

Disrupting Standard Mode

A Big Picture Story of Family Inclusion in Substance Use Services

by Stephanie McCune, Bernadette Pauly, and Sarah VanBoven

January 2017



*An Inquiry on Building System Responsiveness
to Increase Collaboration with Carers in
Substance Use Service Systems*



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of Family Inclusion in Substance Use Services

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Acknowledgments

This project was inspired by many heart-felt and thought-provoking conversations with individuals and families, practitioners, educators, and program leaders. The generosity of others to share, explore questions, and imagine has sparked, shaped and formed all of the recommendations and suggestions within.

Thank you to the Collaborating with Carers Advisory Committee and the Island Health Research and Capacity Building Department.

Funding for this resource was provided by the Island Health Research and Capacity Building Program.

Illustrations by Drawing Change

Graphic design by Hands On Publications



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The Back Story

Including family members in substance use programming can improve outcomes for the individual and enhance the health of the family at large.

A Brief Literature Review

Family members are important sources of support for a loved one accessing substance use treatment services. Family members hold a wealth of historical understanding, first-hand insider knowledge, and have profound investments in the long-term wellbeing of their loved ones.

Substance use is often associated with social and health consequences that can affect the individual in relationship with alcohol and/or other drugs and, most often, echos throughout the whole family network. Including family members in substance use programming can improve outcomes for the individual and enhance the health of the family at large.

However, family inclusion is not regular or customary practice within substance use treatment systems. Family members often encounter walls when engaging with substance use treatment services. Propelled by stigma, shame, individualized treatment orientations, and limits set by confidentiality, such walls prove to be formidable constraints to inclusive family-minded substance use treatment.

At present, research contributing to understandings of how to include family members in formal substance use treatment is limited. Research regarding service provider experiences supporting affected family members is particularly sparse. Thus, limited research and literature is available to those working in helping services to inform practitioners about how they might breakdown walls and open doors of support for family members engaging with substance use service provision.

The purpose of this qualitative study was to explore practitioner experiences involving families in out-patient substance use treatment services across the lifespan in youth, adult and senior's programs. The term out-patient is used for the purposes of this report to describe substance use treatment outside of live-in, residential, or hospital-based programs.

Youth, adult and senior's programs have unique features and approaches to engaging family systems. It was the intention of this project to understand from

the perspective of the service provider, what family inclusion looks like across the lifespan and what opportunities for change exist within allied and interrelated programs. This report focuses on service providers in order to access a window into service delivery, however is limited by the absence of critical perspectives from families with lived experience.

The aim of this resource is to outline answers to the three key research questions initially sparking the CWC project. The questions are as follows:

- What does family inclusion currently look like in the context of Island Health community substance use services? What factors have made inclusion possible?
- What are the possibilities for increasing practitioner and organizational capacity to facilitate family inclusion in substance use treatment services?
- In what ways can the broad substance use field increase system responsiveness to families?

This document is a culmination of the findings from the *Collaborating with Carers* (CWC) research project. Beyond reporting data, this resource was created as an invitation for service providers and programs to engage *with* the findings, locating self in the ensuing ideas and ideals, while serving as a prompt for further conversation, team consultation, and strategic decision making.

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Overview

Research method

The CWC research project utilized a qualitative, Appreciative Inquiry (AI) research method. This method was used to understand the current landscape of family inclusion in youth, adult and senior out-patient substance use service and the “best” of what could be in ideally inclusive substance use programming.

The intention of this inquiry is to strengthen and expand capacity of Island Health, and the broad health care system to provide relevant, available, accessible and sustainable services to family members. By understanding the practitioner perspective and generating practitioner inspired visions for care, the treatment system will be better informed as to how to highlight, enhance, and modify workforce development activities and structures that promote family inclusion.

Appreciative inquiry is a method for analysis, decision making and strategic change. Rather than focusing on a problem-solving or a deficiency model, the method of AI allows for fuller understanding of what is, what could be, and in turn, the creation of future directions. The intention of this research project is to stimulate ideas and stories that generate new possibilities for applied and inclusive services.

The research method of the CWC project was not only *appreciative* but also *collaborative*. The study placed heavy reliance on coordinated efforts with direct service providers, stakeholders and other members of the host organization. Participant stories can and will directly inform the future visions of the larger system of care, sparking generative capacity and transformative opportunities to raise questions and foster new alternatives for practice and change.

The primary processes of this AI project was two-fold:

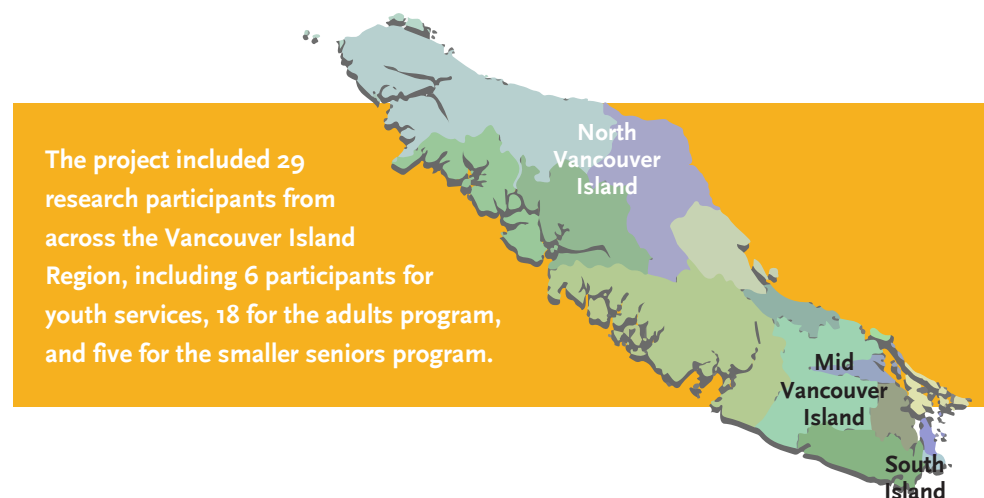
- To identify and value the “best of what is” in relation to care that involves families.
- To envision and construct the future vision of what “might be.”

Participants reported working in substance use services from 10 months to 24 years with the average length of practice being 9 years.

Research participants

The CWC project included 29 research participants from across the Vancouver Island region. Proportional sampling was used to recruit numbers representative of programs for youth, adult and seniors. For example, 6 participants were from youth services, 18 from adult services and 5 were service providers working with seniors.

Participants were recruited based on their active involvement providing direct service in out-patient substance use services and care of families including counselling, intake, and outreach services. Participants were from across the Island Health region including both urban and rural/remote communities. Participants reported working in substance use services from 10 months to 24 years with the average length of practice being 9 years.



Data analysis

Data collection and analysis was completed using an Interpretive Description methodology and a narrative inquiry lens. Interpretive description is a research method used specifically for the purposes of increasing knowledge of clinical phenomena in the health care field and other applied disciplines. Interpretive description can be used with different approaches to qualitative research including AI.

From Findings to Future Practice

One of the predominant features of applied research is the translation of findings to clinical practice. Throughout this document the reader will encounter groupings of three specific symbols. These symbols are reflective opportunities to invite thought about how the out-patient substance use treatment system, including practitioners, might mobilize findings, making shifts from intention, where family inclusion is acknowledged as significant, to practice, where family inclusion is customary performance, or a part of regular, ongoing practice. Each symbol is accompanied with a specific frame of reference or reflective task:



THE BIG PICTURE questions and prompts: An invitation for service providers to consider and locate themselves in best efforts to actualize preferred visions of family inclusion.



DISRUPTING STANDARD MODE considerations: Thoughts to spark shifts in organizational structures that address constraints and build opportunities for family inclusion as a customary performance.



SPOTLIGHT on additional finding or future curiosity: Topics to engage in ongoing exploration and further research.

Throughout the document the reader will encounter groupings of three specific symbols: these are reflective opportunities to invite thought about how the substance use service system might mobilize findings to where family inclusion is a part of regular, ongoing practice.

FAMILY

CONTEXT: What do we mean by Family ?

Family, specifically family in relation to out-patient substance use service, was in all cases understood as being defined by the person accessing services.

To better understand the possibilities and potentials of family inclusion in substance use services, the research team endeavored to elucidate understandings of what the term *family* means. In order to do this, all research participants were invited to share definitions. Upon eliciting numerous responses, it was clear that, according to practitioners, the label family and the construct of how family is conceptualized is highly variable.

Family, specifically family in relation to out-patient substance use service, was in all cases understood as being defined by the person accessing services. Unanimously across interviews participants identified the authors of *who* is family and *what* constitutes family as being the person, or client, accessing services, for example “*it is the client who gets to say who they’d like their family to be.*”

Family was not considered to be a stagnant concept but constantly changing, fluid and contextual. The term was identified as being *broad* in description and *inclusive* with respect to what a family was considered to comprise and for what purposes.

According to practitioners, families were acknowledged as being a part of a “*circle of care*” contributing *love, connection, a belief in capacity, shared experience, influence, support, helpfulness, belonging, wellbeing, attachment, emotional bonds, and intimacy*. One participant described family as being those “*closest to you, your biggest supports.*” Another shared that family is “*inclusive of anyone that a client sees as a main source of support or attachment.*”

“Family is whatever my client calls it. So it can be family through birth, adoption, not just biological but extended family, community, or even family we just kind of pick up along the way, it could be street family. I think [family] is very fluid and it changes over time too, so what might be family today may not be the same tomorrow.”

Family was understood as encompassing blood relations and those identified as “chosen” family. One service provider stated, “you live rough with this person for years and you talk to your [biological] family once a year for Christmas—so what carries more weight... I am pretty sure that the person would say ‘these people who are in my immediate life and shot me up with Naloxone last week when I overdosed’ have a much stronger bond.” Speaking to the diversity of lived experiences of people accessing substance use services, another participant explained that for some “family is who you sleep outside with.”

When articulating a definition of family, participants talked about going “wide,” or as one participant noted “you can go so big with it that it includes everyone in a person’s life.” Another participant explained “Aunties and uncles can play an important role and often people are raised by grandparents. It is not just mom, dad and siblings, it can also be aunties, cousins, Elders, community members, or really close friends.”

Additional examples of who was identified by service providers within this conceptualization of family or circle of care were:

Mom	Aunties	Family friends
Dad	Uncles	Best friends
Siblings	Cousins	Foster parents
Grandparents	Adopted family	Social workers
Professionals	Members of faith groups	Blood relatives
School personnel	Pets	Children
Spiritual leaders	Deceased loved ones	Spouses
Probation officers	Employers	You
Community members	Street family	Elders
Room mates	Neighbours	Partners

This is not a definitive list but an example of the wide net participants cast as they were invited to consider who people accessing services might identify as family during their encounters in formal substance use service systems and who might be affected by substance use and would potentially benefit from the provision of services in their own right.

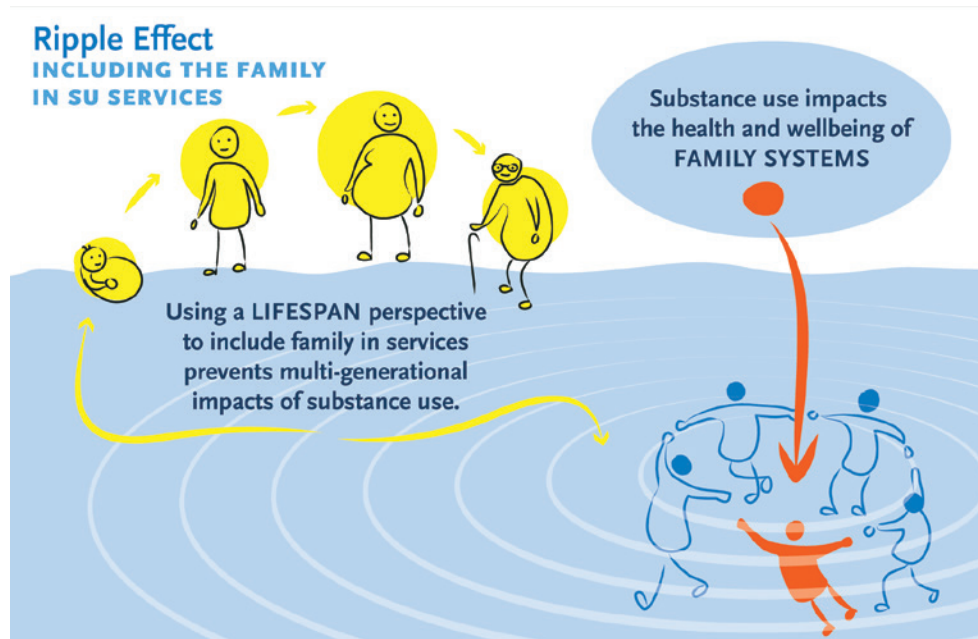
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The following image offers a conceptual grouping of the major themes specific to the notion of *what is family* in the context of out-patient substance use services.



A prominent feature of the research data was the description of a notion participants described as the “ripple effect.” The ripple effect was used to explain the interconnected relationship between adversity and triumph (healing, change, health) on all members of a family unit. The ripple effect was notably described as extending beyond the individual, throughout the family context and reverberating through multiple generations.

This concept of the ripple effect was evidenced by explanations of the vital interconnectedness between individual wellness on the collective whole, and the impact of broader contextual factors, organizational responses, and practitioner efforts on not only the individual accessing care, but the entire family system. The ripple effect is described in further detail throughout the CWC report.



THE BIG PICTURE: How do you locate yourself within the context of “family?” What impact might this have on your professional practice with individuals and families accessing substance use services?



DISRUPTING STANDARD MODE: What is the dominant description of family where you work? In what ways might it be broadened? In what ways would intake and engagement processes need to shift in order to include a broader definition of people (pets) who provide support and care (comprise a circle of care)? If belonging, care, support, love, and connection, for example, were qualifying characteristics of family, who might people accessing services identify as being family.



SPOTLIGHT: A number of research participants identified themselves and/or other service providers as being “family” or a part of a client’s circle of care. *“We’ve had clients we have worked with for years, they know the team, they know different workers, the reception, and at times we become a lot like people’s families.”* What do you think about this connection? How do you see yourself in a client’s circle of care? How might this description challenge personal and/or professional boundaries?

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The Problem Story of “Standard Mode”

What does Family Work currently look like in the Context of Substance Use Services?

Regardless of the particular program research participants were speaking to, all shared a broad story of the need to increase availability and accessibility of services that include families in the provision of care to a loved one involved with substances.

Although the *Collaborating with Carers* research project was an Appreciative Inquiry designed to elicit stories of what is currently working and what possibilities might exist for family inclusion, a dominant narrative pervaded all of the participant interviews. Regardless of the particular program research participants were speaking to, all shared a broad story of the need to increase availability and accessibility of services that include families in the provision of care to a loved one involved with substances.

This story was called “*standard mode*,” an overarching interpretation of systems in general that are not actively engaging and acknowledging families. Standard mode was not about specific programs or organizations, but was understood as being about broad far-reaching philosophical values and theories informing and influencing at the system level, substance use service program design and delivery.

Standard mode was described as being oriented to individualism—the idea that problematic substance use is a function/problem of the person, and biomedical responses—a focus on treating physical processes and biological factors causing disease/disorder/defect. As noted by one research participant “*There is certainly the view that’s held by some that addiction is a disease. If that is the conclusion that*

Standard Mode of Substance Use Services SUBSTANCE USE SERVICES IN CONTEXT



you reach, then you are going to have a very different approach to the client and the family.” Others shared “Services are for the individual, people access us, we are stationary, people revolve around us,” “I think we are really good at identifying one person as being the problem.” This taken for granted set of discourses (individualism and biomedicine) was noted as prohibitive and constraining to involving families. Standard mode was evidenced in statements such as “families are not involved,” “family involvement is limited,” “family is invisible.”

Participants identified that the individualized understanding of problematic substance use, was perpetuated through socio-political factors that included broad values, beliefs and attitudes, *“the ongoing stigmatization of families.”* These socio-political factors reverberated to influence specific organizational factors *“the absence of structure or protocol,”* in turn impacting practitioners *“family work is not accepted practice.”*

The problem story of standard mode was described, from the perspective of the practitioner, as creating actions and responses that span out beyond the individual accessing services directly affecting the experience of families as a whole. As told by one participant, *“families are burnt out and exhausted, they don’t know where to go;” “there is judgment—there is a whole population out there that are not getting service right now.”* Practitioners explained that stigma and judgment contribute to exclusionary practices and family experiences of inability and blame.

The CWC research illuminated the problem story of standard mode and the ensuing ripples as contributing to a barrier constraining practitioner intention to include families in treatment services and practice or ongoing customary performance of including families. As described by one participant *“I think that there is awareness that it is important, there is an intent and desire [but] in my own practice it is difficult to match the intent and desire.”*

This dominant narrative of individualism and biomedicine, or problem story of standard mode is integral to understanding the factors that are impeding efforts to involve families in substance use services and what is required to address this ubiquitous barrier.

In addition to considering impacts of standard mode on people and families, participants shared their experiences of the effect of this dominant story on the helping professional. The research interviews illuminated stories of frustration, moral distress, hopelessness, and exhaustion when referencing what it was like to hold a preferred vision that was not in line with a broader societal perspective or value.

Throughout the research interviews, many participants talked about Aboriginal perspectives and Indigenous concepts of interconnectedness, relational practice, and relationship. Much of what practitioners identified as a preferred way of

Standard mode was described as being oriented to individualism—the idea that substance use is a function/problem of the person, and biomedical responses—a focus on treating physical processes and biological factors causing disease/disorder/defect.

“Primarily we are working directly with the clients. Typically, that is sort of standard mode.”

working or recommendations for the future were identified as being located within an Indigenous worldview of relationality. Most talked about efforts to disrupt standard mode by learning from and working with Aboriginal partners.

The above factors do not exist in isolation nor are they identified as a means to perpetuate blame. Each of these factors is intimately interconnected, creating a highly nuanced and complicated picture of what broadly is constraining readily available, accessible and ongoing practices, or customary performances of family inclusion.



THE BIG PICTURE: How might a focus on family wellness influence mandates and objectives of out-patient substance use treatment programs? What resources would you need to contribute to such a focus? What philosophical lenses inform your understandings of substance use and what impact does this have on your work with people and families accessing services? How is Indigenous knowledge informing system changes?



DISRUPTING STANDARD MODE: The widely accepted discourse of substance dependence and/or addiction as being a function of the individual, informs how services are designed and delivered. Such a philosophy ascribes problematic substance use as being a feature of the person, implicitly excluding context and those involved around the person involved with alcohol and/or other drugs. Such a philosophy constructs organizational responses to substance dependence and expectations and assumptions of the practitioner role providing direct service treatment. This dominant individualized discourse conceives wellness as being a condition of the person versus a relational feature of a broader system, such as a family system. What might be some noticeable shifts in substance use programming if design and delivery was considered through a relational perspective or lens?



SPOTLIGHT: Many research participants referred to individualised, bio-medical discourses as colonizing and structurally racist in their implicit and explicit exclusion of collectivist worldviews. Solely privileging a Western, individualistic perspective excludes additional ways of knowing and understanding substance use, health and ultimately family. How might you envision out-patient substance use treatment differently?

The Counter-Story: The “Best of Intentions”

What does family inclusion currently look like in Island Health community substance use services?

Appreciative inquiry is a research method used to draw out stories and examples of the *best of what is* currently informing, invigorating and contributing to systems. By understanding the best of what is, programs can look to maintain, enhance, and celebrate current capacity and opportunities. In terms of this particular research inquiry, the best of what is, offers a lens to consider present family inclusion practices.

Despite the problem story of “*standard mode*,” and the limited overarching description of family inclusion, the CWC participants elucidated exceptions to this dominant narrative. This counter-story is what participants identified as standing up to and resisting the walls of standard mode. They offered exceptions that came to be understood as “*the best of intentions*.”

The best of intentions, was captured by the resounding acknowledgment by participants of the importance of family, a recognition of the importance of family inclusion in treatment programming, and intentional actions of family inclusion. Intention was expressed as “*I want to...*,” “*I know families are important because...*,” and “*I am working with families by...*” Intention often came alongside descriptions of a desire for “*holistic*,” and more relationally orientated substance use services.

There are three features that characterize “the **best of intentions**.” They are as follows:

- One:** Practitioner acknowledgment of the importance of families.
- Two:** Practitioner contributions to family inclusion in out-patient substance use treatment service.
- Three:** Programmatic and organizational examples of family inclusion in out-patient substance use treatment services.

The best of intentions contribute to the telling of a counter-story narrative within the out-patient substance use treatment system. The acknowledged importance of family and examples of practitioner and organizational response are key drivers for making moves or shifts towards a preferred story of family inclusion as ongoing customary practice.

Each of these features of intention are described in further detail throughout the remaining section.

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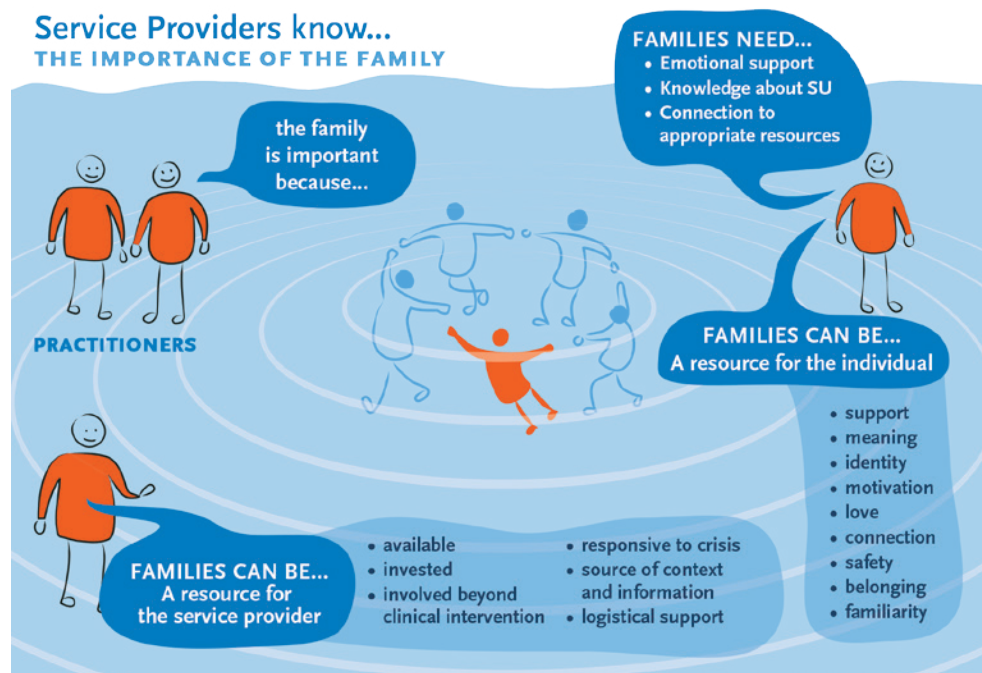
The Best of Intentions One: Practitioner Acknowledgment of the Importance of Families

As noted by one participant “what comes to mind is the kids, I’m thinking if we have kids growing up in a home with addiction, we are looking at the longer term impact.”

All research participants noted and described, for a variety of reasons, the importance of families. Most spoke both generally and specifically as to why families should be increasingly included in substance use service programming. For example, one participant shared “It is easier to make change if you have people on board around you to provide support, people can’t do it on their own.” Another participant explained “Treatment is an artificial environment—when you come home there are issues around who is going to vacuum, pay bills, you know mundane things. How the individual and family as a whole responds to these things plays a big role.”

One of the most discernible descriptions of why families were said to be important was what was described as, and previously noted as, the “ripple effect.” The ripple effect was heard many times throughout most of the interviews as conceptually referring to the notion of wellness as not being an individual issue but more broadly as a whole family issue. For example, “If you support the whole family system when one person is struggling, then it will contribute to better outcomes for all members of the family.”

Participants across youth, adult and senior’s programs described family inclusion as being *preventative* in nature, mitigating distress from being passed on throughout the generations, and necessary for addressing the adverse effects of substance use



on those within family systems currently impacted by substance use. As noted by one participant *“what comes to mind is the kids, I’m thinking if we have kids growing up in a home with addiction, we are looking at the longer term impact.”* The following are descriptors of the *“ripple effect”* noted in research interviews:

- Conflict in a family ripples out
- Everyone is impacted by substance use
- We are all interconnected
- Wellness is a family issue
- Substance use is multi-generational; if the family is not healthy, the kids will struggle
- Generation to generation
- We are looking at the long-term impacts of substance use reducing risk for future generations
- It is not just who is using, it is the people who love them that are also effected

From the perspective of service providers, participants described in detail the importance of families as integral resources for both the individual accessing services and for the service provider.

For the person accessing services, families were noted as being sources of support, love, meaning, identity, belonging and safety to name a few *“families can provide a sense of identity, a reason to live for many, motivation to try and find a life that is more stable – it is the ultimate form of human connection and we are social species, we can’t survive without that.”*

For service providers, families were identified as being readily available resources beyond the parameters of clinical constraints. As one participant shared *“there is only so much that I can do, where if I support the family maybe there is more they can do.”* Another explained, *“Myself as a professional, I am there maybe an hour a week. Family is accessible a lot more then that so they are definitely their greatest asset in terms of resources and support.”*

Families were described as likely being available 24/7, more responsive to crisis, holders of history, providers of collateral information and perspective, and potentially able to meet logistical needs such as housing, transportation and child care.

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The Best of Intentions Two: Practitioner Contributions to Family Inclusion in Out-Patient Substance Use Treatment Service

Family inclusion was not identified as being a consistent and customary performance (practice) across the substance use service system. However, the dominant story of *standard mode*, or family exclusion, was challenged by many examples of family inclusion enacted in individual practice.

The CWC research project illuminated a rich description of what service provider's value about their contributions to family wellness and what qualities have made these contributions impactful. Beyond clinical modality and approach, practitioners identified themselves as vital resources for family inclusion.

Practitioner qualities were described as disrupting the walls of standard mode, reducing barriers between intention and practice, or family inclusion as a customary performance. Despite the constraints of an overarching individualised perspective guiding substance use theory and response, many practitioners took exception. This exception was noted in a practitioner *way of being* inclusive of specific values, skills and qualities.

Practitioner's identified the following as being conducive to meeting the needs of diverse families accessing community substance use services:

The dominant story of *standard mode*, or family exclusion, was challenged by many examples of family inclusion demonstrated in individual practice.

Practitioner Skills	Values	Qualities
Ability to build safe and open space	Positive regard for the abilities and capacities of family systems.	High tolerance for distress and uncertainty
Ability to self-reflect and ground	Commitment to social justice	Creativity
Ability to let go of outcome to be present	Strength-based	Openness to learning
Ability to build rapport and connection	Collaboration	Adaptability and flexibility
Ability to resist judgment and remain neutral	Humility	Patience
		Perseverance
		Encouraging

Ability to go at the families pace		Trusting of self
Good listener		Genuineness
Ability to mediate		Kindness
Good at coordinating		Compassion
		Transparency

Alongside the many qualities noted above, a number of practitioners specifically emphasized their ability to sit alongside families as present, supportive partners. They described this presence as not being attached to outcomes or the development of solutions but about compassion, empathy and witnessing. Participants indicated that by being present witnesses, family members experienced relief and care which contributed to their own movement towards ideas and solutions for future directions.

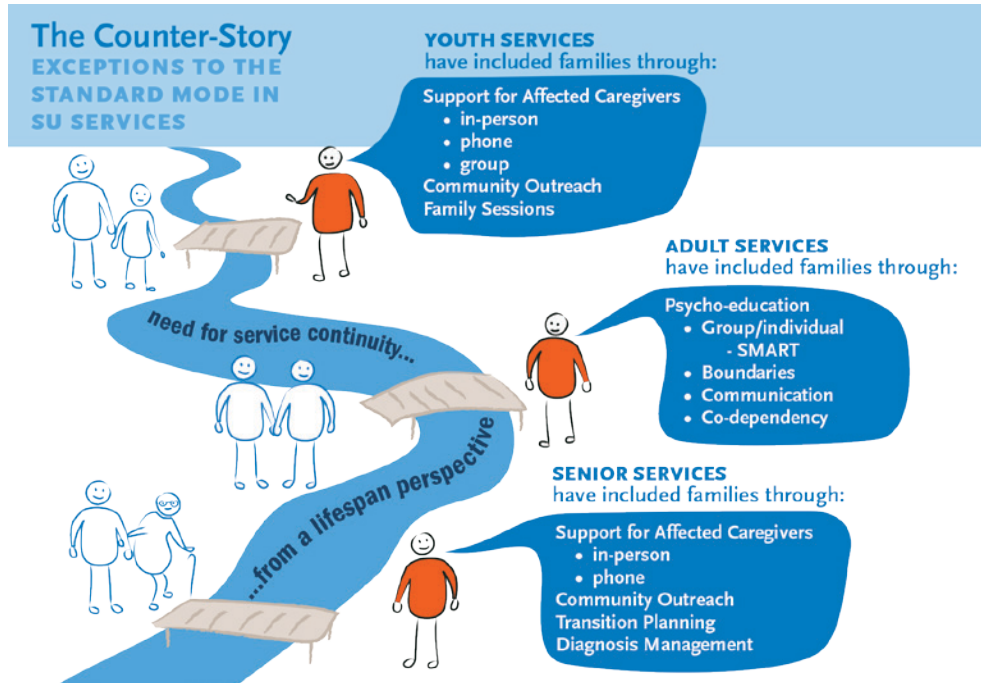
The Best of Intentions Three: Programmatic and organizational examples of Family Inclusion in out-patient Substance Use Treatment Service

Instances of family inclusion were evident across youth, adult and senior services. Efforts to include families were described as either indirect, for the benefit of the individual, or direct, for the benefit of the family in their own right.

Indirect	Direct
Transition planning	Phone calls
Resource referral	One with one counselling
Psycho-education	
Psycho-education groups	
Progress updates: information sharing	

Practitioner qualities were described as disrupting the walls of standard mode, reducing barriers between intention and practice, or family inclusion as a customary performance.

As previously noted, variance was identified across programs, specifically amidst youth, adult and senior’s services. The following graphic highlights resources most prevalently identified in each sector.



Practitioners who were supported to have time to engage with community programs and affiliate partners, reported an increased ability and capacity to include families in effective, relevant and responsive service provision.

Youth services acknowledged importance of engaging and actively involving parents and caregivers in individual or family counselling sessions.

Adult services identified multiple resources for providing education including specific psycho-education groups.

Seniors services emphasized the importance of supporting caregivers in efforts to coordinate treatment and transition plans. Seniors services has experienced significant program shifts as of late and indicated a lack of clarity on program mandate to provide substance use specific services to individuals involved with and affected by alcohol and/or other drugs.

Specific to the system of care, intention also included the provision and allotment of time for peer and supervisor consultation. Peer and supervisor consultation were described as important components to encourage, validate and grow capacity to engage with families. When asked *who* was involved in their work with families, one participant said *“My supervisor. Often I find myself sitting with discomfort, because at times there can be high risk involved in my work with families. I need someone to help me consider my role and how I can continue to manage and support families without swerving way off base.”*

More broadly, participants also identified coordination and collaboration amongst community agencies and multidisciplinary partners as being a contributor to family inclusion. Coordination of services was described as being essential to reducing barriers while enhancing system capacity to attend to complex needs of family systems. Practitioners who were supported to have *time* to engage with community programs and affiliate partners, reported an increased ability and capacity to include families in effective, relevant and responsive service provision.

Impacts of Family Inclusion

From the perspective of the practitioner, families are impacted by acknowledgements of importance, the practitioner way of being, and programmatic and organizational offerings of service provision. Research participants identified impacts on families as including the following:

Impacts of Family Inclusion	
<ul style="list-style-type: none"> • Increased belief in capacity/ability • Feelings of being heard and validated • Reassurance • Connection • Personal reflection • Increased efficiency • Organization • Reduced experience of stigma 	<ul style="list-style-type: none"> • Release of need for solution and answers • A sense of relief • Decreased feelings of blame and judgement • Prevention of ongoing family distress and multi-generational impact (ripple effect) • Increased safety



THE BIG PICTURE: What are some examples of how you have included families in your work with people accessing substance use services? What do you value about your efforts to include families in substance use service programming? What qualities have contributed to your best efforts? What might be the impact of these qualities being at the foreground of family involvement?



DISRUPTING STANDARD MODE: A menu of service options allows for family members to access a variety of resources that meet their unique needs at any given moment/situation. A menu of service options also allows practitioners to provide services based on their varying degrees of comfort. For example, consulting with a family over the phone about community resources would be a demonstration of family inclusion that might be more accessible for some. Providing family counselling or therapy might also be an option within the broader systems menu of available services, however this resource may be of interest to select families and practitioners. What might be some examples of menu options that could be enhanced or additionally offered within youth, adult, and seniors substance use service? How might these services be offered in ways that acknowledge for example, cultural diversity and/or a multi-generational lifespan perspective?



SPOTLIGHT: A number of research participants identified an interest in learning more about what other programs are doing to currently engage families and what clinical specialization practitioners engaged in youth, adult or senior services holds. Such coordination of learning would be an opportunity to build capacity to work collectively with families from a lifespan perspective thus acknowledging the concept of the ripple effect in clinical practice and the preventative nature of holistic, multi-generational interventions.

Family inclusion was described as being preventative in nature, mitigating the adverse effects of substance use on younger generations. However, as previously noted, services for affected family members in their own right are sparse. How might an understanding of family inclusion as a preventative mechanism enhance a comprehensive, multi-layered system of care?

The Preferred Story: “Shifting Culture, Shifting Practice”

What are the possibilities for increasing practitioner and organizational capacity to facilitate family inclusion in substance use treatment services?

Another element of an Appreciative Inquiry project is to invite participants to dream big! Dreaming big elicits stories and descriptions of ideals, highest hopes, wishes and ultimately preferred directions or preferred stories. In order to gain a fuller understanding of what possibilities might exist within an inclusive substance use service system participants were asked to create a picture of “*what could be.*”

Individual responses contributed to an elaborate whole, a multifaceted, interconnected picture of necessary features of what could equate to an increasingly family-informed system of care. Participant ideas and dreams painted a picture of the possibilities and potentials for family inclusion as a customary performance or ongoing practice.

Upon reviewing the data, the research team identified several resounding themes. Perhaps most striking was that, according to participants, in order to strive for family inclusion a larger *culture shift* or what participants often noted as a “*shift in a way of working*” and a “*shift in a way of thinking*” within the out-patient substance use service system, and broadly within society needs to occur. Such a culture shift would be largely value-based affecting changes in organizational response and in turn, in practice. One participant described this shift as “*revolutionary.*” In response to an invitation to share highest hopes another participant said “*We will have progressed more in our cultural awareness and safety and I think more programs would be working similarly. There would be acknowledgment, from the whole system, that people accessing services are the experts of what they need and how they need it rather than them having to fit our services we would be working harder to fit what families need.*”

In addition to the need for a shift, participants emphasized a desire to turn dreams into reality. All talked about a wish to be actively involved in change “*I want to be a part of a culture shift [within the organization] and within my own team—versus people not even wanting to take a phone call from a family member, to supporting a broader perspective of how we can work with families.*”

In addition to the need for a shift, participants emphasized a desire to turn dreams into reality. All talked about a wish to be actively involved in change.

Preferred Story for Substance Use Services PRACTITIONERS' 'BIG DREAM'



Culture Shift: Dreaming Big for a Preferred Story

The following list offers dreams and ideals offered by participants upon being invited to generate a preferred story of family inclusion as ongoing, customary practice.

Shift in Values

"I would be really proud of a society that normalized distress, normalized human experiences and in turn normalized the capacity of humans to move through. Maybe the family member did try substances but that is not to say that they are destined to a life of this. There needs to be a shift in our ways of thinking about substance use—that is critical."

- Families as important: holding knowledge and expertise, resources
- Substance use as contextual: beyond individualised discourse
- Lexicon of strength, capacity, ability: strength-based language shifts
- Family as broadly defined
- Acknowledgment of family wellness throughout the lifespan/ as a marker of health as preventative
- Multiple ways of knowing and understanding: de-colonizing, collectivist worldview

Shift in Organizational Response

“What would make me proud is if the system knew what was happening in our efforts to provide direct service. I would be happy if my workers here were included in discussion about policy, changes, and the direction of health care. We have so many talented people in substance use that need to be utilized for their experience and knowledge.”

- Structural/Operational Considerations
 - Family policy and standards of practice (across the lifespan with specific considerations for youth, adults and seniors)
 - Service design and delivery based on a broad definition of family
 - Professional Development Infrastructure: Education, training, supervision
 - Family inclusion modifications to wait-list, intake, and reporting/charting criteria
 - Family-friendly, culturally safe, trauma-informed service spaces (i.e. larger offices, child-friendly spaces, community outreach, community spaces, provision of food).
 - Reduced barriers to service including transportation and childcare
 - Allocation of time for family inclusion, service coordination, and professional development
- Capacity building to contribute to family inclusion as customary practice
 - Leadership Endorsement of Family Inclusion
 - Staff diversity/access to service providers with multicultural perspectives
 - Collaboration with First Nations organizations, Elders and traditional healers
 - Provision of clinical supervision and consultation, mentorship and time for peer supervision
 - Feedback and consultation loops between leadership and direct service providers
 - Collaboration across systems: Coordination within substance use programs across the lifespan, shared resources, education and service delivery, and support.
 - Efforts to reduce stigma through community-based education on substance use (available to allied service providers and communities at large).

Shift in Practice

“If the opposite of addiction is connection, being a part of that connection is so important. To be a face that says ‘this is not a shameful thing, we don’t have to go into this little room to do this work, we can be out here with you. ‘ It just takes away the shame.”

- Increased commitment to include families indirectly and/or directly in service provision
- Acceptance of multiple lenses through which to view substance use and dependence including contextual, bio-psycho-social-cultural.
- Expanded family work menu of options
 - o Traditional healing and culturally relevant practices
 - o Individual sessions and process groups for caregivers and family members affected by substance use
 - o Individual family counselling including couples counselling
 - o Peer support groups
 - o Experiential and activity based counselling and support options (e.g. art, outdoor, cooking)
- Responsive, early, proactive involvement with families
- Permission to provide support to caregivers in their own right
- Use of mediated technology such as the Internet to increase access and options for support
- Multi-generational, lifespan approach to service provision
- Community-based service delivery for families
- Partnerships with community agencies and coordinated service provision (i.e. psycho-ed and process groups, experiential activities).

According to research participants, a broad structural culture shift would have direct implications on the experience of the practitioner and the experience of the family. *“Being more responsive and accessible, I think we could actually save lives. I really do!” “People would feel a sense of being cared for and being safe and feeling like ‘okay there is help and I am not alone.’ It would be a feeling of like society cares.”*

From the Perspective of the Practitioner: Impacts of a Culture Shift	
Practitioner Experience	Family Experience
Excitement	Decreased need for services
Hope	Decreased stigma
Clarity	Safety
Confidence	Decreased isolation/ Increased connection
Cultural awareness	Decreased generational trauma
Pride in broader organization	Increased wellbeing within family system
	Increased control and choice
	Confidence in broader organization
	Decreased barriers/walls

As the CWC findings illuminated, the implications of the above shifts would have resounding impacts on all stakeholders including organizations, practitioners, community, and at the heart, families. To summarize such an impact on families one participant explained *“More people would be accessing services and people accessing services would feel a lot more control over their own lives and they would feel more empowered to choose from a menu of options, rather than limited resources. They would have access to diversity because [practitioners] would be more open to working in different ways.”*



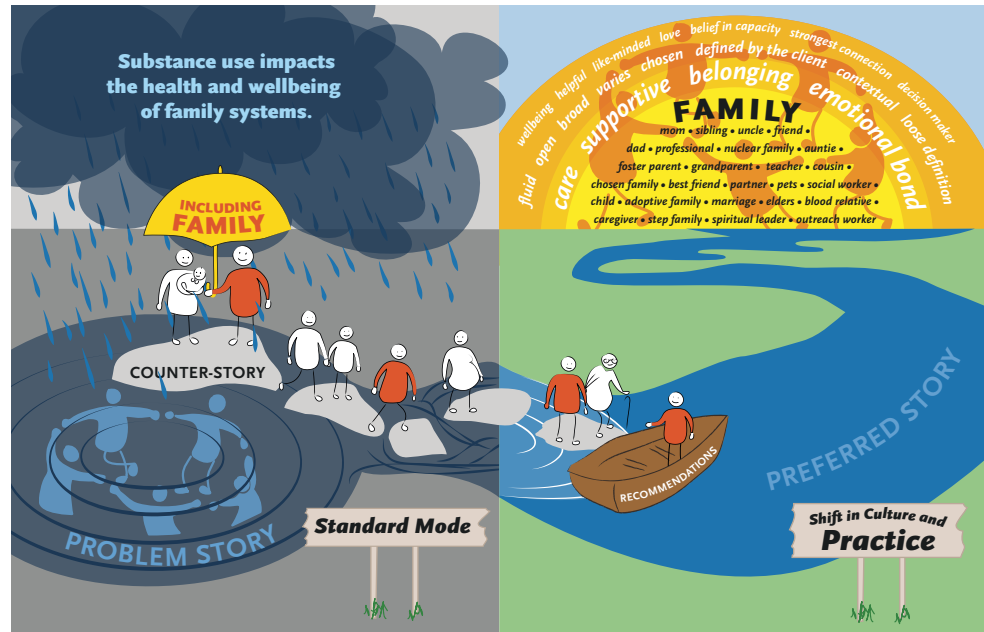
THE BIG PICTURE: What are your highest hopes and biggest dreams for family inclusion in substance use services? What would be happening in your work, your program, your organization, and socially that would make you feel proud?



DISRUPTING STANDARD MODE: At the heart of the aforementioned culture shift is a philosophical movement from an individualistic discourse for which to conceptualize and respond to substance use to a more relational and contextualized viewing. Such a shift would ripple to inform organizational structures and operational responses in turn contributing to practitioner capacity and expectation.



SPOTLIGHT: In what ways might the above preferred vision for out-patient substance use services shift and form to account for differences in in-patient and/or live-in substance use services, and/or within programs across the mental health system of care?



The Story of the “Big Picture”

Disrupting Standard Mode: Intention to practice

Unless changes are made to include relational ways of knowing and understanding substance use, ongoing and accessible programming will remain inconsistent across substance use services.

Findings from the CWC research project highlight the need for a multi-layered shift to contribute to current knowledge about the intention to include families in out-patient substance use treatment programming as a customary performance/part of service provision. These shifts involve a careful consideration of what dominant values are informing services and how these values privilege individualized, Westernized service focus. Unless changes are made to include relational ways of knowing and understanding substance use, ongoing and accessible programming will remain inconsistent across substance use services. A coordinated response to substance use service provision spans across the lifespan acknowledging the multi-generational ripples of substance use and the preventative efforts required to mitigate ongoing family distress.

Exceptions to the dominant story of family exclusion or individualized practice, glimmered throughout participant responses. Such exceptions were framed in intention highlighting the importance of family inclusion and current offerings of family inclusion. Practitioners particularly valued how they engaged with families and identified strengths and abilities allowing them to do so. Broader system strengths included relationships with allied partners and community stakeholders and opportunities for clinical and peer supervision.

Family inclusion as customary practice can be made possible by supporting recommendations that disrupt, or stand up, to standard mode and support shifts that construct a conducive context for responsiveness, accessible and available services.

Recommendations and Further Discussion

An Invitation to Ongoing Conversation

The CWC research project highlighted clear intentions and big dreams for substance use service provision. The following section provides specific recommendations developed to align the best of intentions with the customary performances of available and accessible family inclusion practices. These recommendations are multifaceted and require active and coordinated efforts across social, organizational, community, and professional domains. Such coordinated efforts will ripple to influence a big picture of family wellness from a relational, lifespan perspective. Each of the following recommendation includes a general description and specific considerations relevant to Socio-Political, Organizational, Cross-Sectoral and/or Practitioner contexts.

Despite the influence of families on the individual accessing substance use services families are generally not included in conventional service provision as a customary, ongoing and readily available practice.

Sparkling Shifts in Socio-Political Values and Attitudes

Many of the following recommendations are intimately connected to a broader systemic movement, or socio-political value shift moving beyond singular individualised perspectives and ways of working with and responding, to include relational ways of conceptualizing the context around people accessing services and people providing services. A relational perspective/value humanizes people living *and* working in complex systems. It shifts the binary of us and them, inviting awareness and active efforts to engage people in coordinated and collaborative actions, mutually invested in the wellbeing of the whole.



Acknowledge prominent values and theoretical perspectives currently informing substance use service delivery and both organizational and practitioner responses to individuals and families.

An expanded definition of family

The term “family” is a highly nuanced construct, underscoring not only pragmatic operational connotations but complex principle-based, philosophical perspectives and dominant societal norms and attitudes. For any substance use service, defining family is a necessary precursor to establishing a clear understanding of what family inclusion involves.

The Centre for Addiction and Health (2004) describes family as who the client sees as a significant support in their life and the Ontario Centre for Excellence described family as “a circle of care and support offering enduring commitment to care for one another related either biologically, emotionally or legally, [taking] into account those who the client or person with lived experience identifies as significant to his/her well-being” (2012, p.15).

The term “family” is a highly nuanced construct, underscoring not only pragmatic operational connotations but complex principle-based, philosophical perspectives and dominant societal norms and attitudes.

Similar to the above descriptions, the CWC research project illuminated practitioners understanding of the term family as being broad and including people identified as members of a community of care at a given point in time, by the person accessing services. This community may include those who are connected by traditional blood ties and other perhaps more significant or long-standing informal relationships. Friends, community members, Elders, mentors, neighbours, and even pets, might be a part of an individuals preferred network of carers. Such acknowledgment highlights the importance of supporting an individual’s right to define what family means to them and who family includes. The concept of family is authored by its members. Further, the notion of who comprises family is not stagnant, but within the context of helping services, shifts and changes depending on the presenting circumstances at the time of need. This description of family recognizes the various relationships of importance that exist in a person’s life influencing the practical application of what family inclusion could look like in practice.

The notion of who comprises family is not stagnant, but within the context of helping services, shifts and changes depending on the presenting circumstances at the time of need.



Broaden the definition of family to include individuals and groups as identified by the person accessing services. Recognizing people as resources of care and support will widen the circle of care and reduce stigma and shame.



Expand the definition of who and what constitutes family by inviting people accessing services to cast broad nets of who might be perceived to offer support, care and wellbeing.

Identify family at the beginning of service provision in order to enhance opportunities for family inclusion at the outset.



Participate in efforts to develop shared definitions of family across service systems.

Wellness is a family issue throughout the lifespan

An inclusion of a holistic, relational based lens would serve to open the door to families as resources, while acknowledging the impact of substance use on the wellness of families and communities throughout the generations.

The theoretical/ideological lenses guiding dominant substance use knowledge directly influence the design and delivery of substance use programming. What became clear in the CWC research findings is the impact of the singular standard mode of knowing and responding to substance use. Such a perspective places substance use and dependence in the individual, locating the problem within the individual as a function of choice, moral failings, or, as with a bio-medical view point, disease/disorder. Individualistic ways of responding to substance use privilege interventions that place primary focus on the person identified as the client, implicitly and explicitly excluding external contexts including informal resources and sources of wellness and support such as families.

An inclusion of a holistic, relational based lens would serve to open the door to families as resources, while acknowledging the impact of substance use on the wellness of families and communities throughout the generations. A relational understanding emphasizes the preventative nature of family inclusion as a resource to mitigate the ripples spurred by consequences of, what might be called, problematic substance use.



Incorporate a relational perspective to health, considering people in the context of historical, social and political influences. Acknowledge people in relationship with home, community, work and school environments. As the family as a whole benefits from family inclusion, understand health outcomes as being reflective of family wellbeing versus individual wellbeing.



Acknowledge substance use across the lifespan and the multi-generational effects. Encourage coordination and collaboration between service systems youth to adult to seniors while committing to a shared vision for family inclusion. Develop processes that allow for cross-program/lifespan transition planning, resource sharing, and the support of family members throughout the generations.

Recognize the preventative nature of family inclusion and the provision of services to affected family members as allaying the ripples of distress and throughout generations. Coordinate services for youth, adult, older adults affected by a loved one's involvement with alcohol and/or other drugs.



Enhance collaboration between government and community programs with mandates to support the health and wellbeing of families. Ensure basic needs are met, resources for housing are provided/maintained so that successful outcomes/wellbeing can be better realized across the system of care and throughout the generations.

Deconstruct stigma and shame associated with substance use and dependence

Societal stigma and judgment contribute to exclusionary practices and family experiences of inability and blame. Dominant socio-political attitudes and values influence the construction of family identities including how families see themselves and how families are perceived by others.



Develop and deliver community education campaigns and initiatives to breakdown stigma and other social barriers to accessing substance use services.



Organizations and direct services providers can shift problem-saturated, deficit based stories of family by shining a light on preferred descriptions of capacity, strength and ability. Shift narratives by describing families as beneficial resources of support for the individual, service provider. Acknowledge the need of families to receive services in their own right and the ripple effect of family wellness as a determinant of health throughout the generations.

Consider and critique dominant language often used in substance use practice and what implications words have on the construction of lived experiences (i.e. “enabler, addict, co-dependent”).

Enhancing Organizational Responsiveness

System responsiveness includes important aspects in terms of increasing accessibility and availability. The experience of people and families accessing substance use systems can be influenced by an overall system way of being. Characteristics of this way of being were described in section 2.1 Practitioner Qualities

Dominant practices of systems, practitioners, and client populations are largely structured as a hierarchical composition built with system stakeholders at the top, client populations at the bottom, and dominant substance use constructs as scaffolding framework. Developing resources for family inclusion requires the recognition of all parts of the helping structure as interconnected and influenced by and contributing to the other—a conceptualization of *we* rather than *us and them*. The barriers of standard mode can be disrupted by engaging and working with people as resources as opposed to the problem to be fixed or the cause to be constrained.

Developing resources for family inclusion requires the recognition of all parts of the helping structure as interconnected and influenced by and contributing to the other—a conceptualization of *we* rather than *us and them*.



Organizational

Managers and leaders endorse family-inclusion and practices that enhance capacity to provide services for families.

Provide ongoing direction and oversight by managers and leads including opportunities for consultation, evaluation and reciprocal exchange of information from direct service providers up.

Engage families, people accessing services and direct service providers in consultation and development of policy/practice standards specific to the definition of families, menu of service options for families, and ways of supporting families connected to people accessing services, and in their own right, within the parameters of confidentiality. Increase clarity on system expectations and practices.

Promote multiplicity and considerations for diverse ways of knowing and understanding substance use, family, treatment, and health

Considering multiplicity in terms of substance use knowledge, theory, and treatment efforts expands applicability and relevance to accommodate the diversity and inimitable contexts of people accessing services. This in turn supports the expansion of current scope of ideas and practices beyond taken for granted, westernized and conventional traditions.

The CWC project did not engage in a dedicated process to engage with Aboriginal practitioners providing substance use services. Although a number of participants identified their own Aboriginal ancestry during interviews, this project provides a snapshot of information of a small group. Findings from the CWC project align with several principles outlined in the First Nations Health Authority (FNHA) Mental Wellness and Substance Use 10-Year Plan, *A Path Forward* including “holistic wellness,” “community care,” “integrated care,” and “specialized care.” *A Path Forward* can be viewed in entirety at http://www.fnha.ca/Documents/FNHA_MWSU.pdf



Increase availability of community-based services in concert with existing community resources as preferred by families accessing services.

Include culturally-based family healing practices and traditions beyond Westernized concepts of individual counselling and office-based service

Engage with Elders in service design and provision, staff development and training

Increase access and collaboration with First Nations counsellors, community members and service providers.

System responsiveness: Increase access

Responsiveness requires a movement from an expectation in which one adjusts to the system, to a consideration of how the broader substance use treatment system adjusts in response to the unique person and family system.

Families accessing complex health systems navigate convoluted pathways that lead to resources that may, or may not, be culturally, socially, and/or contextually relevant. Some might encounter additional barriers/walls accommodating program hours, intake criteria, and program mandates.

System responsiveness requires an attention to the degree in which services are accessible and a consideration of how they can be increasingly open and meaningful to meet the many exceptional needs of people requesting care.

Responsiveness requires a movement from an expectation in which one adjusts to the system, to a consideration of how the broader substance use treatment system adjusts in response to the unique person and family system.

Organizational

Evaluate office space settings to enhance safety and comfort for families – see the BC Trauma Informed Practice guide and Island Health Review of SU Services

Accommodate multiple family members by increasing access to larger office spaces and child-friendly meeting rooms.

Review wait-list criteria and barriers preventing family members from receiving timely and responsive access to substance use services.

Explore the option of flexible parameters regarding service provision including evening hours.

Advertise resources for families in community – agencies, locations where families would be able to access such information. Use mediated technology to promote programs.

Expand office-based counselling to include community-based outreach.



Collaborate with community service programs in order to coordinate resources for families, and affected family member across the lifespan, providing increasingly seamless services within the substance use system of care. Recognize the preventative nature of coordinated multi-generational service provision that views wellness as a family issue.

Expand availability

Family-inclusion is dynamic, varying based on the needs of people accessing services and their identified circle of care. The CWC project highlighted a number of examples of what family inclusion currently looks like across the landscape of out-patient substance use services. Examples ranged from psycho-education on the phone, and/or within individual/group sessions, in-person counselling with affected caregivers, transition/treatment planning meetings to name a few. However, although a variety of resources do exist to support identified family members, not all forms of support are accessible and not all are acceptable as culturally and/or relationally appropriate.

Family-inclusion is dynamic, varying based on the needs of people accessing services and their identified circle of care.



Identify a menu of service options that encourage a family lens throughout service planning. Consider both direct and indirect options for practitioners with varying degrees of training and interest in working with families attached to existing client, or not, and affected by SU.

Explore the option of hiring/training and/or identifying practitioners with family-specific training, interests and expertise.

Expand capacity to provide services to family members in their own right including individual sessions, psycho-education groups and process groups.



Organizational

Support the allocation of time for practitioners to include multiple family members on existing caseloads, including time to coordinate with community agencies, colleagues and clinical supervisors.

Expand availability of experiential and expressive service options and other diverse practice perspectives to accommodate the unique dynamics, values, beliefs and understandings of family and substance use.

Use mediated technology to expand service provision for families in rural and remote communities. In addition, use technology to expand services for those unable to access services because of current responsibilities to family members (e.g. children and other dependents).

Explore existing models of family inclusion including those that demonstrate family inclusion along a spectrum or continuum, for example, family-aware to family-centred. See Families at the Centre: Reducing the Impact of Mental Health and Substance Use Problems on Families. A Planning Framework for Public Systems in BC.



Practitioner

Explore opportunities for family engagement at the point of intake. Identify with people accessing services who they would include as being contributors of support and part of their circle of care. *“Immediately engage families in the intake process.”*

Review, with people accessing services, limits to confidentiality, thoroughly explaining both risk and benefits of including informal supports in service delivery. Complete release of information documentation and, with consent, include families (as defined by the person) in treatment planning, transition planning and progress updates.

Develop feedback loops to share information between people accessing services and direct service providers and upper/executive management.

“Those who seek to change an organization should harness the natural creativity and organizing ability of its staff and stakeholders”.

Leadership, government, and academic communities can collaborate with people accessing services as teachers and allies, while supporting practitioners to engage as learners and partners. The family voice can be privileged by opening space to share what they deem as important and encouraging active participation in the development of substance use services and resources. Including people as contributors in the development of programming allows for the co-creation of relevant responses and unique understandings, while standing up to the walls of standard mode.

Similar to how one might describe the importance of a family system, practitioners identified their own belonging to an organizational system and the need to engage with leadership in back and forth consultation, feedback, and program planning. The need to share an audience with leadership, including executive leadership, was noted as being an important component of practitioner wellbeing. Practitioners highlighted the importance of relational ways of being, reverberating through how organizations interact with service providers and how service providers interact amongst colleagues and peers.

Similar to how one might describe the importance of a family system, practitioners identified their own belonging to an organizational system and the need to engage with leadership in back and forth consultation, feedback, and program planning.



Develop mechanisms to receive and incorporate feedback from family members and individuals accessing substance use services including family advisory committees, surveys and follow-up.

Develop opportunities to support the best efforts of practitioners providing substance use services. Include leadership in the practitioner circle of care by eliciting and appreciating feedback, consultation and information sharing.

Sustaining the Vitality of Practitioners

Ongoing education and formal support sustains the health and wellbeing of the practitioner, contributing to vitality and vigor in clinical work.

Despite substantial research supporting family inclusion and the recognition from practitioners that families are important contributors to substance use services, as highlighted in the CWC study, there is a divide between intention and family inclusion as customary practice. Participants attributed a lack of education and training as being a current constraint to effective work with families. Organizations, educational institutions can address this need through ongoing workforce development and educational opportunities. Ongoing education and formal support sustains the health and wellbeing of the practitioner, contributing to vitality and vigor in clinical work. Sustaining of practitioner efforts requires commitment and collaboration amongst direct service providers, leads and broader systems.

A green circular icon with the word "Organizational" written inside in white text.

Organizational

Develop a sustainable and long-term workforce development plan inclusive of ongoing staff professional development opportunities reflective of diverse modalities and practitioner interests, cultural traditions, and roles.

Create and encourage opportunities for peer and clinical consultation as a regular practice to enhance confidence, capacity and effectiveness involving families (indirectly and/or directly) in substance use services. Support the allocation time for service providers to engage in consultation/supervision.

Provide access to substance use specific education in order to contribute to substance use specific knowledge including theoretical perspectives, evidence-informed treatment, family-inclusive care, cultural competency and humility, Trauma Informed Practice. Deliver training and education across programs, encouraging opportunities for youth, adult and senior's knowledge exchange and information sharing.



Develop and encourage involvement in Communities of Practice (CoP's)/ Family Committees and other means for exchanging and enhancing resources and skills for working with families from a relational lens.

Develop resources to be shared across programs to support practitioner's best efforts to include family members affected by a loved one's involvement with substances.



Engage in practices that support awareness of self, the location of self, in relation to family, and implications for responses to families accessing services.

Participate in sustaining practices to support the longevity and wellbeing of practitioners working within the complexities of SU service. Sustaining practices include activities and strategies that contribute to health and wellbeing.



Provide coordinated family training amongst community agencies and allied stakeholders—inclusive of practitioners representing the broad substance use system of care.

Conclusion

At the heart of this understanding is a conceptual awareness of individuals within the context of family and community (biological and/or chosen), and an appreciation of the importance of supporting families as a preventative and treatment mechanism to bolster wellbeing of the entire family unit across the lifespan and throughout generations.

The *Collaborating with Carers* research project endeavored to engage direct service out-patient substance use service providers in an Appreciative Inquiry exploring the current and preferred landscape of family inclusion in substance use treatment programming. In an effort to add to applied substance use practice, the project elucidated rich descriptions of the importance of family inclusion, the barriers to family inclusion and the recommendations necessary to bridge intention and the customary, ongoing practice of family inclusion.

This inquiry emphasized a rich understanding what might necessitate increasingly inclusive out-patient substance use services. At the heart of this understanding is a conceptual awareness of individuals within the context of family and community (biological and/or chosen), and an appreciation of the importance of supporting families as a preventative and treatment mechanism to bolster wellbeing of the entire family unit across the lifespan and throughout generations.

Practitioners are deeply invested in the health and wellbeing of people accessing services and with the support of broad and organizational culture shifts will benefit from moves in practice that enrich and enliven confidence and clarity on approaches and mandates to involve families, indirectly or directly, in substance use programming. Further, as holders of unique knowledge, programs offering youth, adult, and/or seniors specific services stand to provide increasingly coordinated and comprehensive services for all members of a family system impacted by substance use, while sharing resources, participating in joint education, and validating the integral aspect each service plays in family wellbeing across the lifespan.



THE BIG PICTURE: How does this research inform your ideas for how you might move closer to your preferred vision of family inclusion in community substance use service programming? Imagine it is one year from now and you are working with people, specifically families, in your most preferred way. What would you be doing? How would you be feeling? What steps can you take today to make this vision come to life?



DISRUPTING STANDARD MODE: Which recommendations can be immediately addressed to reduce the walls of standard mode and begin bridging the divide of intention and practice? Which recommendations need to be considered from a long-term perspective and what key stakeholders will be required to bring these recommendations to life?



SPOTLIGHT: What sparked as possibilities for future research? What questions remain to be answered or new interests have emerged?

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ISBN: 978-0-9950533-1-1



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