

GOSNOLD, INC.
Becoming Family Informed, Family Involved

There are many compelling reasons to reach out to family and friends of those entering treatment. However, many programs have systems to limit family input and control contacts out of fear family members will assist in relapse. Other programs are dedicated to serving the primary client and do not have either the time or the clinical knowledge to expand the base of their efforts.

By looking at the natural points of contact between the program and the family it is possible to improve engagement without significant expenditures of time or money. We encourage programs to learn from family members. The goal is to find ways to use family as ally in the process, casting a net of support and intervention on the disorder of addiction.

SECTION 1. Improving engagement and services in normal contact points

Below are discussion points where programs might improve engagement

- A. at first phone contact.
- B. at first meeting at admission
- C. at first orientation
- D. at family visiting times
- E. access for family members.
- F. at discharge/continuing care planning/change of level of care.

Discussion, examples:

PHONE CONTACT:

Welcomes questions from family members, includes in referral process. Gives name, followup phone number when possible (If you have further questions, call x name, number).

ENGAGEMENT AT ADMISSIONS

- 1) greets
- 2) provides staff to describe program
- 3) provides a point of contact for questions after intake: phone numbers and names of staff members involved with the treatment care, and or dates of visiting times
- 4) provides time to gather information about the individual entering treatment from the family
- 5) offers to address family questions.
- 6) offers a tour of program and.
- 7) offers a family support system in the community (alanon, a peer family to contact)
- 8) supportive contacts materials:
looking at the concern by the demands of the addicted individual. Yet programs seldom take time to help families adjust those roles.

ENGAGEMENT AT VISITATION:

It is not uncommon for family members to be viewed as a potential source of problems, and in some cases this occurs. Thus, we have observed programs offering “Orientation programs for Family and Friends” which attempt to regulate behavior during visits.

Programs may increase collaboration in recovery programming by providing basic education. Some programs start with the four c’s: Families did not cause, cannot control, cannot cure addiction---however they can learn to collaborate in the recovery or collaborate with the addiction. This simple formula becomes a basis for discussing the validity of rules, the difficulty of setting limits with the addicted individual. Shame is common in families because of stigma, isolation and lack of information about the chronic nature of addiction. Bringing families together without the patient/client can foster change. Offering short sessions on issues pertinent to coming home is a great help.

ENGAGEMENT AT VISITING TIMES: Adding in activities which can be shared can ease communication during visits. Providing food to share or cooking food together can create an easier atmosphere. Programs that allow residents to cook or allow family to bring food to the facility notice an easier less disruptive visitation.

Families can be offered a range of low cost services: a ½ hour question and answer time with staff. If staffing is available, an educational system which assists families in their grief, anger, fear, shame and frustration can be offered.

ACCESS FOR FAMILIES: Programs typically restrict phone calls, drop in visits and the like. Although there are many good reasons to do this, providing the family with an update on the progress, and easy emergency contacts can ease the burden on families and increase the likelihood that the family will be prepared to work with the individual upon release.

DISCHARGE AND CONTINUING CARE PLANNING. This is an opportunity to provide a complete plan that includes the family. One model has the client list all of the relapse triggers and propose an action plan. The family often knows those triggers, and the plan can include a healthy plan for coping with inevitable triggers. Similarly, it is reasonable to talk about the “what ifs”. What if the person relapses? What if the family witnesses behavior that could lead to relapse. Both family and client create a contract of agreement to deal with the inevitable ups and downs of early recovery.

SECTION 2

Engagement of family members in treatment programs varies widely. Although it is a great benefit to have a family focused clinician, there are many other ways programs can become family friendly and family informed. What follows is a partial list of ways programs have expanded their interaction within the treatment episode.

- 1) A history of the family is collected and assessed for difficulties and for possible motivators.
- 2) Family may be considered as part of emergency intervention *team during treatment*.
- 3) Family difficulties considered in continuing care recommendations.
- 4) Treatment staff is informed about family issues as they impact the patient/client.

ENGAGEMENT IN TREATMENT:

Often information gathered by a family team is left segregated from ongoing treatment/planning. Is the family part of treatment planning?

There are compelling results from family members when they are provided with an opportunity to meet their needs for education without blame. Families can receive communication skill development including refusal skills.

Families can become part of an intervention team during treatment episodes, either by phone or in person. They can serve as important part of motivation for continuing treatment.

On the other hand, some family situations will continue to be profoundly difficult and may need other strategies. Because family relationships are a source of pain for many, it makes clinical sense to understand those dynamics in treatment as they reoccur through phone, letters, and visits.