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| Do Governments recognise the needs of affected family members? First indications from an AFINet project |

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*Introduction*

This paper will report first indications from one of AFINet's projects – *Country policies and practices regarding affected family members (AFMs)*. The overall aim of this project is to find out how AFMs, both adults and children, are recognised and responded to in a number of geographically and economically contrasting countries. In each participating country, the project would attempt to determine how well or poorly recognised AFMs were, as well as the quantity of service provision available to AFMs in the country, and how policy influences service provision. We envisaged the project having three stages, as follows:

Stage 1: Examining relevant policy documents; for example, health and social policy documents.

Stage 2: Identification, enumeration and categorisation of services, specific and generic, providing help for AFMs, and

Stage 3: A more detailed survey of a representative sample of those services.

So far we have been engaged in Step 1, an examination of relevant policy documents. Eight countries have been actively involved in the project and others may still join the group. As the Table shows, at least 36 documents have been analysed to date.

**Country policies and practices regarding Affected Family Members**

Documents analysed to date (all cover alcohol and drugs unless stated):

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| COUNTRIES | NUMBER OF DOCUMENTS | COMMENTS |
| South Africa | 2 | Both from Western Cape area (1 drugs only)  Plus a previous analysis of 3 national documents |
| India | 1 | National |
| Brazil | 3 | Includes 2 drugs only |
| Mexico | 15 | Includes 5 regional |
| Germany | 7 | 1 national covers all addiction incl. gambling; 6 regional |
| Irish Republic | 3 | covering 3 periods incl. current policy |
| Netherlands | Several | Summary of several documents, mainly local (Amsterdam, Rotterdam, etc.) |
| UK | 5 | 3 UK (1 alcohol, 1 drugs, 1 gambling),  1 Wales, 1 Northern Ireland) |

*Scope of the Stage 1 document analysis*

Before we embarked on the analysis we obviously needed to be clear about the scope of the document analysis. How broad a search for relevant documents should we be undertaking? Should we limit the documentary analysis to a small number of obviously relevant documents produced by government and other national bodies? Should we include regional as well as national policy? We have for now recognised the following three document categories.

Category 1: Government policy documents on alcohol and/or drugs and/or/gambling

This is the core category for the Stage I document analysis. It should cover policy documents, produced by Government departments, which set out current Government policy on alcohol and/or drugs and/or/gambling. These will be important to include even if they say nothing at all about affected family members (AFMs) because the absence of reference to AFMs would itself be very significant. This core category should also include Acts of Parliament if there has been such an Act specific to alcohol/drug/gambling in the timeframe.

Category 2: Key documents on alcohol and/or drugs and/or/gambling policy produced by bodies set up by Government or working closely with Government.

For example, this category might include documents produced by bodies set up to regulate or control the availability of alcohol/drug/gambling, or set up to advise Government on research or treatment strategy. Again, it is important to include such documents even if they say nothing at all about affected family members (AFMs) because the absence of reference to AFMs would be significant.

Category 3: Other documents, not principally about alcohol/drug/gambling, but which contain a section or theme which is specifically about substance- or gambling-AFMs

This category would include policy documents which are specifically about families or family members and which recognise substance- or gambling-AFMs as a relevant group. For example, there may be such documents which are principally about child protection, domestic violence, mental health, or crime and justice. Because there are likely to be many documents which address those and other issues, we would only include them if they did contain a section or theme specifically about substance- or gambling-AFMs.

One consideration for some countries is whether it is thought best to go for the whole country or for one region or state. For countries that are large and diverse, and/or if relevant laws and regulations vary a lot from one part of the country to another, it may well be sensible to concentrate on just one, possibly two, areas within the country. On the other hand, people taking the lead on the project may for their own reasons want to make the project nation-wide.

*Analysis of the documents: Indications so far*

**Overall there is very limited recognition of ‘affected family members’**

This limited recognition takes several forms:

1. **No mention of AFMs at all**.

An example is the 2015 Brazilian document from the Ministry of Justice and Public Security - National Secretariat for Drug Policy(although AFMs are mentioned in another Brazilian document, from the Ministry of Health which gives guidelines for Psychosocial Care Centers when dealing with problems related to substance use).

2. **Mention in name only** (e.g. repetition of the phrase, ‘and their families‘), with no special section or focus on families and nothing specific said about family members. This is very common.

e.g. The 2016-17 annual report of the Department of Social Justice and Empowerment, Government of India. The remit of the Ministry of SJ&E is to empower various socially and economically marginalised groups including the ‘victims of alcoholism and substance abuse’ which ‘generally includes the immediate family also’. Although there are statements to the effect that it is best to take ‘a family/community-based approach’, AFMs are nowhere a focus in the document.

3. **Families are mentioned, sometimes quite frequently, but AFMs in general remain largely peripheral to the document’s main concerns**

e.g. the UK Government Alcohol Strategy 2012. This includes several quite specific family-relevant statements, which is encouraging, but where families and family members are mentioned it is mostly in the context of already identified high priority policy areas such as domestic violence, ‘troubled families’, heavy drinking and hospital accident and emergencyadmissions, or foetal alcohol syndrome. Perhaps reflecting the Home Office lead on this document and the publicity given to binge or heavy drinking at the time, it is mostly ‘heavy drinking’ that is referred to throughout the document rather than alcohol addiction or dependence. There is lack of a general awareness of ‘affected family members’ as a group of stakeholders or of alcohol’s harm to others in general.

e.g. In the 10 Mexican national documents examined, family was mentioned 57 times; 24 times as a means of prevention, 12 times as a means of accessing treatment, 7 times as support for adherence to treatment and only 7 times as a system that has its own needs in the face of problems related to consumption. State documents were found to be similar. References to the family are specific in some cases about the family’s role in prevention and help for the person in the family consuming substances but not when it comes to family members’ own needs as people affected physically and emotionally by such consumption.

e.g. A document from the Provincial Government, Western Cape, South Africa. A Section on: Prioritising the role of families in relatives’ treatment refers, for example, to:A Drug Intervention Team (DIT) can be set up with outreach- (i.e. can be deployed to police stations, schools and courts, for example) and office-based workers who engage with drug users and their families. They will engage with clients and their families and motivate them to go to the next level of care; as well as giving advice on how to reduce the harms caused by drugs. The Drug Assessment Team would work with all clients, even those who are not yet ready to stop using drugs, and if necessary develop a care plan for them and their families.

4. **Mention, sometimes quite specifically, but not followed through**; for example, not followed through to assessments, costing or reviewing whether objectives have been met.

e.g. a 2013 Dutch document, National Institute for Public Health and Environmental Protection. A paragraph on harms to others in society (‘victims’) says: ‘An important cost item, which has not been discussed previously, concerns the loss of quality of life of family members of alcoholics, for example, through fear for domestic violence, or by having to take care of their alcoholic family member… As there is no quantitative data available, these costs have been stated solely as ‘to be determined’.

e.g. Responsible Gambling Strategy Board (UK) National Responsible Gambling Strategy 2016-17 to 2018-19 which appears to show commendable recognition of affected families. They are mentioned in the Executive Summary and in no less than 11 separate places in the main document. Harm to families is recognised as a general category of harm, not confined, as is the case in UK Government alcohol and drug strategies, to certain sub-categories such as children, pregnant women or foetuses. On the other hand, these mentions of family harm are brief and very general. It looks rather as if RGSB was paying lip service to the interests of families. This impression is strengthened by an analysis of their report, a year later, *One year on: progress delivering the National Responsible Gambling Strategy, June 2017,* a 20-page document with 56 sub-sections in which affected families are mentioned only once and then indirectly. It seems that affected families have been lost sight of between the writing of the Strategy document and the first year progress report.

5. **Although families are therefore mentioned a number of times, it is mostly children who are the focus**

e.g. German National Strategy on Drug and Addiction Policy 2012. (NB the only document about addiction in general including gambling; and a local Munich document is more encouraging).

e.g. UK Government 2017 Drug Strategy. Among mentions ofspecified projects, programmes or interventions are several which refer to the work of Public Health England (PHE).It is stated that PHE will be expected to work with Family Drug and Alcohol Courts and local public health teams to help them to work together to improve outcomes for families and children (Extract 6). PHE will also review the evidence and provide advice on the estimated number of children likely to be affected by the drug and/or alcohol use of their parents, and provide advice to national and local government on where action could have the greatest impact on improving children’s outcomes (Extract 7). It will also develop a toolkit for local authorities to support local responses to parental substance misuse, which will include local prevalence data on parental/carer use, the associated harms and likely costs, guidance and information on effective interventions (Extract 20).

**There are good examples of supporting family members as a priority**

Example A: Substance Misuse Strategy for Wales 2008-18. The bulk of the Strategy is structured around four Priority Action Areas of which ‘Supporting and protecting families’ is the third. A Figure shown in the introductory section of the Executive Summary shows ‘Support for Families and Carers’ as a main element of relevance to all points on a continuum from education/prevention to harm minimisation to treatment to aftercare to recovery. Inclusive: adults too although children still biggest priority. Harm is a central idea in this document, appearing in the title and repeated often (although, interestingly, ‘public health’ as a concept is not).

Example B: Reducing Harm, Supporting Recovery - A health-led response to drug and alcohol use in Ireland 2017-2025. The most recent Irish National Drugs Strategy had considerable input from the National Family Support Network, a peer led organisation supporting family members living with drug and alcohol use. From the outset the impact on families and the involvement of family members in the design and delivery of services is given precedence. This is seen in both the vision and five main objectives of this strategy. Throughout the document the importance of family involvement in supporting the rehabilitation of a service user and the impact on family members when a relative is engaged in problematic substance use is acknowledged.

*Preliminary conclusions to consider taking forward*

1. We should be looking for good examples of family-positive government statements
2. Understanding why most government statements are not family-positive
3. Emphasising the impact on children