**

**Program Overview**

Family Counselling is delivered by a full-time\(^1\) qualified family counsellor who provides counselling and mediation to family members referred from other FDH and SHARC programs such as the residents of Recovery Support Services and their families, as well as family members referred from external agencies. Both individual and family counselling is offered as single session or ongoing up to twelve sessions.

**Program Rationale**

Not every affected family member can get the help they need through an education course such as ARC or through the groups. More intensive interventions can be delivered by one-to-one counselling.

Similar to other FDH programs, the focus of the counselling is to provide a supportive environment to help families change their relationship to the problems they are facing, as well as building upon the skills and strengths the family possesses.

Unlike the other FDH programs there is no proscription against conventional counselling strategies, such as directive advice giving when necessary. However, the counsellor values and utilises the wider FDH strengths-based, solution-focused and self-directed approach.

**Demand, Delivery and Activity**

There is one family counsellor employed at SHARC. There is a consistently high demand for the service and in 2012-13 the family counsellor completed the quota of 110 episodes of care, completing an average of twelve counseling sessions per episode of care. She stated that she tried to keep waiting lists to less than a month.

**Intake**

The family counsellor manages her own caseload including intake, assessment and referrals to other services. She stated that she accepts most referrals unless they would be better suited to relationship counselling.

**Governance and Quality Control**

SHARC has accredited governance practices, protocols and systems in place for all its programs. Each SHARC program has an advisory group made up of people with lived experience and professionals. The Family Advisory Group meets every six weeks to advise on issues of program development and client feedback. The Family Counsellor keeps detailed, confidential client records and receives regular professional and line-management supervision.

**Staffing**

Like many staff at FDH the family counsellor has a personal history of addiction in their family, however, in contrast to other FDH programs, the family counsellor interacts with clients predominantly as a trained professional rather than as a peer with lived experience.

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\(^1\)Since this evaluation was conducted, the program model has been changed to employ two part-time family counsellors (1FTE).
Evidence Informed Practice

Evidence for family therapy for drug abuse is well established. Rowe (2012) claims adult-focused models based on behavioural and systems theories of change are among the most effective approaches for treating both adults and adolescents with drug problems. The modality favoured by the current counsellor, namely CBT, has a well establish evidence base.

Outcomes

NOTE – because only 3 past clients completed the survey a comparison between current and past clients was not possible. It was therefore not possible to report outcomes for this component of the project. However, free text responses from all 18 respondents provide some information about the value of the program for participants.

How has Family Counselling helped you make changes in your life?

The participants valued the opportunity to come together as a family in a safe space, with an independent person involved.

Boundary setting was the key strategy respondents mentioned as helping to protect their well-being. This applied not only to making clear what was unacceptable behaviour but an understanding that they were not responsible for the actions of their relative and greater awareness of when they were interfering.

“I am more able to view things as his issues and my issues – to not let him ‘muddy the waters’“

“It has allowed me to realise that the addiction is not mine and therefore allowing me to get on with my own life.”

“Using images such as hoops as to what my space/needs are and when the addict has been allowed in or not by me”

Greater awareness of the nature of addictive behaviour allowed them to change their thinking and approach to situations, such as avoiding enabling or being manipulated.

“She showed us how addicts think and how we as parents react - explaining relationships and changes needed to encourage change in the addict”

“It has helped me understand how deeply my brother’s addictions are ruling our lives.”

“It has enabled us to talk more frankly with our son and also with each other.”

“I’m more confident to say "NO" to unreasonable requests from my son.”

They also gained greater self-awareness and knowledge.

“She helped me understand it is not my fault, how to understand and deal with our situation, our relative, all of our emotions. “

They also spoken of gaining greater self-confidence to use boundaries and other techniques to reduce stress and emotional burn out and thus take better care for themselves and other family members. Other spoke of being able to detach with love and let go of constant worry.

“We have felt reassured and more confident that our decisions are correct and wise. Fear was a strong driver in our lives before and we are learning to identify what drives us and our actions.”
“How to take care of and protect myself in the worst and best of times. How not to be a rescuer and to be a coach. How not to guess what may have happened sticking to the facts.”

**Impact on relative and overall family dynamic?**

Participants reported a positive impact in their overall family dynamic.

With respect to the relative, participants reported more productive communication, less nagging and less conflict. Some suggested the relative themselves showed improvement as family members took less responsibility for their relative’s decisions and interfered less. Others found they were able to support their relative to make better choices through changing the way they interacted with them. One respondent claimed through family counselling she was able to help her daughter accept the need for treatment.

“How to take care of and protect myself in the worst and best of times. How not to be a rescuer and to be a coach. How not to guess what may have happened sticking to the facts.”

“By shining the light on what’s going on, by loving encouraging me and by osmosis the addict I love so dearly. We were finally able to move forward.”

**Suggestions for improvement**

The respondents found little to criticise or suggest beyond expanding the service to include additional after hours, more sessions per episode and more counsellors. Two respondents would have liked to have included their relative in the process (it should be noted that this option is offered to all clients). Praise for the counsellor was glowing.

“I really cannot think of anything that could be improved I’m trying to be very critical I have been very fortunate in this very unfortunate situation to have a very caring compassionate clever enthusiastic and helpful counsellor. And thank you for giving me this opportunity to tell you how satisfied with this service.”

“By cloning duplicates of {family counsellor}. She is THAT good honestly. Maybe it could be mandatory for recipients of counselling to fill in these evaluation forms to help the recipient consolidate and confirm in writing for themselves what they have learned in their session enabling them to later be reminded of their progress. Thank you for giving me the opportunity to give back when I’ve received just so much.”

**Conclusions**

The evaluation of the family counsellor was extremely positive. We found it very hard to collect quantitative data in this area but the qualitative data was extremely supportive – with very positive feedback about the contribution of the counsellor. However, there is only one counsellor* and it is clear much of the positive feedback is specific to her and there is a risk management issue for SHARC were she no longer to be available to fulfil this role.
Family Drug Helpline & Volunteer Program

Family Drug Helpline is a free, anonymous and confidential telephone information and support service provided by trained volunteers with lived experience of substance use in their family. The volunteers are described on the FHD Website as people who “know what it’s like to love someone who’s misusing drugs or alcohol” and who can offer “support, referrals and above all, to be heard”.

“The power of just being heard and understood by someone who has been there cannot be underestimated.” (Helpline Volunteer 1)

The Family Drug Helpline service is answered from 9am to 5pm, Monday to Friday by the volunteers, with over flow calls taken by FDH staff including the team leader. Outside these hours calls are diverted to DirectLine, an external professional service providing 24-hour, 7-day counselling, information and referral.

Comparing Helpline with Directline

To clarify the distinctive peer-based support service that Helpline provides, it is useful to compare the Family Drug Helpline and Directline services, and what each provides to family members. The two telephone services offer distinct and complementary support. Family Drug Helpline provides a service that DirectLine is not intended to replicate and vice versa.

The Programs Manager described how FDH and DirectLine have recently worked together to develop procedures to help staff of both services explain these differences to callers and to facilitate cross referrals.

Strong and specific family focus versus broader focus

The Family Drug Helpline is specially designed for affected family members.

“It provides a space where family members can begin focusing on themselves and their own health and wellbeing – we remind callers that looking after themselves and that self-care is paramount.” (Helpline Team Leader)

DirectLine, on the other hand, is designed for people seeking counselling, information and referral for their own substance use or relating to someone else’s substance use.

Peer-based versus professional

The Family Drug Helpline, like the other FDH programs, is a peer-based model which relies on engaging and supporting through the sharing of lived experience. Volunteers are encouraged to use their own history as both as resources of information as well a means of engagement with the caller.

“They feel at ease talking with someone that has been through it – often you sense they relax and have less resistance when they know you have experienced addiction with a loved one. The feeling of being alone with the problem is reduced, which reduces their anxiety.” (Helpline Volunteer 2)

“Family members often feel guilt and shame and feel and responsible for their loved ones addiction – when they talk with a trained volunteer they soon realise the person talking to them is just like them and it can happen to anyone.” (Helpline Team Leader)
In contrast, Directline uses a professional counselling model, where calls are answered by trained health professionals from a variety of disciplines who have a minimum qualification of Cert IV in AOD. In this model, it would not generally be considered good practice for a counsellor to disclose personal information such as a family or personal history. This practice maintains a clear boundary between helper and helpee and preserves a sense of distance and objectivity, qualities that are highly valued by professional human services (White, 2009).

**Support and information versus counselling and intervention**

Directline provides “immediate counselling and support, including crisis intervention” (Directline, 2014). A Helpline manager from Directline described it as designed to be more directive with a focus on ‘the next step’ in terms of practical advice.

Family Drug Helpline is not funded to provide counselling or interventions and does not use any formal counselling modality. Volunteers will offer information and refer to other services if required but they will not give directive advice on how to handle a particular situation. When callers do seek advice, the volunteers take a non-directive, client centred approach in the spirit of motivational interviewing. For example, they will try to help callers to come up with their own ideas and solutions - such as what worked well in the past - with an emphasis on self-care and improving communications with their relative. This was described by the Team Leader as “walking along beside the caller” as opposed to “leading them by the hand”.

While Helpline volunteers do not provide counselling, they are trained to use key counselling skills such as active listening, paraphrasing and reframing, refraining from judging, displaying empathy and being genuine through sharing lived experience.

Despite the emphasis on personal connection, Helpline volunteers do not try and establish an ongoing therapeutic relationship nor are callers encouraged to speak with same Helpline volunteer again. Callers are encouraged seek ongoing support by engaging with other FDH services and programs such as ARC, the FDH support groups and the FDH Family Counsellor or are referred to other professional agencies and services.

The Helpline follows standard privacy and confidentiality procedures, while they do not develop care plans or keep client records they do record demographic data and what services were provided, as summarised below.

**Demand**

The following information refers to the calls received between 9am and 5pm, Monday to Friday. Over the six months between July and December 2013, 1,675 calls were recorded. Most calls were by family members for the Helpline service (75%) followed by family members referred by Supportlink (10%). Supportlink is a national referral and diversion gateway for police and other emergency services to NGO community services (www.supportlink.com.au). A small percentage of calls were internal queries (5%) and from external agencies (3%).

The median number of calls to the Helpline each weekday was 14. Seventy percent were first time callers and 75% were Victorian, 10% interstate mainly NSW and QLD and the rest unknown. Callers found out about the Helpline from agencies (35%), the internet (34%) and Supportlink referrals (17%). A small number (4%) were referred by friends or family.
Demographics
The great majority of callers (79%) were women and most (58%) were parents aged 40 to 60. The second most common groups were partners aged 25 to 40 (14%), followed by siblings (9%) and other family members (6%). Fifty-six percent of parents were living with their relative (child) and 80% of partners were living with their relative (partner). Callers stated that an average of 4.5 other family and friends have been impacted by the relative’s substance use. With 14 individuals daily, mainly new callers, and an average of 5.5 people affected as well as the substance user, the reach of FDH is significant.

Seventy percent of relatives (substance users) were male, most were aged 40 or under and over a third were under 25 years old. Sons were the most common relationship group at 40% and were evenly split into ‘under 25’ and ‘25-40’ age groups.

When asked to nominate the primary substance of concern callers reported ice (Methamphetamine) (39%) followed by Cannabis (23%), Alcohol (20%) and unsure (15%). Parents reported ice (42%) and cannabis (23%) as the primary substance of concern whereas partners reported alcohol (37%) and ice (34%).

Service Delivery
The operators offered information to 47% of callers, referred 42% to other FDH services such as ARC Support groups or Family Counselling, sent resources to 39% and referred 23% to external services. These services were mostly drug and alcohol agencies (including Directline) (51%) or mental health agencies (23%) and smaller number to emergency services such as 000 or suicides lines (11%), psychiatric triage (3%), housing (2%) and child welfare (2%).

Staffing
The Family Drug Helpline is managed by a team leader who is a trained professional and like all other FDH staff has a lived experience. The Team Leader also manages FDH staff in other programs.

Although FDH volunteers are not trained counsellors and do not require any professional qualifications, considerable effort is expended in vetting, training, monitoring and supporting the Helpline volunteers.

Recruitment and Training
Over half (58%) of the volunteers are former and current clients of FDH programs and have a high degree of familiarity with the service. Volunteers apply by written application and shortlisted applicants are interviewed by the FDH Team Leader and another FDH staff member. Successful applicants are required to complete three days of training on the nature of drugs and addiction, safety, confidentiality and privacy policies and active listening skills.

Quality Control
The peer-based model has both strengths and weaknesses compared with professional health care (White, 2009, p19). Volunteers can mistake their own lived experience with ‘the whole truth’ which can lead to dogmatism and rigidity and inappropriate advice giving. The emphasis on relational connection and personal involvement can spill over into over-involvement, over-disclosure and excessive intimacy. The Team Leader seemed well aware of such dangers and emphasised that she vetted applicants with such issues in mind. The policy of not giving advice and a high level of monitoring and support also helped manage these vulnerabilities.
During their induction period volunteers are heavily monitored by the Team Leader listening in on calls and able to intervene, if necessary, on a second headset. The Team Leader can also listen in from her office which is adjacent to the call room and have a discussion about a call if anything needs to be addressed. All volunteers undergo regular supervision and can access debriefing with the Team Leader when necessary. Ongoing professional development and training is provided quarterly to all staff and volunteers.

**Support**

A key feature of the peer-based model is the diffuse boundary between the role of helper and helpee. FDH volunteers and staff members often continue to manage their own situation at home and so continue to need support from the service.

The peer-based model acknowledges that volunteers can gain as much from helping as those helped. The volunteers interviewed claimed that volunteering at the Helpline aided their own recovery and personal development and allowed them to form supportive networks and a strong sense of community. They spoke at length of how well supported they felt at FDH and how being able to give back helped them manage their own ongoing situations.

**Retention**

FDH reported an 80% retention rate for volunteers in the second half of 2013. Of those that left many reported it was to commence full time employment often after years of being too impacted by their situation to hold down work. Some volunteers go on to further studies and then careers as professionals in the sector. Several of the current FDH staff were former clients of FDH programs.

**Conclusions**

The Helpline and Volunteer program aligns well with the SHARC Mission and Vision, fulfils the Program Objectives and is informed by best practice for peer-based support programs.

In particular, the high level of training, monitoring, development and support for the volunteers shows a commitment to quality improvement. The description of the service provided seems to align with best practice for peer-based support programs such as the Five Step method of listening non-judgmentally, providing relevant information, exploring ways of coping, discussing social support and establishing the need for further help.

The volunteers gave evidence of reduced harm, and improved health, well-being and connectedness for both themselves and the callers they helped. The relationship with DirectLine and Support link is evidence of an integrated approach to service delivery.

The Helpline and Volunteer program are an example of how SHARC and FDH are able to build a legacy of ongoing and sustained peer support for affected family members. Many of the volunteers are former clients of the services and several staff members previously worked on the Helpline.
6. SUMMARY & CONCLUSIONS

This evaluation examined the extent to which the four programs under review (FDH Helpline & Volunteer Program, Action for Recovery Courses, FDH Support Groups, and FDH Counselling) met the stated objectives. The objectives were to:

1. Deliver project outcomes:
   i) Facilitate and deliver the ARC across Victoria and
   ii) Provide family counselling and mediation to RSS residents and families and
      referrals from FDH and external sources.
2. Adopt an integrated approach to service delivery
3. Manage services within a Quality Improvement Framework
4. Reduce use and harm
5. Improve health, well-being and connectedness
6. Build a legacy of ongoing peer support

The Family Drug Help services provided by SHARC fill an important community need, ensuring that the families of those with substance misuse problems have access to professional support. These services are provided by a dedicated pool of paid and volunteer staff who are committed to the values of SHARC and to supporting their community. The four programs under evaluation form a pathway of support for families of those with substance misuse problems, and a vital peer network that enables participants to both gain and provide support at the level that best suits their needs. Dedicated staff and management are committed to ensuring that the programs are tailored to participant need and are delivered in line with best practice. Together this suite of programs provides a valuable service to the community and SHARC is to be commended for the ongoing delivery of these quality programs.

The following section provides a brief summary of the extent to which FDH have met these objectives in their delivery of the four programs under evaluation, including:

- Family Drug Helpline
- Action for Recovery Courses
- Family Drug Help Support Groups
- Family Drug Help Counselling

Objective 1) Deliver project outcomes (ARC & Family Counselling Service)

Both the ARC and Family Counselling Services are delivered in line with their stated objectives. Specifically, the ARC program aims to assist participants to better understand the complexities of addiction; explore ways of improving relationships; learn skills and strategies for coping with anxiety and depression; and, gain greater self-awareness look after themselves and plan a positive future. Participant and program data indicate that these aims have been achieved, with many reporting positive experiences of the program. Further to this, ARC facilitators are well informed by research evidence and good practice for family support programs, and embed this within their program delivery. Critically, they were also able to cultivate safe, supportive and non-judgemental environments in which ARC participants could learn and share.
The Family Counselling Service aims to provide 110 episodes of care each year, with each episode consisting of between one and twelve sessions. This aim is regularly achieved, with a number of people waiting to access the service. Participants reported positive experiences and outcomes from their sessions with the Counsellor.

**Objective 2) Adopt an integrated approach to service delivery**

These four programs together demonstrate FDH’s integrated approach to service delivery. Clients who call the Helpline speak with volunteers who have invariably used the service, or one of the other FDH services, previously. Volunteers, who have used the service, also facilitate the Support Group sessions, which people often attend before, during and after completing ARC. Clients from these services are also referred into the ARC or counselling service, as relevant, or to external services if more appropriate. Staff sit across FDH programs, with a single manager co-ordinating the four programs.

**Objective 3) Manage services within a Quality Improvement Framework**

FDH applies a process of continuous review and improvement across all its programs. In addition to the many processes they have in place (supervision, professional development and training, program content review, peer support, professional debriefs, Advisory Committee Review structure, regular staff meetings), this evaluation is evidence of quality review and improvement activity. Better data collection across the programs, including participation statistics and routine perceptions of care surveys (of both participants/clients and staff) and health and wellbeing surveys (staff) would further assist in quality improvement activities. Conducting qualitative focus groups as part of program reviews could also be a good way of collecting rich data on program experiences.

**Objectives 4) Reduce use and harm and 5) Improve health, well-being and connectedness**

To deliver the four programs, FDH has adopted an approach that aims to directly change behaviour in the family to reinforce positive behaviour in the individual (Grant, Potenza, Weinstein & Gorelick, 2010). Their interventions are influenced by Family Specific Interventions, specifically the Stress-Strain-Coping-Support (SSCS) model (Orford et al, 2010; Copello, Templeton, Orford & Vellemian, 2010) and the Community Reinforcement And Family Training (CRAFT) model. These models work with affected family members as clients independently of whether their relative is making changes or not. The goal is behaviour change of the family member and not the relative. Family members are seen as people under stress and at risk of developing health problems in their own right. These approaches emphasise different ways of coping and thus general improvement in health and functioning without directly trying to control or influence their relatives behaviour. The SSCS model in particular may represent best practice in family specific support in addiction (Vellemian, 2010).

These approaches are applied across the FDH Helpline, the Support Groups and the ARC program. The Family Drug Helpline and Volunteer program is informed by best practice for peer-based support programs. It utilises the Five Step method of listening non-judgmentally; providing relevant information; exploring ways of coping; discussing social support; and, establishing the need for further help. The Family Drug Help Support Group program in particular provides peer
support, and improves the health, well-being and social connectedness of participants. Participants reported improvement in coping with their situation and their lives and attributed outcomes to participating in the support groups, which enabled them to share experiences and coping strategies. They also reported positive impacts on other family members (not attending the Support Group), including better communication and clarity about boundaries and responsibilities. The Family Counselling Service also directly contributes to these objectives, providing personalised support to clients wishing to improve their coping, management of their situation and family member, and health and wellbeing.

**Objective 6) Build a legacy of ongoing peer support**

Three of the four programs aim to provide peer support. The FDH Helpline provides an example of the development of a legacy of ongoing and sustained peer support for affected family members, with many of the volunteers being former clients of the FDH services, and a number of staff members being former volunteers on the Helpline. ARC graduates demonstrate leadership in other FDH programs such as the FDH Support Groups and Helpline. Further, the Support Groups contribute to the legacy of ongoing peer support for affected family members, with many members attending the groups for years and supporting newer members.

**Next steps**

On the whole, the evaluation identified that Family Drug Helpline and Volunteer Program, Action for Recovery Course, Family Drug Help Support Groups, and Family Counselling Service are delivered in line with their stated objectives, and to the satisfaction of participants. A few small areas for attention, including both challenges and opportunities were identified.

At the time of the evaluation the Family Drug Help Counsellor role was completed full time by a single counsellor. This was identified as a key challenge for the organisation. SHARC responded quickly to restructure their program model to employ two part-time family counsellors (the equivalent of 1FTE), implementing an effective strategy to mitigate the risks to service continuity posed by a single counsellor.

Better data collection by the programs would support a more robust evaluation and process of continuous improvement. The capture of information relating to participation in Support Groups (e.g. number attending, number per session) would assist with this, as would routine analysis and use of participant/client and staff perception of care surveys and health and wellbeing surveys (staff).

**Recommendation: Improve data capture to support evaluation and continuous improvement processes.**

**Opportunities**

Current policy and practice for drug and alcohol treatment highlights the importance of the involvement of families in that treatment (Roozen et al, 2010; NDS, 2011). There is also an increased awareness of the need for specific family counselling and support services. Particularly, programs need to address four key areas in which families are affected by and respond to a
relative’s problematic substance use, including the stress of worry and active disturbance to family life; the resulting strain on physical and mental health; their ways of coping; and, the social support they receive from others (Orford et al, 2010).

The FDH program is ideally placed to capitalise on this increased focus on the role of the family in substance use treatment, and in addressing the needs of the family members of a substance using individual.

Recommendation: Investigate opportunities to continue providing Support Groups, and/or strategies to address participant needs through other FDH programs.

Further, the FDH has the potential to inform the evidence base in family support practice in such areas as the place of mutual aid services as a social network replacement, the impact of the provision of support to families on treatment outcomes, and the impact of funding family support independently from treatment on family functioning, social functioning, social connectedness and treatment outcomes. An opportunity also exists to develop evidence based guides for participants, covering such information as how family members can understand and approach co-occurring substance and mental health issues, how to “lead loved one to” treatment and strategies to manage difficult issues.

Recommendation: Develop practice guidelines and session tools for family members in support groups.
REFERENCES


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Appendix 1 – Outcome Measures

Family Impact – Stress, Strain, Coping and Social Support

The Family Member Questionnaire (FMQ) assesses;

1. Stress in the form of worrying behaviour (FMI-WB) eg. “Are you worried that your relative has neglected their appearance or self-care?” and active disturbance (FMI-AD) eg. “Has your relative upset family occasions?”
2. symptoms of physical strain (S-PHYS) eg. “Awakening early and not being able to fall asleep again”, and psychological strain (S-PSYCH) eg. “Being irritable”
3. four different style of coping behaviours and
4. social support from family, friends and professionals.

These measures are based on the SSCS model of understanding the effects on family members of living with a relative affected by addiction problems, discussed above in the literature review, (Orford et al, 2010a & Orford et al., 2010b).

Personal Wellbeing Index (PWI) - Satisfaction with Life

The Personal Wellbeing Index (PWI) is designed to measure people’s subjective wellbeing or “satisfaction” with eight life domains and an overall score (Cummins, 2003). DeGraaf and Bruno (2010) report both the Australian normed score for these measures and the scores for the Tasmanian sample of injecting drugs users taken from the IDRS.

We have used the Australian normed scores represent an ideal score and the IDRS represent a proxy for the relatives personal well-being. We added two additional items, “How satisfied are you with 9) your family dynamic, and 10) your relationship with your relative.”

Contemplation Ladder (CL)

The Contemplation Ladder measures self-reported readiness to consider smoking cessation on a scale of 0 to 10, where 0 “I have no interest in making changes”, 5 “I know I should make changes but I’m not ready” and 10 “I’m already making changes”. The Contemplation Ladder predicted subsequent participation in quit programs (Biener & Abrams, 1991). The scale has been recently used to assess readiness to abstain from substance use and predicted participation in treatment and abstinence up to 1 year later for people in drug-free treatment, (Hogue, Dauber & Morgenstern, 2010).

We have amended the Contemplation Ladder to measure of readiness to change substance using behaviour of the relative as perceived by their family member, where 0 “they have no interest in making changes”, 5 “they know they should make changes but aren’t ready” and 10 “they are already making changes”. This amended scale is not intended as a proxy measure of the relative’s actual stage of change but the family member’s perception of relative’s stage of change.

The scale was also used to measure the family member’s readiness to change their own behaviour in response to their relative’s using.
Appendix 2 – Detailed description of the ARC program content

Week 1 – Stages of Change

After an introduction and orientation, the well-known stages of change are presented and discussed in relation to the relative’s drug use (Prochaska & DiClemente, 1984). Participants are then encouraged to apply the stages of change to their family’s situation and their own behaviour under the heading of the “Parallel Journey of the Family”

- “Do you feel like you are losing control of your life?”
- “Does the same thing keep happening over and over?”
- “Is there unwanted conflict in your life?”

Each stage of change is explored in terms of feelings and behaviours of the family members as they

1) become aware of emerging problems yet are unaware or in denial of the drug use (Pre-contemplation),
2) identify and accept there is a drug problem (Contemplation),
3) struggle to try and fix the problem (Preparation) the stage many participants are in when they seek help from FDH,
4) realise they can’t solve other people problems, only their own (Action/Maintenance),
5) relapse to the old problem feelings and behaviours such as trying to control their relatives behaviour (Relapse)

It is important to note how the focus of participants is drawn away from the relative and their behaviour back to the family member and their own behaviour. Indeed, after the first week, talk of the relative and their behaviour is discouraged and the focus repeatedly brought back to the participant and how they can change their own behaviour to better look after themselves and their other family members.

This is a good example of FDH’s overall attitude towards the relative’s drug use - one of acceptance and perhaps influence rather than control. Most family members come to FDH wanting to fix or control the problem yet the key message of FDH is that they cannot. They can only fix their own problems such as the way they react to their relative’s drug use which keeps them in the negative cycle that causes them such distress.

The Negative Cycle is described as:

- Reactive not proactive responding
- Confrontation and conflict
- No plan or strategies developed
- Overwhelmed by emotions
- No boundaries established
- Relatives’ behaviour reinforced

One section highlights how the family member and the relatives behaviour often mirrors each other and that by modelling healthy behaviour such as self-care and responsibility, the family
member may encourage similar behaviour in their relative. It is important to emphasise that participants are not encouraged to be passive in the face of their situation. While they participants are taught they cannot control their relative, they are given hope they may be able to indirectly influence their relative by changing their own behaviour.

A key distinction is made between being proactive and reactive, such as asking questions strategically rather than making demands. For example, the participants are given suggestions on how they can constructively communicate with their relative based on the relative’s stage of change.

For example, at the pre-contemplation stage, participants could subtly raise doubts by asking what the relative likes about using, what they don’t and what do they value in life. In contemplation, they can ask questions that help tip the balance towards change such as “What are some of the things you would like to do that you can’t because of your drug use?” and “What do you think may happen to your long term health?”.

**Week 2 – Boundaries**

Similarly the message of acceptance of the lack of control over their relatives drug use does not mean participants are encouraged to passively accept their relative’s unacceptable behaviour towards the family.

This week’s content focuses on how the participant can assertively and confidently establish boundaries focused on their own self-care rather than forcing change in their relative. Participants are encouraged to learn to define “what’s yours and what’s mine” and knowing when to step into or out of another’s problems. A key message is the distinction between the person and their behaviour - that it is possible to show unconditional love for their relative without letting oneself be exposed to their behaviour.

“We distinguish the person from their behaviour, we may withdraw from their behaviour but not from the person - behaviour is unacceptable but person is always acceptable. We use the metaphor of ships at sea – I will come by your side but I will not storm aboard.”

**Week 3 – Guilt and Worry**

The third week focuses on understanding and overcoming guilt and worry with practical activities based on the concepts of locus of control and achieving life balance regardless of what the relative maybe doing.

**Week 4 – Praise and Acceptance**

This week focuses on communication skills and the power of gratitude, acceptance and forgiveness in restoring and maintaining both personal well-being and healthy relationships with their relative and other family members.

**Week 5 – The Choice is Mine**

Positive psychology is the focus for this week and participants have the opportunity to hear from a person in recovery and gain insights into the world of addiction.
**Week 6 – Where to from here?**

This week focuses on planning and goals for the future including how to manage the stress of relapse. The participants are linked in with other FDH programs such as the Support Groups and Family Counselling. Participants are encouraged throughout the course to access the Helpline to review homework assignments and seek support.