



**The 'Can Do' Initiative:
Managing Mental Health and Substance Use in General Practice**

***'Can Do' for Young People, Families and Carers
Facilitator's guide***

***Presentations and facilitator's notes,
case studies and facilitator's trigger questions***

**Unit three: Families and Carers – *how can
we support and include them?***

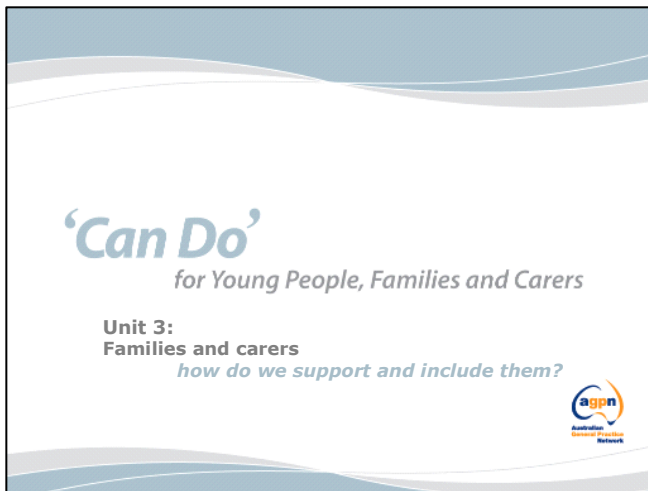
Joint learning module for general practitioners, allied health practitioners and other service providers involved in the provision of care for young people at risk of or experiencing mental health and substance use issues and their families and carers.

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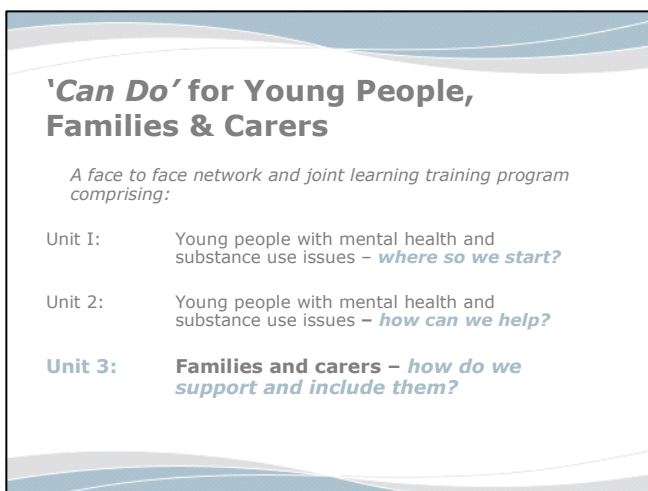
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Slide 1: Title page



This is the title slide for the session. It is a good idea to have this slide up as participants are entering and during welcome.

Slide 2: About the training module



This slide describes the whole training module

Key points

- Emphasise to participants that this is a series of three units.
- This is the final unit in the series, which will address the issue of inclusion and support for families and carers of young people with mental health and substance use issues.

The focus of this unit is on:

- Families and carers of young people with mental health and substance use issues.
 - Who are they?
 - Why are they important?
 - What they experience
 - How to support them
-

Slide 3: Learning objectives

Learning objectives

Participants will :

- Share information with other service providers
- Map local services
- Identify local networks
- Explore ways to work together
- Identify appropriate referral pathways for young people
- Understand the role and needs of families and carers

'Can Do' is about working together for better health and social outcomes

The overall educational goal of this accredited training program is to provide general practitioners, allied health professionals and other service providers with specific knowledge and skills to work with young people and their families and carers to improve mental and drug health.

Key points

Learning objectives aim to:

- demonstrate an increase in confidence, capacity and understanding of general practitioners, allied health professionals and other service providers when working with young people with mental health and substance use issues
- demonstrate an increase in awareness of the risks and protective factors associated with common mental health problems and substance use in young people
- demonstrate increase understanding of the role of families and carers in treatment of young people with mental health and substance use issues
- demonstrate increased confidence in providing support and understanding required by families and carers of young people with mental health and substance use issues
- identify health and community services at the local level, particularly those that engage with young people, their families and carers
- demonstrate an increase in ability and confidence in developing appropriate pathways of referral and care for young people with mental health and substance use issues and their families and carers.
- pathways of referral and care.

The following are the desired **key outcomes** of 'Can Do' for Young People, Families and Carers:

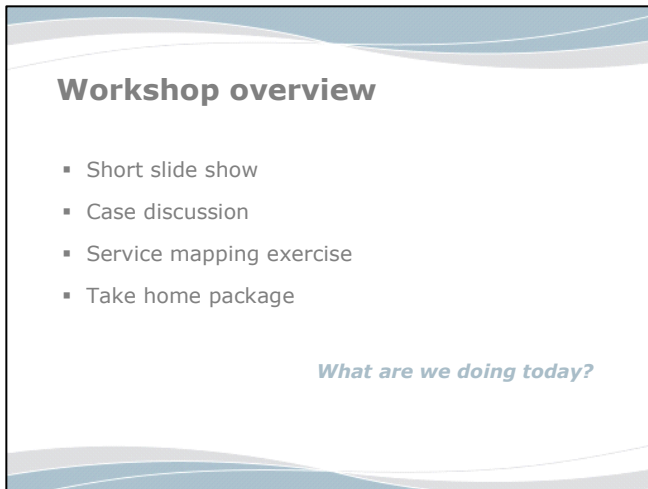
- local partnerships and interagency collaboration is fostered
- professional networking is enhanced
- young people's needs are understood
- families and carers are included
- shared care arrangements are understood and strengthened
- knowledge about local services is improved
- referral protocols and processes are identified

- care plans are streamlined
- stigma about working with young people with mental health and substance use comorbidity is reduced

This families and carers training unit provides the opportunity to:

- discuss how best to provide support for families and carers
 - acknowledge the challenges that face families and carers in their support of a family member
 - place emphasis on understanding the broad picture of issues affecting families and carers and
 - gain a better understanding of available local and national services.
-

Slide 4: Workshop overview



This slide provides an overview of the 'Can Do' for Young People, Families and Carers workshop format

Key points

- Provide an outline of the workshop.
 - Note that coexisting mental health and substance use in young people is an extensive and complex subject.
 - Key issues and ideas will be highlighted in the slide show.
 - Discussion of youth stories will provide an opportunity to share knowledge, skills and practical advice on working with young people, their families and carers.
 - Service providers will be given an opportunity to introduce their service in the service mapping exercise.
 - Additional material and references are in the take home package provided.
-

Slide 5: A typology of families and carers



A typology of families and carers

- Nuclear family
- Extended family members
- Blended families
- Single parent families
- Non-parental primary carers
- Partners
- Friends

Anyone who cares...

This slide defines 'family' under present day conditions.

The definition of a family member or a carer is any one who cares for and chooses to remain connected with a person with co-existing substance dependence and mental health issues. It is important to identify and accept that 'those who care' in the 21st century go far beyond the traditional concept of a nuclear family.

Key points

Family descriptions:

- **Traditional concept of a nuclear family** – a family group consisting of father, mother (married), and their children. The children have dual roles as sons and daughter, and as brothers and sister.
- **Partners** – including both heterosexual and same sex couples.
- **Extended family** - a family group consisting not only the nuclear family but also including the grandparents, aunts, uncles, cousins, and sometimes more distant relatives or kin.
- **Blended or step family** – a coupled family containing two or more children. Children may include the biological children of the couple as well as children from previous relationships.
- **Single parent families** – where either the father or mother is the primary carer.

Carer descriptions:

- **Non-parental primary carers** – when the biological parents are unable to care for their children, others step into the role of primary carer. These may include grandparents, foster parents, god-parents, adopting parents, other family members and more.
- **Mentors and Friends** – Those who do not fit into the above categories but still choose to remain connected – to care for, to support and to love. When a person with mental health and substance use issues does not have, or is disconnected from their family, friends, mentors and carers may be their only source of support.

Additional information

Blended family and stepfamily – often used interchangeably. The National Family Resource Centre (US) notes that members of a stepfamily are sometimes expected to blend into an entirely new family unit, which may cause them to lose their individuality and attachment to other outside family members.

Grandparents – there are increasing numbers of grandparents with children with mental health and substances use issues who subsequently become the primary carers for their grandchildren.

Grandparents may be coping with:

- the loss of 'normality' as a grandparent
- loss of time with their peers
- having to be a parent again to a younger generation
- stress and physical exhaustion in caring for a young child again
- mourning the loss of retirement – a time to enjoy the fruits of their lives
- custody issues
- financial burden
- relationship issues with their adult child/partner.

In some instances this may be compounded by mental health and substance use issues emerging in the grandchild.

These issues impact on the health of the grandparent and on relationships between grandmother/grandfather and other family members and friends.

References:

- Grandparents raising Grandchildren Tasmania. [online] available: <<http://www.grandparentsraisinggrandchildrentas.com.au>>
- Maclaine, J. & Townsend, H. (2001). *When someone you love is addicted to alcohol or drugs*. Bantam Books: New York.
- National Stepfamily Resources Center. Frequently Asked Questions: Stepfamilies and Blended families. [online] available: <<http://www.stepfamilies.info/faqs/faqs.php>>
- Newman, M. (1994). *Stepfamily Realities: How to overcome difficulties and have a happy family*. New Harbinger Publications, CA.

Slide 6: Importance of families and carers

Importance of families and carers

- Families and carers are the most important resource
 - able to grow, change and adapt
 - experts with wisdom, strength and experience
- Young people who remain connected to families or carers do better in treatment for mental health and substance use

Connection leads to better outcomes

Hartnoll 1992; Spooner et al 1996; Treloar et al 2005

Support from family and friends has been important for those who wish to moderate their drug use without seeking professional help (Shearer et al 1999; Dietze et al 2003) and in the treatment seeking process (Hartnoll 1992; Treloar 2005). Stanton (1997) in a review of studies on the topic of the role of family and significant others in the engagement and retention of drug dependent individuals points out that whether or not drug dependent people actually live with their parents the evidence suggest that most are closely tied to their families at many points with communication often routed through siblings, relatives and spouses and that they tend to use a given household as a constant reference point in their lives.

Key points

- Families play an important role in identifying the need for treatment, facilitating entry into treatment and providing support during treatment processes (Mitchell et al 2001).
- Research shows that family involvement in treatment has a positive impact in adolescent treatment retention. Family involvement may be difficult to achieve and is even less likely if it is not actively recruited. Approaches employing active engagement of the family have been trialed with positive effect, although they might need some modification with different cultural groups (Spooner et al 1996).
- Families and carers need to be supported and nurtured themselves. Health professionals and community services are a source of strength for families and carers – including general practice, alcohol and drug and mental health services, community pharmacy, youth services, family support groups and more.
- Growth, change, & adaptation – change is inevitable within the family context and it can be either positive or negative. The same holds true for the influence families and carers have on a young person's mental and drug health. The move towards potential change and positive outcomes enhanced by providing support, education to families and carers and encouraging self-care.
- Families and carers are the experts when it comes to knowing the young person. It is important to acknowledge that families and carers are ideally placed to support a young person who may be experiencing mental health and substance use problems.

Additional information

Involvement of all family members is preferable – however, this is not always realistic. Effective change is achievable with one or more supportive and committed family members.

Unbundling the behaviour from the person – families and carers are able to remain connected when they can separate the young person from the behaviours associated with drug use and mental health issues.

As one person put it *'I would have been dead ages ago if it wasn't for my family. The fact they remain connected despite my behaviour was what kept me going.'*

References:

- Dietze P, Richards J, Rumbold G, Aitken C, Day C, Ritter A. (2003) Treatment utilization by heroin dependent persons in Australia: Implications for treatment service systems. Fitzroy, Victoria: Turning Point Drug and Alcohol Centre.
- Hartnoll, R. (1992) Research and the help seeking process. *British Journal of Addicition* 87, 429-437.
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- Gossop, M. (1996). *Living with drugs*. Arena: UK.
- Mitchell, P., Spooner, C., Copeland, J., Vimpani, G., Toumbourou, J., Howard, J., & Sanson, A. (2001). *The role of families in the development, identification, prevention and treatment of illicit drug problems*. Commissioned by the National Health and Medical Research Council for the Strategic Research Development Committee's National Illicit Drug Strategy Research Program. Canberra: Commonwealth of Australia.
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- Shearer J, Wodak A, Mattick R, van Beek I, Lewis J, Hall W, Doan K (1999) *A randomized controlled trial of the feasibility of monitoring controlled prescribing of dexamphetamine*. Technical report No 75. National Drug and Alcohol Research Centre, Sydney.
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- Treloar C; Abelson J, Brener L, Kippax S, Schultz L, Schultz M, Bath N. 2005. *Barriers and incentives to treatment for Illicit drug Users*. National Drug Strategy Monograph No 53. Cmwth of Australia.
- Holt M, Schultz L, Schultz M , Bath N. 2006 *Barriers and incentives to treatment for illicit drug users with mental health comorbidity and other complex vulnerabilities*. (in press *National Drug Strategy monograph*) Cmwth of Australia.

Slide 7: Who are families and carers supporting?

Who are families and carers supporting?

Young people 12 -25 who may be:

- at different developmental stages of their life
- living at home or away from home
- in early stage mental health and/or substance use issues
- experiencing years of problematic mental health and substance use
- in trouble with the law
- alienated from mainstream society
- aggressive and abusive towards families and carers

It is important to take into consideration the age, gender and developmental stage of the young person that the family or carer is supporting. Young people are not a homogenous group. Young people who have mental health problems or use drugs are real people and individuals. Avoid labels like 'dual diagnosis', 'addict' or 'junkie'. Young people with mental health and substance use issues are someone's son, daughter, father, mother, partner or friend. The use of labels is not helpful and increases stigma and social isolation.

Key points

Families may be helping a young person with mental health and substance use issues who:

- is living at home (and sometimes their partners as well)
- has other siblings in the home
- is living away from home
- is in detention
- is in a residential treatment program
- is transient and presents at home occasionally
- has disappeared from home and with whom they wish to restore contact.

Families will be coping with different issues depending on the age and development stage of the young person. For example:

- **12 – 15 y/o** usually involves school attendance; increased exposure to alcohol, tobacco and illicit substances; increasing autonomy or desire for autonomy; increasing awareness of sexuality; profound hormonal changes occurring; still legally considered a child.
- **16 – 19 y/o** involves the assumption of formal adult status; begin to be treated as adults under the law; permitted to drive motor vehicles; may be completing school and attempting university entry or may have left school and be working, training or unemployed. May be living at home or have left home. Experimental substance use and sexual activities are common for this age group.
- **20 – 25 y/o** increasing assumption of adult responsibilities and freedoms. Likely to be regarded culturally and socially as adults.

Additional information

Where young people have experienced long periods of problematic mental health and substance use it is quite common for them to have missed out on many of the usual learnings that are experienced during adolescence. This can mean they are less aware, less able to rationalise and have poorly developed coping skills. Adult carers may 'expect' that they will behave and cope in the same way as other young people in their age group. This mismatch between adult expectation and the abilities of the young person can exacerbate conflict and reduce self esteem and resilience in the young person.

References:

AIHW (2007) Australian Institute of Health and Welfare 2007. Young Australians: their health and wellbeing 2007. Cat. no. PHE 87. Canberra: AIHW.
Nicholson, J., Carroll, J.A., Brodie, A., Waters, E., & Vimpani, G. (2004) Child and youth health inequalities in Australia. The status of Australian research 2003. Paper prepared for the Health Inequalities Research Collaboration: Children, Youth and Families Network, October 2004.

Slide 8: Making the first contact

Making the first contact

- GPs are often the first point of contact with the health care system
- Families and carers may be accompanying a person with mental health and substance use issues or as a patient themselves
- Families often present in crisis or when a major event has occurred – e.g. the young person has been in trouble with the law
- Families and carers are often in need of some support for themselves.

Who can they turn to?

For many families and carers, a visit to the GP is often their first contact with the health care system. This may be because families and carers have a long term trusting relationship with a GP or may be because families and carers are taking or accompanying the young person to the GP because of their mental health, substance use or another matter. Families often present in crisis, with or without the young person. It is important to consider both the role the family or carer can play in supporting the young person AND the health and wellbeing of the family members or carers.

Key points

- For many families and carers, a visit to the GP is often their first contact with the health care system.
- Distinguish between the young person's needs and the family needs
- Follow the same 'rules of engagement' that were discussed in unit one
- Outline the way your service works with young people and how you include families and carers
- Make sure issues related to confidentiality are explained and understood
- Point out the fact that there are two issues here – the health and wellbeing of the young person and the health and wellbeing of the family member or carer and that at times these will need to be considered separately.
- Arrange for time for thorough assessments to take place either through your service or by appropriate referral.
- Encourage the young person and/or the family member to come back so care plans can be worked out and support strategies can be discussed

Additional information

Accompanying the person with drug and/or mental health issues

The young person is the primary patient or client. It is helpful to outline the way in which your service works with young people and their families and to gain as clear a picture as you can about the current relationships between the young person and the family. As for any other person, it is important to obtain a thorough history, undertake a comprehensive assessment of physical and mental health (including substance use) and social circumstances. Depending on the age of the young person, this

may best be undertaken without the family member or carer present so that confidentiality is maintained.

Including family members and carers in care planning is a useful way to verify the young person's experiences. They should also be offered time for discussion of their own circumstances and current health and wellbeing.

Families and carers may be presenting to a health or community service as a 'last resort' having tried to cope with the young person's mental health and substance use by themselves for some time. Frequently families and carers contact a health service at the time of a crisis or just after a crisis has occurred for the young person.

The family member or carer may present as the patient with a myriad of symptoms.

It is not uncommon to find the following:

- uncontrolled crying
- eating disorders
- relationship problems
- alcohol misuse
- prescription drug misuse
- sexual dysfunction
- suicidal thoughts
- uncontrolled anger
- insomnia.

Slide 9: Engaging with families and carers

Engaging with families and carers

- *Establishing trust through*
 - Maintaining confidentiality and safety
 - Establishing roles and boundaries
 - Remaining non-judgmental

- *Reality based support through*
 - Differentiating the young person's needs from the family member or carer
 - Not looking to 'fix' the problem
 - Empathy and listening
 - Acknowledging the need for on-going support

Sending out consistent messages

It is important for families and carers to be provided with an environment that will motivate and enable them to access on-going support.

Key points

- establishing trust
- defining professional roles and boundaries
- remaining non judgemental
- ensuring confidentiality for all parties
- differentiating the young person's needs from the family's or carers' needs
- validating the role of family and carers
- building on family and carer strengths
- setting realistic goals
- providing practical advice, information and support strategies
- referring to other services where appropriate.
- reviewing frequently

Additional information

Establishing trust –shame/stigma, emotions and past experiences would have a negative and cumulative effect on families and carers. They also become hyper-vigilant towards people judging them, feeling unsafe, and of not being able to trust. Being let down has often become the norm.

Identifying strengths – focus on drawing out the strengths and what's worked for families and carers in the past rather than dwelling on problems and barriers. Keep solution focused!

There are no 'right or wrong' ways for families and carers. Each family has its own unique set of circumstances and people involved. Generally, families do the best they can with the skills and experience they have and according to the circumstances at the time.

Defining professional roles and boundaries – these are critical areas to establish. It is important to start the engagement process by explaining and establishing what your service can do and what it cannot or will not do.

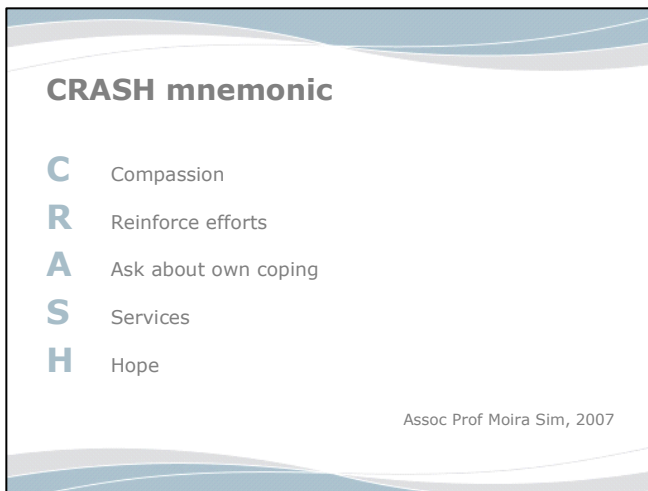
Realistic modes of engagement – the following are useful in relating with families and carers effectively:

- **Recognise the stage that families and carers are at:** Remember that what may seem simple to you (eg 'go and talk to this service') may be just too great a hurdle for someone who is emotionally and physically exhausted.
- **Avoid 'fixing the problem'.** This is what the family or carer has been trying to do for some time. Families and carers have had their fair share of others trying to solve the problem for them.
- **Empathy and listening** - most family members and carers would have tried most things. Some might have received and acted upon advice that have had negative results. Others might have taken advice that they were not comfortable with but have nonetheless acted upon. Ask about their experiences.
- **Acknowledging the need for on-going support** – recognise that this is often a long journey.
- **Validating their role** – acknowledging and strengthening the importance of their supportive role and their choice to remain connected.
- **Respecting their expertise** – that they are the experts when it comes to their family and loved ones. No one knows them any better.
- **Acknowledging their strengths, wisdom, and experience** – that despite the difficulties, families and carers have survived this far. This takes an enormous amount of strength and wisdom.

References:

ETR Recapp. Non-profit Health promotion & education. *Adopting a non-judgment stance*. [online] available: <http://www.etr.org/recapp/practice/edskills200011.htm#AdoptingNonjudgeStance>
Trimingham, T. & Heslep, J. (2002). *A guide to coping: A guide to for families and carers in coping with problematic drug use*. Family & carer resource kit. Family Drug Support: Leura NSW.
Trimingham, T., Rose, J., & Houareau, C. (2001). *Stepping Stones to Success Manual – an experiential course for families and carer supporting a drug user*. Family Drug Support. Unpublished.

Slide 10: CRASH mnemonic

A slide titled "CRASH mnemonic" with a decorative header and footer. The content lists five points: C (Compassion), R (Reinforce efforts), A (Ask about own coping), S (Services), and H (Hope). The text "Assoc Prof Moira Sim, 2007" is at the bottom right.

CRASH mnemonic

C Compassion
R Reinforce efforts
A Ask about own coping
S Services
H Hope

Assoc Prof Moira Sim, 2007

The above mnemonic can be used when working with a family member or carer of a young person with mental health and substance use issues.

Key points

- C Compassion: acknowledge the difficulties the family has experienced.
- R Reinforce efforts: there is not right way, whatever they have tried is part of a learning curve and worth trying.
- A Ask about own coping: how is the family member or carer surviving the journey so far?
- S Services: give the family a list of services and resources that they can get assistance from.
- H Hope: reinforce the message that most drug users do eventually stop, hard as it is to feel like one can do nothing.

More about these points and how to implement them will be discussed in the next slides.

Reference:

Assoc Prof Moira Sim, Edith Cowan University, 2007

Slide 11: CRASH – Compassion

CRASH - Compassion

Acknowledge the difficulties experienced:

- challenge of mental health and substance use
- impact of caring for young people with mental health and substance use issues
- burden of caring
- a confusing world
- shame, stigma, guilt and blame

These will be discussed in the next five slides

Many families and carers just want to know that they are not the only ones going through this experience and that their difficulties are understood. Many of these difficulties can be minimised by appropriate support and referrals from health professionals. Each of the difficulties listed here will be discussed in more detail on the next slides.

Slide 12: CRASH - Compassion: Challenges of mental health and substance use in the family

CRASH - Compassion

The challenge of mental health and substance use

- Drug use or mental illness are complex enough on their own
- Co existing mental health and substance use brings greater complexity:
 - Increased stigma and alienation in community
 - Difficulties with diagnosis
 - Difficulties in finding coordinated care
 - Medication interactions with drug of choice
 - A higher level of care
 - Less stability
 - Psychotic episodes

It is so much more complex and chaotic

Supporting a young person with substance use or with mental health is complex enough. Coexisting mental health and substance use increases the complexity especially when it comes to access and retention of the young person with health and community services. Life can become chaotic for both the young person and for their families and carers. There may be difficult or antisocial behaviour, non compliance with family values, non compliance with treatment and/or psychotic episodes – all of which put high demands on the level, type and consistency of care provided by families and carers.

Key points

- Mental health and substance use are chronic relapsing conditions.
- Young people present with a wide range of characteristics and symptoms.
- Families expect a quick fix for the young person and gradually adjust to the fact that this is a long term process.
- Families frequently find themselves going from one service to another.

Additional information

Common characteristics of a person with unstable mental health and substance use: all or some of these impact at various times on family and community values and lifestyles.

- chaotic life
- may not cooperate with their health care providers or families
- may be non-compliant or erratic with medication
- emotionally labile
- may have disturbed sleep patterns
- may have psychotic episodes including aggressive or violent behaviour
- may be homeless, or else moving frequently from one place of residence to another
- likely to relapse (drug use)
- repeated long-term hospitalised/ institutionalised or taken to casualty departments
- nicotine dependency
- poor physical health
- broken relationships
- debt

- in trouble with the law

Seeking treatment and support

- Families initially seek a 'quick' fix for the young person's problems. It takes time to adjust to the fact that mental health and substance use issues are usually long term and that improvements come in small steps, often with retrograde as well as progressive steps.
- Families can find themselves going from one service to another as the young person is passed between mental health, drug and alcohol and other services.
- People with mental health co-morbidity respond well to an integrated approach towards mental health and substance use. Service that take this approach are limited, although recent policy initiatives at Federal and State level encourage improvements in integration of services.

References:

- Copeland, J., Gerber, S., & Swift, W. (2006). *Evidence-based Answers to Cannabis Questions*. Australian National Council on Drugs: Canberra.
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- Minkoff, K., & Drake, R.E.(1991). *New Directions for Mental Health Services, Dual Diagnosis of Major Mental Illness and Substance Disorder, No. 50*. Jossey-Bass: New Jersey
- SANE Guide to Families #16231. Sane Bookshop/Sane Guides: Melbourne VIC
- SANE Guide to Drugs #16136. Sane Bookshop/Sane Guides: Melbourne VIC

Slide 13: CRASH - Compassion: Impact of caring for people with mental illness and substance use issues

CRASH - Compassion
Impact of caring for people with mental illness and substance use issues

Research data on 'the effects of caring for someone with mental illness'

- 56% stated their physical and mental health was worse
- 72% received no rehabilitation or community support
- 70% received no training or education
- 54% had no access to carer support services

SANE Australia – Sane Research Bulletin (July 2007) www.sane.org

Most do not get or feel supported...

Young people who have a caring consistent adult 'other' supporting them do better in treatment and experience better health outcomes in the long term. In 2007 SANE identified the challenges that face families and carers of those with mental illness or substance use issues. Although this survey relates to the general population and not just to families and carers of young people the findings are significant in terms of the negative experiences described. The statistics above indicate some of the burden that falls on families and carers.

Keys points made by families and carers

- **State of physical and mental health** – 56% of respondents identified:
 - frustration and anger due to lack of consultation from professionals
 - being disregarded and excluded from treatment planning
 - feeling alienated in their community
- **Rehabilitation or community support** – **72% did not receive any.**
 - 50% have trouble finding accommodation for those with mental illness
 - 50% have experienced verbal aggression
 - 25% have experienced physical aggression
- **Training or education about mental health/substance use** – **70% never received any.**
- **Accessing support services** – 54% did not access any support.
 - 32% used the internet to find information
 - 5% used telephone support
- **Summary of findings (SANE 2007)**
 - Families and carers report a range of health, financial and other problems when caring for the mentally ill
 - Families remain unsupported and isolated
 - There is an expectation from mental health professionals for families to provide the day-to-day care without being provided with support or the information to carry out this role
 - Majority of families struggle alone without help or support
 - Almost 75% receive no education or training on how to care for someone affected by mental illness
 - Families and carers urgently need practical day-to-day support

- Families and carers want respect from mental health professionals and inclusion in treatment planning and programs

Additional information

An Australian study (Treloar et al 2005) reviewed more than 100 written accounts of personal experiences, mainly drawn from Family Drug Support (FDS) and the Australian and Illicit Drug Users League (AIVL) and printed in the records of national conferences and newsletters. The focus was on people who use illicit drugs, many of whom also had mental health issues. These stories were coded into broad categories and analysed according to main themes.

Main themes from an examination of available family and user written stories

Demographics: The experiences show that dependent drug use can happen to anyone, irrespective of education, economic status, employment or locality.

Family Types: The families of drug users in these stories could be grouped into three broad categories: those who did not want to know, those who helped and those who wanted to help but did not know how.

Hitting Rock Bottom: Families had a strong aversion to agencies waiting until a substance user reaches rock bottom before offering treatment. 'She hit rock bottom alright, but now she's dead and what can you do once you're dead?'

Treatment Episodes: After the initial hope and search for a quick fix, families become resigned to view treatment as a 'long and bumpy journey' but encourage others 'not give up on your kids'.

Family Support: Families would go to considerable lengths to help, even to the extent of providing funds or even procuring drugs for their child.

Treatment works: Families had mixed views on whether 'treatment works'. This however, could reflect their earlier search for a 'quick fix'.

Inclusion in Treatment: On the whole families felt excluded from treatment, although individual service providers and counsellors were found to be useful.

Substance user contact with family members: Whether or not users with problematic drug use were actually living with their parents, those included in this sample were closely tied with their families. Users regularly or periodically made contact with a family member.

Eligibility: There were many examples of users and their families experiencing knock backs when seeking treatment. For example, users were turned away because they were too young, didn't look like an addict, their dole cheque was too low to cover costs or because they also had mental health problems.

Treatment staff and treatment philosophies: In general there were two types – those who sought to empower and those who sought to straighten and punish the user.

Inappropriate treatments: There were many examples (eg an 18 year old girl placed in a detoxification service with middle aged male dependent drinkers).

Social stigma: Widely encountered (eg 'we live in a country town so everyone knows her and her addiction. We have to put up with the glares, gossips, police, courts and the embarrassment to us all in our family')

A plea for normalisation: As a society, we need to look closely at our values regarding those who need our help and try not to judge them'.

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Slide 14: CRASH - Compassion: The burden of caring

CRASH - Compassion

The burden of caring

- Fear
- Loss of trust
- Alienation
- Broken relationships
- Financial losses
- Grief & loss
- Conflict and violence
- Declining health and well-being

Will this journey ever end?

Families and carers are often left on their own to carry many burdens. There is a general lack of understanding, much less empathy, from others in society. Contrast the differences in acceptance, services and support infrastructure between families and carers of someone with a chronic disease (cancer, diabetes, asthma) versus those with drug and/or mental health issues.

Key points

The level of stress experienced by families is high. Stressors include:

- **Fear** – the family fears for the safety of the young person and sometimes for their own safety.
- **Loss of trust** – trust with the young person may never be fully re-established. Other aspects of trust are also affected.
 - **Trust of self** – ‘am I able to make the right decision or do the right thing?’
 - **Am I trustworthy** – ‘am I manipulative, do I spy on the user, do I collude with other family members and so on?’
- **Alienation** – left unsupported, families and carers feel as though they are the only one travelling this journey. They feel that no one can possibly understand. Shame and stigma play a big part in enforcing this isolation and helplessness. Normal greeting rituals among family and friends and the exchange of news about family members becomes something to avoid.
- **Relationships** – relationships between family members may be strained because of the young person’s behaviour. Differences of opinion between family members about the best way to manage situations are common.
- **Financial losses** - from a monetary perspective, families and carers carry most of the burden that would otherwise have fallen on government and services. In extreme cases, they have exhausted all their resources and are in danger of relying on welfare for their existence.
- **Grief and Loss** – families and carers grieve for the loss of the young person they knew before the onset of mental health and substance use problems. Society, through a lack of understanding and driven by negative stereotypes, often condemns those who have mental health and substance use problems. Negative statements such as the following are hurtful but not uncommon, compounding family grief:
 - ‘Let him go, he is not worth worrying about!’
 - ‘Why are you destroying yourself trying to save her?’

- 'Aren't they better off dead?
 - **Conflict and violence** – Conflict, physical abuse and on-going emotional abuse are realities when dealing with young people with mental health and substance use issues. For many families and carers, these are not isolated instances but are part of an on-going cycle of abuse.
 - **Declining well-being** – self-esteem/worth erodes away. The lack of self care also begins to take its toll spiritually, emotionally and physically as exhaustion increases.
-

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Slide 15: CRASH - Compassion: A confusing world



CRASH - Compassion
A confusing world

- Mixed messages from everywhere
- Segregated services
- Lack of services for young people
- Bewildering array of treatment options
- Significant shortage of support services for families and carers

What is myth and what is real?

There is a bewildering and conflicting array of messages about mental health and substance use. Finding the right services to support the young person opens up another set of confusion. Barriers include restrictive service policies and protocols about access to treatment, mixed messages about suitability of treatment options, and lack of integration of services. The young person and their family or carer often have to tell their 'story' many times over. Families may be searching for a 'cure' – unfortunately none of the strategies on offer will be the magic bullet they are searching for.

Key points

Terms families will hear through media, government policy, treatment services, friends and others include:

- 1. Harm minimisation** – Harm Minimisation/reduction has been National Drug Policy since its introduction in 1984. It encompasses supply reduction, demand reduction, and harm reduction. It includes abstinence as part of its many strategies. It is also associated with a primary emphasis on maximum social, occupational and emotional functioning rather than on an absence of substance use alone. Simply, it is about keeping people safe.
- 2. Tough love** – a 'throw them out' until they reach 'rock bottom' strategy. Unfortunately, for some, rock bottom can mean suicide or death from substance use. Tough love may fragment the family structure – it may not be possible to unite the family again or regain trust and connectedness with the young person.
- 3. War on drugs** – Strategies focused on abstinence and getting rid of drugs in society. Those who use drugs or who support a person who is a drug user may be seen as 'the enemy'.
- 4. Just say no** – popular as a preventive measure in school education especially in the US. There is no evidence to say using this strategy with a young person works. However, the primary message to young people (and others) should always be that it is better not to use drugs.
- 5. Pharmacotherapy** – there are a number of different treatments available for treating substance use. Families and carers need to be aware of the realities of these treatment options and the support that a young person will need to access and remain in treatment. Some pharmacotherapies are offered through general practice and others through specialist services.
- 6. Psychological strategies** – brief intervention, motivational interviewing, counselling and cognitive behavioural treatment.
- 7. Self help** – 12 step program, AA, Narcotics anonymous, websites etc.

Additional information

Service provision – the quality and availability of services ranges from poor to excellent. Some areas have very little choices while others have more. Rural areas generally have limited resources to offer and services specifically for young people maybe hard to find. This varies greatly from area to area, within metropolitan areas and more so in regional and rural areas. In some places, services are simply non-existent.

Integration of services– Up until recently (as is still the case in many areas), drug and alcohol services, and the mental health units were separate entities. For families and carers dealing with mental health co-morbidity with drug use, they were shunted from one to the other repeatedly. Services are now moving to embrace multidisciplinary team approaches and integration of services but this will take some time.

Evidence-based treatment options that families and carers will hear about:

- 1. detoxification** – withdrawal from substance use. Options include medically or non-medically assisted and with or without supervision. Detox can take place at home or through inpatient or outpatient services
- 2. rehabilitation** – long term or short-term, inpatient or outpatient. Most rehabilitation services are abstinence based with many following the 12-step program
- 3. abstinence based** – 12 step programs including Alcoholics Anonymous and Narcotics Anonymous models.
- 4. pharmacotherapy**– e.g. methadone/ buprenorphine/ suboxone treatment programs for illicit drug use
- 5. prescribed medication** –prescribed by a GP or specialist to relieve symptoms or effects of mental health and substance use
- 6. psychiatry** – management through a psychiatrist of mental health problems – usually includes medication
- 7. psychology services and counselling** – counselling through a clinical psychologist, drug and alcohol counselor or other mental health services.

Support for families and carers

There are a handful of formal support services for families and carers of people with mental health and substance use – these include:

- Lifeline
- Inspire Foundation
- SANE
- Family Drug Support
- Carers Association

Generally, there is greater family and carer support through mental health services than through alcohol and drug services.

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Slide 16: CRASH - Compassion: *Shame, stigma, guilt and blame*

CRASH - Compassion
Shame, stigma, guilt and blame

- Families and carers are influenced at four levels:
 - Personal
 - Interpersonal
 - Organisational (institutional) and
 - Societal
- Shame, guilt and blame results from the community and societal stigma surrounding mental health and substance use.

It must be me...who can I trust

When mental health and substance use issues are present, families and carers are pulled in many negative directions.

Shame How could this happen in my family?

Stigma I feel judged by others for these problems

Blame Others blame me and I blame others (police, government, their friends etc)

Guilt Is it something I did or didn't do?

Key points

Shame, stigma, blame and guilt can come from many sources. A number of values are associated with these and may be influenced at several levels: (adapted from Winnett et al 1989)

- **Personal** – “it must be my fault”. Health and illness are primarily a result of personal lifestyle and actions.
- **Interpersonal** – “it must be the parents” - health and illness is influenced by family, friends, work colleagues and other social groups.
- **Organisational/institutional** – “young people’s use of ice is causing violence in our neighbourhoods” - health and illness is influenced by organisational factors and by the environment.
- **Societal** – “we don’t want people like her on our streets” – “methadone clinics are full of dealers” - health and illness and access to treatment is influenced by community norms.

Seeking help can also be fraught with negative attitudes

- **Judgmental** – usually from people who don’t understand or are fearful – that it is somehow contagious.
- **Confidentiality** – Can people be trusted?
- **Bias** – this is encountered everywhere. Even people who are highly educated and should know better can have surprisingly bias views when it comes to drugs and mental health issues.

Additional information

Inappropriate advice and guilt – people who are judgmental are prone to give inappropriate or untimely advice that can lead to negative consequences. In times of chaos and desperation, families

and carers may act on advice that they really did not want and ultimately cannot live with. In the end, families and carers can end up with more guilt as they attempt to live up to someone else's standards and expectations.

Families and carers do the best they can – they generally do the best they can with the knowledge and experience they have at the time and according to their particular circumstance.

Isolation & helplessness – with negative attitude felt towards self and coming from others along with negative consequences of reaching out for help, families and carers withdraw from seeking the very support they need.

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Slide 17: cRASH - Reinforce efforts

cRASH - Reinforce efforts

- How families and carers react
- Cycle of change
- Readiness to change – of young person and family/carer

These points will be discussed in the next three slides

There is no right way – all efforts are part of a learning curve and worth trying.

In order to support and encourage families and carers it is important to reinforce that the efforts they have made so far were not useless and that how they have reacted to and changed because of the mental health and substance use issues of the young person is normal.

These points will be discussed in detail in the next slides.

Slide 18: cRASH - Reinforce efforts: *How do families and carers react?*

cRASH - Reinforce efforts

How do families and carers react?

Families and carers fall into three categories:

1. Active
 - do care
 - active in seeking help - highly motivated
2. Challenged
 - do care but don't know how
3. Uninvolved
 - don't care or don't need to
 - negative over involvement

Some do, some want to, some don't care to

Families and carers fall into three categories in terms of how they react to mental health and substance use. They may be actively involved in supporting the young person, challenged by the behaviours and unsure how to offer support or uninvolved and distanced from the young person. Within a family, individual members may differ in their choice and ability to offer support. It is important to acknowledge these differences and to accept that generally there are no 'right or wrong' approaches.

Key points

- 1. Active** – families and carers are generally supportive and involved. They are highly likely to have good communication skills and actively seek to engage with the young person and treatment and support services. There is a higher level of self-awareness, willingness to change, and they are generally well educated and articulate.
- 2. Challenged** – families and carers do want to be supportive and involved but are up against barriers when seeking ways to support the young person. This may include language and cultural differences. Often, the level of exhaustion centred around coping with mental health and substance use problems in the family restricts motivation and ability to problem solve. Once these barriers can be overcome, they become 'active'.
- 3. Uninvolved** – families and carers for a variety of reasons do not engage or are alienated from the young person. Some may be emotionally and/or physically disconnected from the young person because of the mental health and substance use problems. Others do care but are negatively connected through enmeshment and over-involvement. They work to defined agendas and high expectations, and see no reason for needing external help. Control may lead to 'either/or' situations in which the young person is excluded from support until they conform to parental or family requirements. This may drive young people away from the family temporarily or permanently.

Families and carers in the first two categories are also more likely to be involved in seeking support for themselves and to accessing support services that may assist both the family member and the young person.

Additional information

Below is an example that shows how family members and carers access existing support services. The data comes from Family Drug Support which is a national organisation that provides 24 hour telephone support, face to face support groups, and educational and experiential workshops for families and carers.

1. Family Drug Support 24x7 Telephone Support services statistics –

Telephone Support statistics by gender

Females	70%
Male	30%

Telephone Support statistics by families and carers

Mothers	41%
Fathers	9%
Siblings	7%
Grandparents	2% (increasing)
Other relative	4%
Friends	6%
Partners	14%
Others	17%

Family Drug Support- 24x7 Telephone Support Statistics 2006-2007 of 26,000 calls

2. Weekly/fortnightly support groups

Females	70%
Male	30%

Family Drug Support – National Support Group Statistics 2006-2007

3. Education & experiential groups (27 hours)

Females	70%
Male	30%

Family Drug Support – Stepping Stones to Success Statistics 2004-2007

References:

Family Drug Support 2006-2007 Telephone Support services statistics.
Family Drug Support 2006-2007 National Support Groups statistics.
Family Drug Support 2004-2007 Stepping Stones to Success statistics.

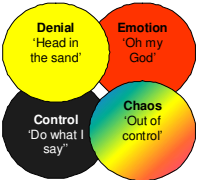
Slide 19: cRASH - Reinforce efforts: Cycle of change for families and carers

cRASH - Reinforce efforts

Cycle of change

Families and carers move through various emotional stages in the cycle of change

- Denial
- Reaction
- Control
- Chaos
- Acceptance



Around and around we go...again

The 'Stages of Change' model (Prochaska and DiClemente 1986) is widely referred to when working with young people with mental health and substance use. It is used to gauge a person's readiness for change of their drug use and identify where he or she is in the 'cycle of use'. You were introduced to this model in Unit One.

Families and carers also have their own cycle of change. These are outlined in the slide.

Key points

- There are five stages which families and carers go through when confronted with mental health and substance use issues in the family.
 - Denial
 - Reaction
 - Control
 - Chaos and confusion
 - Acceptance
- Families often get stuck in the first four stages of the cycle, becoming repeatedly more exhausted and reducing opportunities for positive support for the young person.
- Families need help themselves if they are to move into acceptance of the young person's mental health and substance use issues.
- Health professionals and support groups play an important role in supporting families and carers to reach this stage.

Additional information

The following points expand on the five stages of the cycle:

Stage 1 – Denial:

- don't want to know or are not ready to face reality
- only hear what they want to hear (self-deluded) – (e.g. finding injecting equipment and accepting the young person's explanation that it belonged to a diabetic friend)
- little to no awareness and knowledge about mental health and substance use
- Denial/minimisation can have both beneficial and negative effects:
 - Beneficial: gives positive expectations, avoids stigma and keeps the family/carer in the mainstream

- Negative: avoidance of treatment, cause the family to blame the young person's "bad" behaviour, or leads to excessive demands being placed on the young person (e.g. return to university).
- Families in this stage are often beginning to isolate from society and other family members (disengagement)
- Families can often re-enter denial – thinking problems have been fixed. They might have had some initial success and feel their problems are over only to find them repeated.

Stage 2 – Reaction:

- feeling shame and judged by others
- feeling emotionally 'all over the place' – a sense of being out of control and powerless
- feeling negative emotions range from guilt, uncontrolled anger, anxiety, fear, great sadness through to grief
- feeling stressed and torn in many directions
- looking to blame – government, police, dealers, their partner, their friends etc

Stage 3 – Control:

- adopting a rigid black or white stance
- ordering, confronting, and issuing ultimatums
- becoming judgmental and hard-lined with unrealistic expectations and hidden agendas
- expecting others to re-build trust but unable to trust or work towards re-establishing trust
- controlling, rescuing, and generally being over-involved
- blaming and constantly looking for scapegoats

Stage 4 – Chaos and confused stage:

- exhaustion – physical and emotional – having been around this cycle many times
- confidence and self-esteem at an all time low – feeling incompetent and powerless
- poor communication with the young person and others
- relationships with other family members and other relationships falling apart
- failing to set boundaries and feeling compromised
- tired of keeping the peace, making sure everyone is happy and generally being the meat in the sandwich (particularly true of mothers)
- unable to put up with all the lies, manipulation (and sometimes abuse) and having to cover up and clean up
- alone and unsupported
- feelings of panic and that everything is in a mess

Stage 5 – Acceptance:

It's important to note that acceptance is not the same as approving or condoning. It is a matter of facing the reality of mental health and substance use but does not mean that families and carers have to like the situation.

With help, family members can come to accept and understand that:

- There is no 'quick fix'
- Mental health and substance use are chronic relapsing conditions
- Improvements in mental health and substance use require small steps at a time over a long time
- Change occurs when the young person is ready
- Implementing change can be influenced by support from the family or carer
- Professional support is available and affordable
- There are strategies for coping and health professionals and support groups can help with these
- It is important to look after themselves as well as the young person

Acceptance is difficult to achieve if the family or carer tries to 'go it alone'. Failure to reach this stage results in the families and carers repeating the first four stages of the cycle and becoming increasingly confused and exhausted. There is a direct effect on their own mental and physical health.

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Slide 20: cRASH - Reinforce efforts: *Readiness to change*

cRASH - Reinforce efforts

Readiness to change

- Families and carers will present at different stages of the cycle of change
- Families and carers may be at different points of the cycle of change from the young person
- Assess the readiness to change of both the young person and the family and carers
- Discuss ways to deal with these differences

Ask: What have they already tried and how has it worked?

Key points

- It is important to discover where in the cycle of change the family or carer is at, so that you can assess their readiness to change.
- Stages of change in the young person and in family members may not be synchronised (e.g. a mother may be ready for action for the young person while the young person may be in a pre-contemplative stage).
- Families and carers commonly move through five stages in their cycle of change – denial, reaction, control, chaos/confusion and acceptance. Many families take years to reach the stage of acceptance and become stuck in a repetitive cycle of the first four stages – making both solutions for the young person and moving forward with their own lives difficult.

Handout 3.4 provides some tips for how to communicate with a young person who is using substances. It also includes a table which maps the different stages of both the young person and the family or carer and the thoughts, feelings and actions that are associated with each stage.

Slide 21: CRASH – Asking about coping

CRASH – Ask about coping

Strategies for families and carers to:

- change and regain their lives
- build resilience
- be able to cope better

To survive the journey intact

It is important for families and carers to have options that build on hope and towards success. Despair and defeat are not the only outcomes. It takes hard work between health professionals, families, carers and support services and a willingness to change towards the positive.

In the next few slides we will discuss some strategies to help families and carers cope better.

Slide 22: CRASH – Asking about coping: *Strategies for families and carers*

CRASH – Ask about coping
Strategies for families and carers

Change and regain their lives by

- Valuing self
- Nurturing interest and relationships
- Maintaining and outside life – activities and friendships

Build resilience through

- Regular support
- Building self-esteem/self-worth
- Becoming better educated about drugs and mental health issues

Key points

Change and regain their lives – this includes:

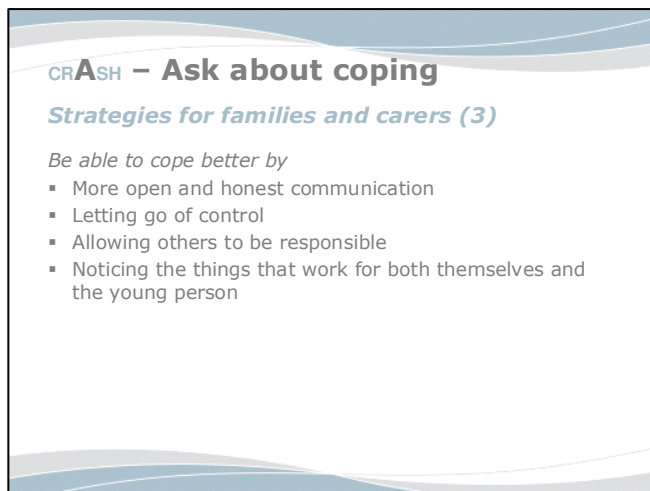
- valuing self
- looking after self physically, emotionally, and spiritually
- having short, medium, and long-term goals that have nothing to do with the drug user and a commitment to work towards them
- treating self on a regular basis
- rekindling lost interest and discovering new ones
- reconnecting with family and friends who have fallen by the wayside
- reaching out and nurturing new relationships.

All of the above are integral parts of valuing oneself. It affirms that families and carers are important and have personal value. It means that whatever happens, they are going to survive with purpose and meaning in life.

Building resilience – this includes:

- reaching out and getting regular support (professionals, telephone and support groups)
- becoming better educated on drugs and mental health issues
- building self-esteem/worth by engaging with professionals/courses etc.

Slide 23: CRASH – Asking about coping: Strategies for families and carers (cont.)



CRASH – Ask about coping

Strategies for families and carers (3)

Be able to cope better by

- More open and honest communication
- Letting go of control
- Allowing others to be responsible
- Noticing the things that work for both themselves and the young person

Key points

Be better able to cope – this includes:

- accepting that change is inevitable and there is a choice of whether it is positive or negative
- recognising that change can only be achieved through hard work, perseverance and pain
- becoming more self-aware of own patterns of behaviour and reactions
- working towards more open and honest communication - not only the drug user
- loving and supporting more and needing to be less controlling and directive
- working on being less over-responsible and needing less to 'fix' things
- allowing others to be responsible for his or her own actions and choices
- allowing others to help and moving from working alone towards working with others
- learning to celebrate life's success no matter how trivial they may seem at the time
- dealing with anger and other negative emotions in healthier ways
- being able to have less but workable boundaries
- letting go of expectation and hidden agendas but not love and hope.

Additional information

Re-evaluating the definition of success – universally, families and carers would like their loved ones to be drug free and to have control over their own mental health issues. As the journey continues, this expectation causes immense frustration and pain – again, it is about letting go of expectations. It is being realistic about what is achievable as opposed to what is ideal.

Most families and carers come to realise that they can't make anyone change or stop using drugs. The drug user is capable of stopping when they decide to do so. It can be a very difficult and long process. To expect too much and too soon can be unrealistic and painful.

As difficult as it is for families and carers, they may have to take a more objective view of where the drug user is in their process and learn to accept it. For some groups of drug users, families and carers have to settle for simple harm reduction strategies – clean needles, safer use, reduced use, less chaos, less crime and other negatives. It doesn't mean they have to like it. Redefining and realigning their definition of success with that of the drug user can provide much relief.

Strengthening families and carers – the more they strengthen themselves by adopting the above strategies, the more options they have for staying connected and being supportive of their drug user. Although they can't directly make them stop, families and carers can provide the most positive environment for change when and if the drug user decides to do so.

Success for families and carers is about becoming more resilient, being better able to cope, and managing to survive the chaos and the journey intact.

Reference:

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Slide 25: CRASH - Services and support



Mental health and substance use affects families and carers. Support and assistance is available. There are a number of programs that support and assist carers. Mostly these are services specifically for carers of people with a mental illness, for carers of people with a disability and for carers of older people. There are few services for families and carers of people with substance use issues and even fewer that focus particularly on families who care for a young person with both mental health and substance use issues. General practitioners and other service providers should be aware of the services that are available locally, statewide and delivered through national programs.

Key Points

- **Self help services provide contact and support**

Talking to other families and carers about their experiences can be a good way to relieve stress and to feel connected to others. It's a way to share information about looking after themselves and about the young person they care for. Self help groups often offer education and information sessions.

- **Telephone support services provide instant and anonymous support**

A limited number of services provide 24 hour phone lines that offer general support for families and carers, counselling services and information about local mental health and substance use services.

- **Respite care gives carers a break**

Planned respite gives carers a break and provides them with opportunities to pursue or pick up other activities and interests. Respite care can be provided in an emergency – for example if the carer has to be away unexpectedly or goes to hospital. It can also be planned at regular intervals or provided in the home. Respite care is rarely sought by families and carers of young people with mental health and substance use issues. 'Respite' tends to occur when a young person enters detox or a residential rehabilitation program for substance use treatment or hospital for inpatient care for mental health stabilisation.

- **Life skills for people with mental illness**

Psychiatric disability rehabilitation and support services, such as day programs and home based outreach assist people with mental illness to develop social and living skills. Life skills programs tend to be offered to those with severe mental health disability where life skills are limited. Group therapy programs are offered through mental health services. Life skills and group therapy

programs in this instance help to provide stability and independence. Carers get a break while the young person attends these programs.

- **Carer Support Programs.**

In some States, carers of clients in the public mental health system are eligible to apply for assistance through the Carer Support Program. The program provides flexible funding to enable highly individualised support.

Additional information

Where to get help:

Health Services

- General practitioners
- Community based mental health and drug and alcohol services

Youth and community services

- Local youth services
- Local youth health services
- Welfare and community service organisations

National self help, information and support groups

- Family Drug Support (national 24 hour telephone support service, support groups and educational workshops) www.fds.org.au
- Lifeline Australia (24 hour telephone support and counselling service) www.lifeline.org.au
- SANE Australia (help 9-5 week days, web materials include a section for young people) www.sane.org.au
- Kids Helpline (telephone support service for parents experiencing problems with their children. Support is wider than mental health and substance use) www.kidshelp.com.au
- ARAFMI (Association for Relatives and Friends of the Mentally Ill) support groups, information materials, a library, telephone and home based outreach service www.arafmi.org
- Alcohol and Drug Information Service (ADIS) Telephone information and counselling about substance use – listed in front page of phone directory in each State and Territory.
- Narcotics Anonymous (national network of abstinence based support groups) www.na.org.au
- Alcoholics Anonymous (national network of abstinence based support groups for alcoholics) www.aa.org.au

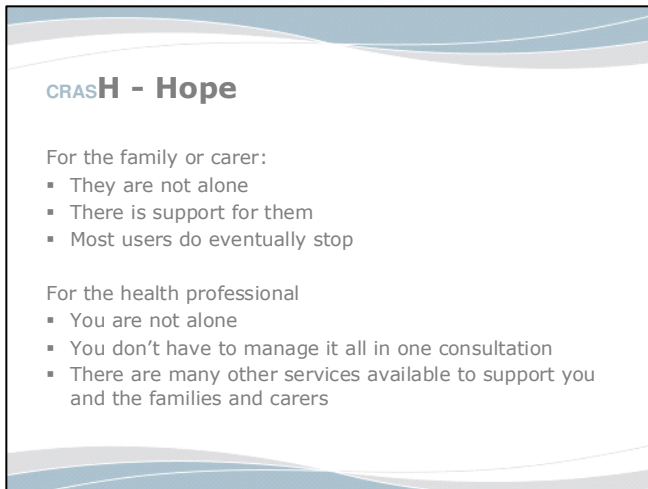
Other useful websites

These web sites are not designed for families and carers but may be useful resources for families to pass on to young people.

- **YDS Youth Drug Support** www.yds.org.au information, fact sheets, chat room.
- **ItsAllright.org** www.itsallright.org SANE's website for young people who have friends or family members with a mental illness.
- **ReachOut!** www.reachout.com.au Web based service to inspire young people to help themselves through tough times. Fact sheets, stories, e newsletter and database

Use the mapping exercise at the end of this workshop to map your local support services and circulate to participants

Slide 26: CRASH - Hope



CRASH - Hope

For the family or carer:

- They are not alone
- There is support for them
- Most users do eventually stop

For the health professional

- You are not alone
- You don't have to manage it all in one consultation
- There are many other services available to support you and the families and carers

This slide indicates how it is important for people to leave discussions on a positive note and with information on where they can go to help.

The purpose of these workshops is to enable local services to network, share information and develop effective pathways of care between their services. This allows professionals to work better together for better outcomes for the young person and their families and carers. You will now be given the opportunity to do this through the case discussion and service mapping.

Slide 27: Story vignettes and case discussion – story A

Story vignette A - Gillian

Discussion points

1. What are the important issues here for Gillian?
2. How do you think she is coping?
3. If Gillian was telling YOU this story, how would you engage with her? Would you involve her son?
4. What role might the general practitioner play in supporting Gillian?
5. Are there strategies could be put in place to prevent Gillian's son from being bounced from one service to another?
6. What support could other local health and community services offer at this point?

"I keep trying to get help from a variety of people but there doesn't seem to be any systematic approach because the resources aren't out there and the few services that do exist have such tight criteria about who fits into the groups they service.

So for me, it's been like 'hang on, you don't understand. I am one person looking after this kid.' I feel like I've got this child who's in trouble and why won't anyone in the system help me? This is the case even with the Department of Health because there just aren't the children's psychiatric facilities.

There was one place where I took Luke to get assessed but they said, 'No, he has a drug problem so he doesn't fit our criteria.' There are only eight adolescent psychiatric beds in the state so during one episode he was sent to an adult assessment place where they put people who are in psychosis. These are adults who are seriously ill and my child was there with them. And they just said, 'Oh, we'll look after him. And we'll give him his own room. That makes it sort of different.' I stayed with him until 10pm that night and when I came back in the morning they just went 'He can go home now.'

No one had dealt with him the night before and I was like 'Hang on a minute, what if I take him home and it happens again?' And they said. 'Just take him back to hospital.'

During these psychotic episodes we're sent away from hospitals with a tablet and bounced from one service to another. You feel totally responsible and totally helpless. Who can you turn to who'll sit with you and actually listen? And offer ideas?"

Points for discussion

1. What are the important issues here for Gillian?
 2. How do you think she is coping?
 3. If Gillian was telling YOU this story, how would you engage with her? Would you involve Luke?
 4. What role might the general practitioner play in supporting Gillian?
 5. Are there strategies that could be put in place to prevent Luke from being bounced from one service to another?
 6. What support could other local health and community services offer at this point?
-

Story vignette - feedback session:

- The points for discussion are to trigger group discussion
- Use the whiteboard to write up main ideas
- The facilitator's notes below are to direct discussion and prompt further exploration of important issues.
- Ensure only one participant speaks at a time and is heard by the entire group. Be aware of who is speaking and who is not.
- Invite participation from everyone
- Reflect, and if necessary, rephrase the participant's comment to link its relevance to the topic

Facilitator's notes

- Explore the issues of Gillian as a sole parent, of her anger and frustration at the health system and her strengths in seeking appropriate help for Luke.
- Discuss how you could prevent this current request from becoming another unproductive episode in the chain of events.
- Explore ways in which clear information about mental health conditions and substance use can be provided to both Gillian and Luke.
- Explore the role that health and community services, especially general practitioners, can play in including Gillian in Luke's treatment.
- Discuss how participants would assess Gillian's own state of health and wellbeing.
- How might participants you find out more about Luke's drug use – there is not much information here.
- How can services improve communication and assistance for families like this? What opportunities are there to keep Gillian in the loop?
- What support groups, help lines and resources are there that you could refer Gillian to?

Note:

Be mindful of potential conflict. Participants may focus on service deficiencies, vent their frustrations or recount negative experiences. Contain the discussion by:

- Acknowledging the difficulty/ frustration
- Identifying the problem or issue
- Problem solving as a group (If time permits)
- If time doesn't permit, offer an alternative e.g. agree to meet about later or pass the issue on to relevant people

Above all, maintain a sense of humour and encourage participants to do so as well!

Slide 28: Story vignettes and case discussion – story B

Story vignette B - Michael

Discussion points

1. Discuss the effect that social stigma connected with mental health and substance use is having on Michael.
2. What does the story tell you about Steve and his family?
3. If Michael was telling YOU this story, how would you engage with him?
4. Discuss the use of anti depressants for Michael.
5. What other support strategies might the general practitioner offer Michael?
6. What support could other local health and community services offer at this point?

"I don't know for certain all the ways that Steve's addiction has affected me but I do know I'm a different person to who I was. And professionally, it has been difficult. I'm normally a very open person and that has been quite damaging to me.

Many people who I work with have been horrified to learn that I would have a son like that and it's made it very difficult for me to continue to do business with them. There's been no support and a lot of negativity. The assumption is that I haven't done a good job as a father, that I must be a bad parent and yet they know me well, we've worked side by side for a long time. These are very smart, highly qualified people and yet their level of compassion is non-existent. Just terribly judgemental.

I have one dear friend, a barrister, who has been wonderful. He persuaded me to talk to our GP about it. Having a child in the throes of addiction, wears you down. You get desperate. And I know that sometimes I've been scratching around for meaning and I've been almost suicidal myself. You think you're going mad.

My GP told me I have to take anti-depressants. But there was no way I wanted to. I didn't think I needed them because how would that solve Steve's problem? But he convinced me.

So I have been taking them and it has given me some breathing space while I continue to live with the chaos and try to find help..."

Points for discussion

1. Discuss the effect that social stigma connected with mental health and substance use is having on Michael.
2. What does the story tell you about Steve and his family?
3. If Michael was telling YOU this story, how would you engage with him?
4. Discuss the use of anti depressants for Michael.
5. What other support strategies might the general practitioner offer Michael?
6. What support could other local health and community services offer at this point?

Story vignette - feedback session:

- The points for discussion are to trigger group discussion

- Use the whiteboard to write up main ideas
- The facilitator's notes below are to direct discussion and prompt further exploration of important issues.
- Ensure only one participant speaks at a time and is heard by the entire group. Be aware of who is speaking and who is not.
- Invite participation from everyone
- Reflect, and if necessary, rephrase the participant's comment to link its relevance to the topic

Facilitator's notes

- Note that substance use affects all strata of society. Discuss the fact that Michael is clearly a professional person, well educated etc and is still highly stressed by his son's experiences.
- Discuss how participants would assess Michael's own state of health and wellbeing and the use of anti depressants (are these for short term or long term use?).
- How can Michael move forward with his own life, while still remaining connected with his son?
- How can services improve communication and assistance for families like this?
- Explore the supports that Michael can access – include his family, family support groups, telephone line options and maintaining close contact with this barrister friend.

Slide 29: Access and referral to local services

Access to local services

- Service philosophy
- Service programs
- Youth specific?
- Inclusive of families and carers?
- Location (near public transport)
- Opening hours
- Waiting list
- Referral process
- Contact telephone numbers/emergency contact
- Inclusion/exclusion criteria
- \$ cost

Knowing what is available and what works

Service mapping exercise:

Participants are provided with a service mapping template which they should complete and bring with them to the training session. If they have not, ask them to spend a few minutes completing the template.

Key points

- Participants share information about their services based on the areas outlined in the slide.
 - Map key services on the white board or ask the coordinator to scribe information
 - Be as precise as possible and include contact phone numbers and key information
 - Where possible, include other agencies and services such as non government organisations and community or council programs.
 - Ask participants for consent to circulate the information provided to all participants
 - Following the workshop, ensure the coordinator circulates a copy of this information to all participants.
-

Slide 30: In summary

In summary

- Meeting the needs of young people
- Including families and carers
- Utilising other services
- Creating partnerships
- Identifying roles and responsibilities
- Maintaining defined boundaries
- Encouraging professional collaboration
- Establishing workable procedures for realistic and sensible referral

What will you do differently now?

(Please take a minute to complete your evaluations)

This slide provides a summary of the training session content.

Key points

- Ask the question: *What will you do differently?* (as a result of knowledge and information received at the training sessions).
 - Ask participants to complete the post test evaluation.
 - Hand out information packs.
-