



Your trusted voice in mental health

Mental Health Families and Friends Tasmania

Alcohol and Other Drug Project

AOD Family and Friend Needs and Experiences Analysis Report

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Background

Mental Health Families and Friends Tasmania is the peak body in Tasmania representing, supporting, and advocating for family members and friends who provide unpaid physical, practical, emotional, social, mental, and or financial support to a family member and or friend living with mental ill health or co-occurring alcohol and other drug use (AOD use) and mental ill health. Mental Health Families and Friends Tasmania's core business is to advocate for the rights and needs of families and friends at all decision-making tables, drawing on lived experience to improve mental health and AOD services, and to dismantle stigma surrounding mental ill health and AOD use. In this advocacy, Mental Health Families and Friends Tasmania emphasises the unique care that families and friends bring to another, as well as the economic value they bring to mental health and AOD services. Mental Health Families and Friends Tasmania works with its Statewide community to promote and improve the wellbeing of family members and friends of living with mental ill health or co-occurring AOD use and mental ill health through peer support, education, information, and referral help, and has been delivering this in Tasmania for almost forty years. Important context for this report, there are two major changes in the organisation's history that needs to be highlighted.

"I never engaged in services. I am not a partner; I am a sister. I became a foster parent to one of my [loved one's] children, but I was never asked along the process if I needed support."

Firstly, in 2019 the organisation changed its name from 'Mental Health Carers Tasmania' to 'Mental Health Families and Friends Tasmania' and has now fully adopted the term families and friends, and advocates for

the adoption of this language in all mental health and AOD services. This language and organisational name change came from lengthy and extensive consultations from our key stakeholders, families and friends, who highlighted a number of drivers for change. Our stakeholders identified the need to better capture the unique lived experience of mental health families and friends. It was a widely expressed view that the term 'carer' did not adequately reflect the relational aspects of the support person role. Respondents perceived

themselves as kin or a friend, colleague or neighbour rather than as a 'carer' and supported someone experiencing mental ill health or co-occurring AOD use and mental ill health because of this relationship.

The term "carer" was found to be problematic and unrelatable because it is often associated with care given to someone living with a physical disability, or who is in aged care. Families and friends describe the nature of the support they provide being unpredictable and episodic. This is also illustrated in Orr, Barbour, and Elliott's (2012) study where the families and friends that participated in their research who did relate to the term "carer" provided physical support to the person living with drug use or were caring for their relative or friend's dependent children. The other half of families and friends who participated in the research defined their role as family doing what families do for each other. All family members and

friends who participated in the research perceived the support given to someone living with AOD use to be unpredictable and more isolating than caring for family or friends with physical illness of disability, noting that the amount of support from services made a big difference. Furthermore, parallel to Orr, Barbour, and Elliott's (2012) study, families and friends we

"Hospital and other services knew of my role but did not engage with me in terms of a 'carer' role even when I was there."

engage with highlight that services don't recognise families and friends as "carers", and so it is difficult for them to relate to the term. Finally, families and friends tell us that the people they support don't identify as needing a "carer" or doesn't identify anyone as being a "carer".

Secondly, at the start of 2021, Mental Health Families and Friends Tasmania commenced supporting families and friends who are supporting someone living with co-occurring AOD use and mental ill health. This came as a response to the fact that many of the families and friends we engage with were already supporting someone with co-occurring conditions of mental ill health and drug use. As a result of this broadening scope of support, Mental Health Families and Friends Tasmania was funded by the State Government, Mental Health and Alcohol and Drug Directorate, to engage with, support, and gain a deeper understanding of

the needs and experiences of, families and friends supporting someone living with AOD use or co-occurring AOD use and mental ill health (AOD families and friends).

Literature Review

When we talk about AOD use we are talking about when someone's use of alcohol, tobacco, illicit drugs, and or prescription drugs are negatively impacting theirs and their family's financial, social, mental, physical, and or emotional health. Adopting this viewpoint aims to support the harm minimalisation approach that is endorsed in the National Drug Strategy, the Tasmanian Drug Strategy, and the Tasmanian AOD Reform Agenda. Harm minimalisation is an approach, built upon justice and human rights (Harm Reduction Australia, 2022), which acknowledges that alcohol and other drug use is not inherently bad, but focuses on preventing the health, social, and economic harms that come from AOD use (Commonwealth of Australia, 2017).

Co-occurring AOD use and mental ill health has always been a complex health issue facing people, their families and friends, and service providers (Marel, et.al, 2016). Co-occurring AOD use and mental ill health, also known as co-morbidity, is when a person lives with and experiences both mental ill health and AOD use. In Tasmania based on the estimated population for the year 2019, it was estimated that 1 in 16 people would experience and AOD use disorder (Government of Tasmania, 2020). In Australia, around 1 in 20 Australians experience addiction (Health Direct, 2019), and up to 75% of people who live with AOD use conditions also experience at least one mental health condition (Marel et.al, 2016).

According to Marel et.al (2016) the Co-morbidity Guidelines describes a number of possible explanations as to why this complex relationship can occur. Firstly, and probably the most commonly thought causality is that the symptom of the mental illness leads to AOD use with the aim to help alleviate those symptoms, or as a result of their AOD use and or withdrawal of drug use, a mental illness or symptoms develop. There is also a theory that suggests an indirect link where a person's experience with mental ill health or AOD use has impacted

their education or employment, leading to a mental illness or AOD use. Finally, there are biological, social, and psychological factors that increase the likelihood that there will be a co-occurrence. This is important to address because it highlights the complexity that the person, the service providers, and the families and friends have to face and navigate. It begins to illustrate how difficult it is for someone to understand what is happening to them, how difficult recovery is, and how difficult it is for the family and friend to support someone with complex support needs.

“Medical staff, nursing staff and others in Emergency I know are busy and stressed. However, once drugs are involved they don’t want to help the patient. Some comments from staff have been quite hurtful. It feels like a hopeless situation each time my [loved one] is admitted”.

Adding to the difficulties of living with, and supporting someone who lives with, AOD use or co-occurring AOD use and mental ill health, is the stigma that surrounds them both. We know that stigma and discrimination has detrimental effects on a person’s physical, mental, social, and emotional health. As a result, stigma and discrimination of any kind, including AOD use, is a violation of someone’s human rights and dignity (Wogen and Restrepo, 2020). It is understood that the stigma plaguing impacts people’s help-seeking efforts (Wogen and Restrepo, 2020), in fear of discrimination from people, even and especially healthcare workers, in which Farrugia et.al (2019) highlights in their Australian report. Mental Health

“I am embarrassed, I feel like the alcoholism is a reflection on me to some degree”

Families and Friends Tasmania has also found that the stigma faced by people living with AOD use is not unfelt by the families and friends.

Families and friends avoid receiving support, particularly in smaller

communities, out of fear of facing stigma themselves and protecting the person they support’s privacy.

Addressing the barriers for families and friends reaching out for support is significant because the Preamble of the United Nations’ Convention on the Rights of Persons with Disabilities (2007) states that:

“the family is the natural and fundamental group unit of society and is entitled to protection by society and the State, and that persons with disabilities and their family members should receive the necessary protection and assistance to

enable families to contribute towards the full and equal enjoyment of the rights of persons with disabilities”.

We know that the families and friends that provide unpaid, informal support to someone living with mental ill health, AOD use, or co-occurring AOD use, and mental ill health are vital to the care on another, as well as the mental health and AOD services. Deloitte Access Economics (2020) found that to replace all informal care to formal care would cost Australia \$77.9 billion dollars, with primary families and friends on average providing 35.2 hours of care per week. Consequently, supporting families and friends is vital for the people they support, the healthcare system, but also for the family and friends' health, and to prevent families and friends from becoming consumers or clients of AOD and mental health services. In a recent survey conducted by Mental Health Families and Friends Tasmania for AOD families and friends, out of 34 responses, 23 indicated that they themselves use alcohol or

“Inside of every AOD support person is a broken heart, a super-sized heart, shattered in to pieces, but continues on every day and pushes their own wants, needs and health aside to try and help their loved one... So be gentle, be kind, and please don't judge.”

other drugs, and out of that 23, 16 indicated they use as a way to cope with their support role.

There is limited research on the impacts of the informal support role on families and friends in general, but even less so on the effects of supporting someone living with co-

occurring AOD use and mental health conditions, as reflected by Biegel, et.al (2007). The literature that is out there, however, consistently recognises that caregiving often has a substantial impact on a number of areas for a family, including economically, socially, psychologically, and physically (Labrum, 2018). Families and friends face a number of challenges when providing whatever support they might give, for example, families and friends navigate isolation, the challenging behaviours that come with the person they support's illness, relationship breakdowns and tension, and at times, family violence (Biegel et. Al, 2007). These challenges are heightened when families and friends don't have enough support for themselves from their own natural support network or health professionals.

Families and friends often experience what's known as "carers burden", where, as a result of their support role, the financial, psychological, social, and physical costs of supporting someone with AOD use, or co-occurring AOD use, and mental ill health is overwhelming. Interestingly, the concept of caregiving burden remains unrecognised and unaddressed in AOD literature (Biegel et.al 2007). Families and friends that we engage with often speak of feelings of grief and loss, loneliness, hopelessness, exhaustion, guilt, and shame, as a result of the stigma surrounding these health issues. Biegel et.al (2007) describes how those living with co-occurring mental ill health and AOD use are at a higher risk of experiencing relapse, hospitalisation, violence, incarceration, homelessness, and serious infections such as HIV and hepatitis. It is important to highlight these experiences because the families and friends who support those living with the co-occurring conditions are exposed and impacted by them as well. Furthermore, people living with these co-occurring conditions experience difficulties managing and undertaking day to day living tasks and have higher rates of unemployment than those living with a single condition (Townsend et.al, 2006). Families and friends carry the financial responsibility to support their loved one, carry the practical responsibility to support someone with their day-to-day living, and carry the responsibility to be the emotional and mental support, and responding to crises. Notably, these activities are the same, if not more than, what the clinical treatment team would do. Moreover, families and friends are carrying and performing these responsibilities without the education and training about current treatment approaches, relapse prevention, and other necessary skills and knowledge that the clinical teams have (Cleary et.al, 2009). Unsurprisingly, it is understood that families and friends who support someone living with co-occurring AOD use and mental ill health experience greater negative impacts from their support role than families and friends who support someone living with just mental ill health or AOD use. These impacts include greater stress, overlooking their own health more and a greater impact on their health, feel more isolated, and perceive to experience greater stigma (Labrum, 2018).

Grief and loss is a significant and multilayered experience for families and friends. In the years that Mental Health Families and Friends Tasmania has been supporting families and friends, grief and loss is always addressed. Grief and loss comes as a result of the loss of personal freedom, of the person they once knew, of the life that they had once envisioned for themselves but also the person they support, loss of friends, opportunities and employment, and in some cases grieving the death of the person they support (Priddis and Asbury, 2020).

Throughout Mental Health Families and Friends Tasmania's 38 years of advocacy, support, and engagement with mental health and co-occurring mental health and AOD families and friends, we hear consistently that what families and friends want, and need is to be included in the person they support's treatment and recovery journey. According to Orr, Barbour, and Elliott (2014), evidence supports that the best practice in drug services is to involve families and friends in the client's treatment and support families and friends in their support role. So much so that internationally, it is understood that family-focused interventions or therapies are more effective in recovery than concurrent and individual therapies for the client and the family (Orr, Barbour, and Elliott, 2014). Despite this evidence and encouragement from policies and research, its practice is scarce.

"[I want decision makers to know] how difficult it is. How stressful it is. How you have to advocate HARD to get staff to listen to your concerns. No one wants to listen to the patient's history unless you insist on meeting with doctors. It is heart breaking to feel like your [loved one's] future is at risk when no one wants to listen to the family."

Orr, Barbour, and Elliott (2014) highlight two theories that impacted AOD services in the past, the co-dependency model and the family systems model. These models suggest that drug use stems from either the mutually destructive relationship between people who use drugs and their family members, or that drug use is the result of dysfunctional relationships in the family. More recently, the stress-strain-coping-support (SSCS) model has been adopted, which theorises that family members are not the cause of addiction, rather family members and people who use drugs are survivors of stress and strain, and drug use is the result (Orr, Barbour, and Elliott (2014). Despite Australia being one of three countries to

develop and adopt the SSCS model, the scars of the family systems model and co-dependency model are still seen today. Those scars are seen in a more implicit stigma that “family is part of the problem” through beliefs such as there not being a family member or friend that is willing to or able to provide reliable and consistent support or not trusting that involving families and friends actually benefited clients (Orr, Barbour, and Elliott, 2014).

AOD families and friends have identified that education around AOD use, and co-occurring conditions is incredibly important. According to Cleary et.al (2009), families and friends’ education needs are similar to that of clinicians to ensure they can accurately communicate, understand information, and ensure the best service provision and client outcomes are achieved. In the study conducted by Cleary et.al (2009), received positive feedback and results from consumers and families and friends on an education workshop which covered topics such as: the prevalence of AOD use and addiction, reasons for AOD use, symptoms that might indicate that someone’s AOD use is becoming problematic, contemporary, evidence-based therapeutic treatment approaches, referral services, and management strategies.

AOD Family and Friend Survey

In May 2022, Mental Health Families and Friends Tasmania conducted a survey to gain an understanding of the experiences and needs of AOD families and friends. 42 families and friends responded to the survey. Out of that 42 respondents, 6 people support someone living with just AOD use, 35 people support someone living with co-occurring AOD use and mental ill health, and 1 respondent preferred not to say. The survey comprised of 17 questions ranging from multiple choice, rating, and descriptive answers. The 17 questions included:

1. *Do you support a family member or friend living with AOD use, AOD use and mental ill health, or prefer not to say?*

2. *How would you describe your experience as a family member or friend who supports/ed someone living with AOD use or co-occurring conditions of AOD use and mental ill health?*
3. *How would you describe your experience engaging with AOD services or AOD and Mental Health Services as a support person who supports/ed someone living with AOD use or co-occurring conditions of AOD use and mental ill health?*
4. *How much has the stigma surrounding AOD use impacted you in your support role?*
5. *Are there differences in the stigma surrounding AOD use and mental ill health?*
6. *What has helped and/or not helped in your support role?*
7. *What do AOD support people need?*
8. *What would an ideal support program look like for AOD support people?*
9. *Have you ever received training or education to help you in your AOD support role?*
10. *Would you like to receive information/education/training?*
11. *How would you like to receive information/training/education?*
12. *What information/training/education would you like to see for AOD support people?*
13. *How similar has your AOD support experience been to your Mental Health support experience?*
14. *What do people or services understand or not understand about supporting a family member or friend who lives with AOD use?*
15. *What would you like to have known in the beginning of your support role?*
16. *What would you like decision makers to know about the experiences of being and AOD support person?*
17. *Is there anything else you would like to share about the needs and experiences of supporting someone with AOD use or co-occurring conditions of AOD use and mental ill health?*

Results

The results from the survey highlighted 4 themes: *experiences, stigma, education, and needs*.

Experiences

Through analysing the data on the family and friend experience it was apparent that there was subthemes within this theme: the experiences of the role, and the experiences of engaging with services and the system. The family and friend role experience is, on the whole, an incredibly negative one. Question 2, as shown on the graph in appendix 1, shows for families and friends, the support role is exhausting, challenging, stressful, difficult, and lonely. Throughout the survey and reading the additional comments that respondents made to questions, common descriptions of the experience became apparent. The experience of supporting a loved one who is living with AOD use or co-occurring AOD use, and mental ill health was described as *hell on earth*, a difficult rollercoaster; one that is heartbreaking, relentless, isolating, and disempowering. Collectively, the feeling of grief and loss is profound, with families and friends grieving the loss of the person they once knew, the life they once pictured for their family member or friend, and the life they once pictured for themselves.

Despite the experiences being commonly negative, families and friends also described it as a rewarding and purposeful experience supporting and walking alongside someone in their recovery journey. They see it as an opportunity to become closer to the person they support and learn and understand them on a deeper level, while also seeing it as a learning experience for themselves.

The survey highlighted a number of things that seem to be, unfortunately, all too common for all families and friends supporting someone living with AOD use or co-occurring AOD use and mental ill health. Firstly, and significantly, is burnout. Families and friends spoke to the mental, emotional, and social burden that comes with this role. Consequently, families and

friends drew attention to the fact that they themselves often experience mental ill health, suicidality and AOD use as a result of the trauma, stress, and role of being a support person. Receiving abuse was also heavily mentioned, with families and friends highlighting that when the supported person is incapable of living alone, or the lack of access to housing, the person lives with the family or with friends. This was evidently important as the survey illustrated a complex situation. It was a common occurrence in the survey that the supported person is not receiving professional help and treatment for a number of reasons including difficulty accessing support, refusing to engage in support, or becoming well versed in telling the support workers what they want and need to hear so that they can be discharged. As a consequence, families and friends described the responsibility that is offloaded on to their shoulders, explaining that they are left to provide support and care that should be provided by qualified professionals. However, the needs and skills of families and friends are overlooked, despite this service they provide. Making this situation more complex is relationship break downs and navigating the justice system on top of everything else, which was mentioned extensively throughout the survey.

“My experience counts. I’m not a martyr and shouldn’t be expected to be”.

Families and friends noted in the survey that they find that most people understand that it is a “*difficult rollercoaster*”, however, it was shockingly universal that families and friends did not receive, were not offered, or did not seek support. The survey highlighted a number of reasons for this. Support for families and friends are often conditional on the person receiving support from the service. Families and friends described losing support from peer workers at a service when the person they support is discharged or moves districts,

“I have never thought to reach out for support in relation to my needs, only their needs. Crazy, huh!”

highlighting the lack of continuity of care for the support people.

The second subtheme, experiences engaging with services and the system, have been equally unpleasant for families and friends. As

question 3 in appendix 1 demonstrates that families and friends have found that AOD services have not been supportive, inclusive, or treated them like a partner in the recovery journey, and that services have been difficult to navigate. Question 13 in appendix 1 shows

us that for those who support someone living with co-occurring AOD use and mental ill health, the experiences have been quite similar, however it was found throughout the survey that mental health services have been more supportive and inclusive than AOD services, and when AOD services do include families and friends, it was described as tokenistic.

The survey results showed that not only was navigating services difficult but finding accessing appropriate services was also difficult.

“The AOD experience was counterproductive. Mental health has been slightly easier to deal with but still very vague”

“Services just handballed me continually getting absolutely no where”

Qualitative data found that lengthy waiting times to see GPs and psychologists/psychiatrists are a significant barrier, and that due to a lack of services and the services that are there are so under resourced and underfunded, that people and their families and friends are given “the run around”. The survey data also highlighted the inability to address AOD use when it occurs at the same time as episodes of ill health or the inability to address the mental ill health when the person they support is in “active addiction”.

The difficulties don’t seem to end when support has been accessed. Families and friends described how they were provided no information about what to expect, what to do, and who to contact if things didn’t go to plan when the supported person was receiving treatment. It was common for families and friends to receive no follow up contact after the supported person was discharged from hospital or a service. Families and friends commonly and frequently experienced a lack of trauma-informed care, judgement, and no person-centred care from staff in emergency departments. It was also frequently mentioned that when co-occurring conditions were present, AOD services try to place the person into the “other’s” (mental health services) basket, and vice versa, rather than collaborating, integrating, and communicating.

Stigma

When analysing the survey responses, it became apparent that there were two prevailing themes within the experiences of stigma. Families and friends are impacted by the stigma surrounding AOD use, as well as the stigma surrounding families and friends. The survey responses highlighted that families and friends experience blame for the supported person's AOD use and surmised that their exclusion by services is because they are seen as part of the problem. Commonly, respondents described feeling looked down on for supporting their loved one, with it being assumed the family and friends condone the behaviour or even join in on the AOD use. Families and friends universally described feeling like an "annoying afterthought" by service providers and viewed as the "nasty person", overreacting, or meddling. Furthermore, families and friends describe their reluctance to reach out due to feeling unwelcome and treated like an interference.

"My daughter is set up to fail and my family are set up to manage the consequences of decisions made by practitioners in isolation"

Coupled with this stigma is the overarching stigma surrounding AOD use that is not unfelt by families and friends. Question 4 in appendix 1 shows that AOD stigma has impacted the support role of families and friends quite a bit. Question 5 also shows us that families and friends feel AOD stigma is worst than the stigma surrounding mental ill health, however, families and friends did acknowledge in the survey that stigma is lessening for both.

Respondents speculated that AOD use is more heavily judged than mental ill health as AOD use is seen as a choice, and that people who use alcohol and or other drugs are "losers" who lack self-control. The survey highlighted a societal lack of understanding of the complex relationship between the co-occurrence of AOD use and mental ill health and why it occurs.

The pervasive stigma surrounding AOD use has impacted families and friends in a number of ways. The survey responses describe how families and friends are concerned about receiving face to face education or support in Tasmania out of fear of outing the person they support and themselves, of people thinking poorly of the person they support and

“The stigma of seeking help would have huge impacts on their professional life”

themselves, shame and embarrassment, and the fear that child safety services will become involved, as a result of the small nature of the communities. It was also pointed out that the supported person avoids seeking support or disengages from support due to the stigma and discrimination they have been subjected to by health professionals.. Furthermore, if they do seek support, often the supported person will address their mental ill health but not their AOD use.

Education

The survey found that most families and friends have not received education needed to help them in their support role, and those who have, have had to access and pay for it themselves. Question 12 in appendix 1 illustrates what families and friends need education and information on to better support them in their role. Families and friends also highlighted other areas not listed in the graph, including:

- How to deal with the trauma and emotions that families and friends experience
- Understanding triggers and how to support them
- Co-occurring AOD use and mental ill health
- Setting boundaries
- How to maintain safety
- Terminology used in the AOD sector
- Having tricky conversations
- How to deal with challenging behaviours
- What to expect
- Biological/chemical impacts on the supported person and how to support that
- Not enabling behaviours but keeping them safe
- Legal information on how to protect the person they support from discrimination from stigma
- How to look after their own mental health

- Coping strategies
- Managing role expectations and living their own life

Question 11 in appendix 1 demonstrates the necessity for education and information to be delivered and made available in a range of methods.

Needs

Analysing the data on the needs of families and friends it was apparent that there was subthemes within this theme as well Families and friends needs range from an individual level, service level, and a system level. Question 7 in appendix 1 highlights what AOD families and friends need. Additionally, guided by the experiences of families and friends and the what respondents commonly highlighted in the survey, families and friends need support to navigate the system. Families and friends need to be included in care planning, safety planning, discharge planning, and treatment planning. This need comes from the reliance on families and friends to keep the person safe, supported, and the desire and need of families and friends to support the recovery journey. To do this, families and friends need to be treated like a partner in the recovery journey by being listened too, treated as an expert into who the person was before the AOD use and mental ill health, welcomed, supported, and given information regarding the person's triggers and how to support them, the person's treatment plan and how they can support that, and the person's diagnosis, how to deal with it, live with it, and what to expect. It was widely expressed in the survey that families and friends need qualified support through AOD and mental health services as they have the knowledge about AOD use and mental health. It was also heavily expressed that this support is unconditional, by which it is available even if the person they support isn't receiving treatment. Families and friends expressed the need for respite, crisis support, mentoring, and validation. The survey highlighted the need for families and friends to be genuinely recognised and acknowledge by services, particularly the invaluable support they provide to

"I remember the person they are without the drug and alcohol and mental illness impacts which now seem intertwined and insurmountable. The comorbidity is now a reason not to stop the drug use, as that is "keeping them sane" despite it causing a demise in everything, including every relationship and function in life"

the person and the services. It was also expressed that support is needed in particular times of their journey, such as discharge from the service or hospital and in times of crisis.

At the service level, families and friends need services to be easier to access and navigate, quicker access to programs and less waiting times, accessible rehab programs in the community that sufficiently meet the needs, and more beds in withdrawal and inpatient care. Families and friends need better and earlier support for those they support who are leaving corrections, and better support available before a crisis occurs. Overwhelmingly, the survey responses expressed the need for support holistic care and wrap around support for the

“A patient in a hospital ward should never have the visit of police leaving orders on the bedside table without first consulting and permission of the doctor under the care the patient is.”

person they support, in which all aspects of their health are addressed, knowing that they are all intertwined and impact each other. The need for services to have staff who are skilled, empathetic, professional, and have lived

experience understanding for families and friends and people who live with AOD use or co-occurring AOD use, and mental ill health was also widely articulated. Families and friends conveyed the need for a primary person of contact for the families and friends and a primary person of contact for the client, and for services that the person they support can go back to without having to jump through the same hoops when there has been a period of time between episodes. Importantly, these service level needs address the person-centred and improved care for the people they support, knowing that if they are better supported, then the family and friends will be better supported.

Finally, the system level needs articulated in the survey results include the need for better co-ordination, integration and communication between services, that being between government services, government and community managed services, between community managed services, and between sectors (mental health and AOD). It was also highlighted that the disability pension pay for the person they support is often insufficient for them to live a life of dignity and promote their own recovery. Families and friends highlighted the need for an investment in AOD treatment services, including workforce development, with the

purpose of creating a sufficient pool of accessible services which will in turn ensure the sustainability of the sector and consequently the care for people. Finally, respondents expressed a significant need for the family and friend voice to be heard at systemic level decision making tables.

Recommendations

From the results of this survey, Mental Health Families and Friends Tasmania make a number of recommendations.

Recommendation 1:

A toolkit and workshops for AOD families and friends that is available online and face to face.

Recommendation 2:

Education on the rights, needs, and experiences for current and future AOD professionals and service providers.

Recommendation 3:

Any government and community managed service that provides mental health or AOD support has funding and resources within those programs to support the families and friends.

Recommendation 4:

Added in all community managed services' funding agreements are KPIs that specify supporting, engaging and including families and friends.

Recommendation 5:

In the development of the AOD workforce, Family and Friend and Consumer Peer Workers are included in the staffing profiles of government and community managed services.

Recommendation 6:

Enhanced support for families and friends if the person they support are on waiting lists.

Recommendation 7:

Family and Friend Representatives are included in the development, delivery, and review of Treatment Models, Guidelines, services, programs, and standards

Recommendation 8:

Family and Friend Representatives AND Consumer Representatives are involved in all decision-making tables, including selection panels.

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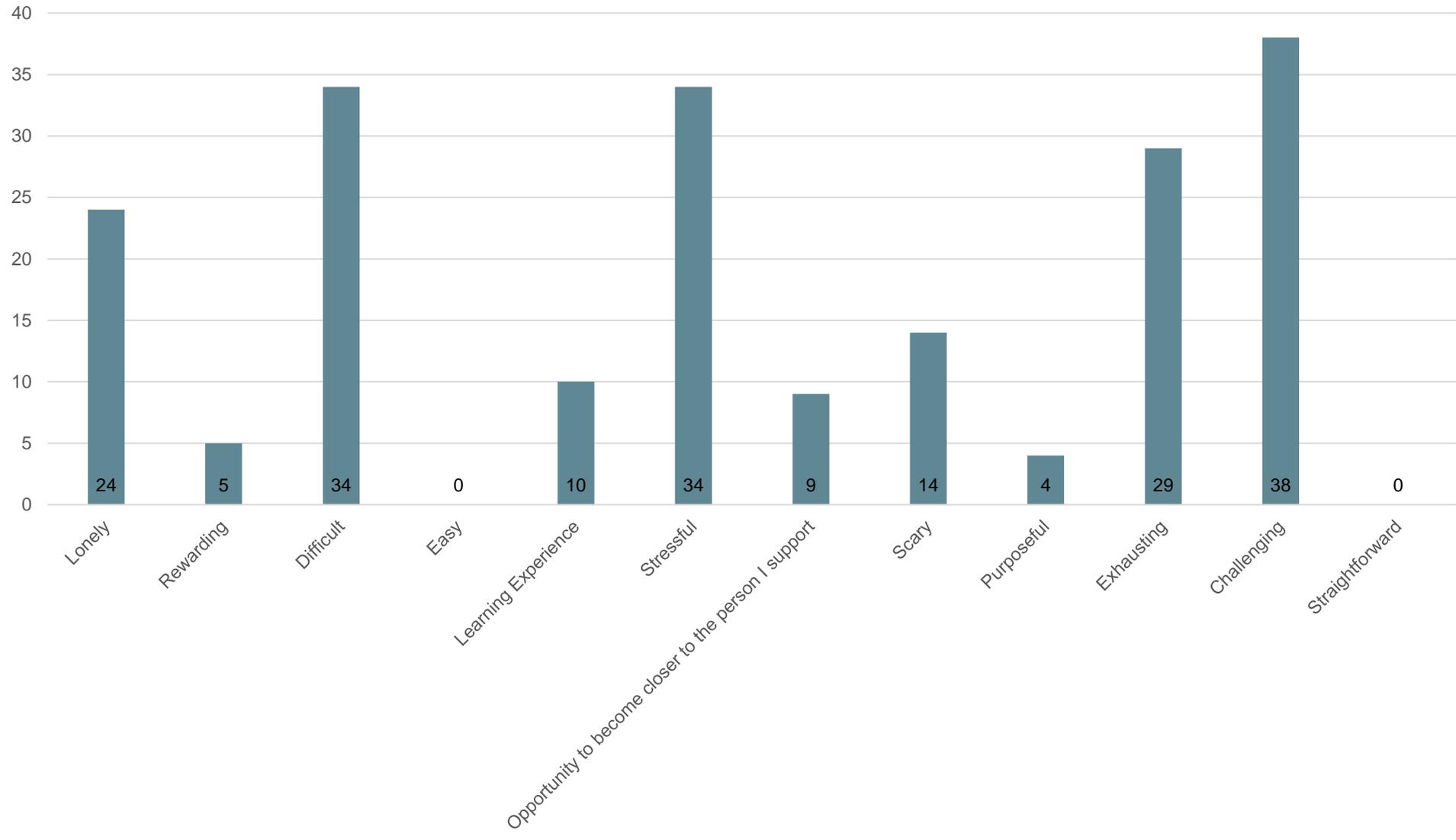
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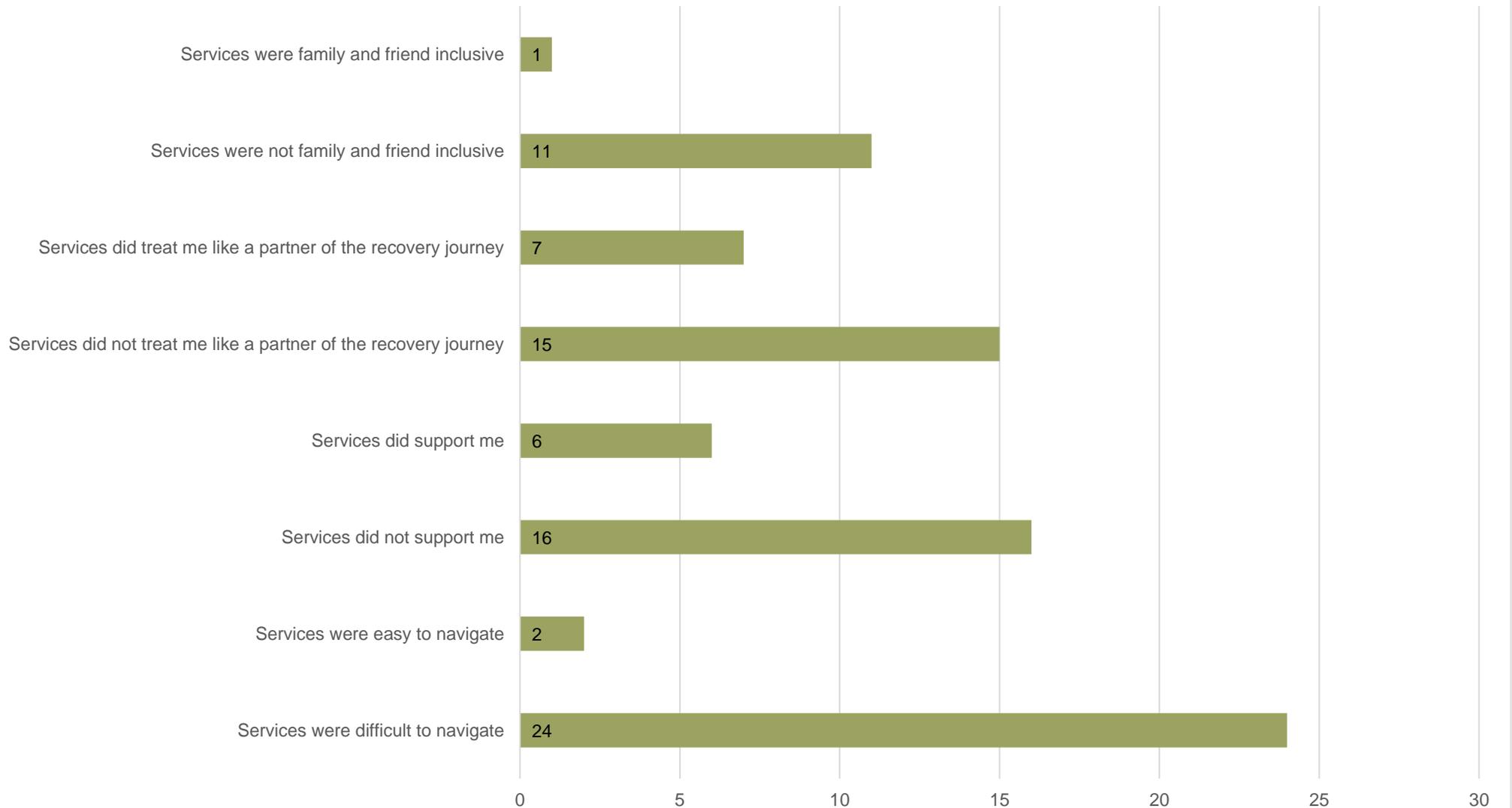
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Appendix 1

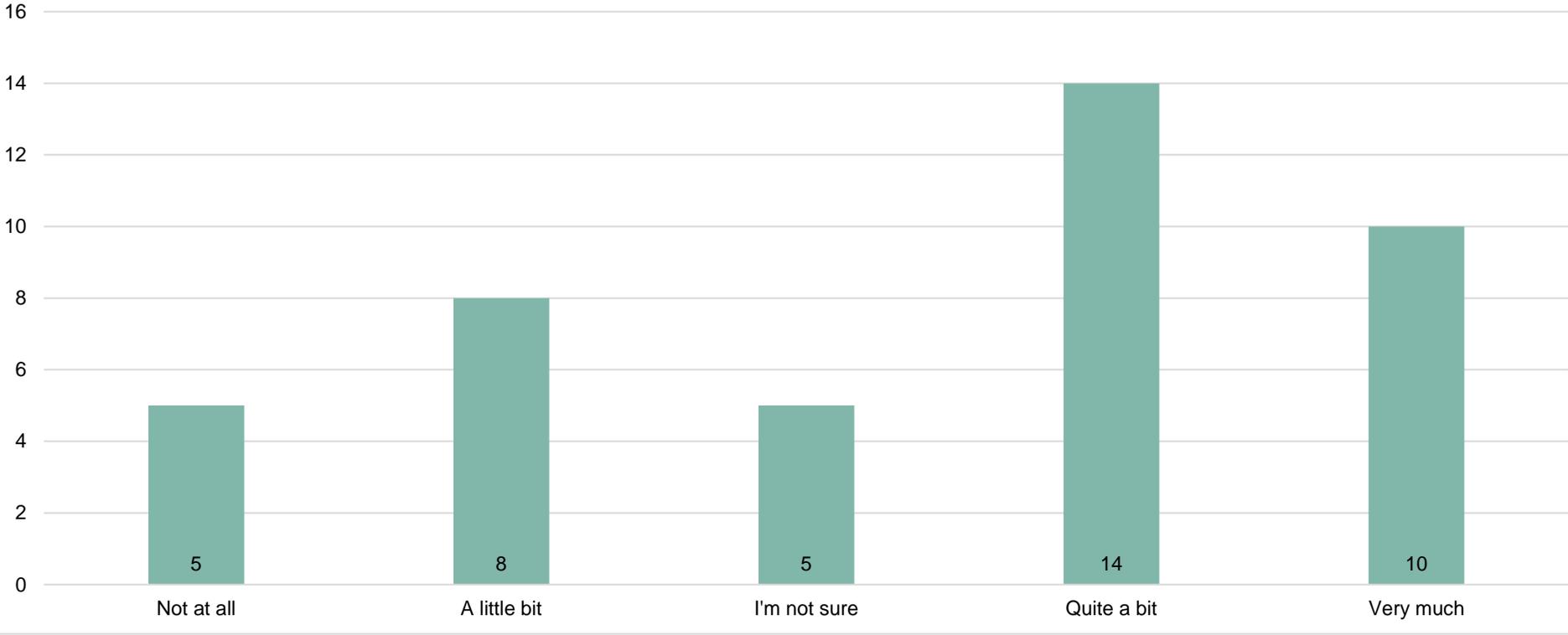
Question 2: How would you describe your experience as a family member or friend who supports/ed someone living with AOD use or co-occurring conditions of AOD use and mental ill health?



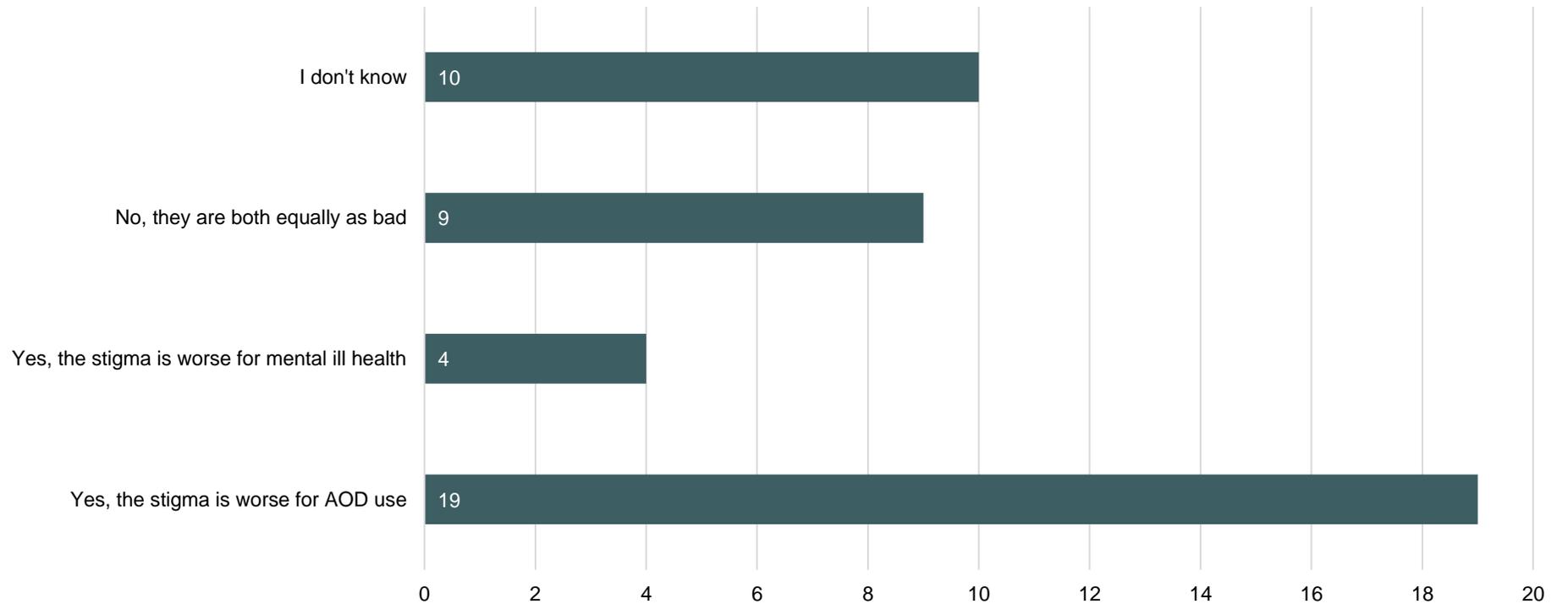
Question 3: How would you describe your experience engaging with AOD services or AOD and Mental Health Services as a support person who supports/ed someone living with AOD use or co-occurring conditions of AOD use and mental ill health?



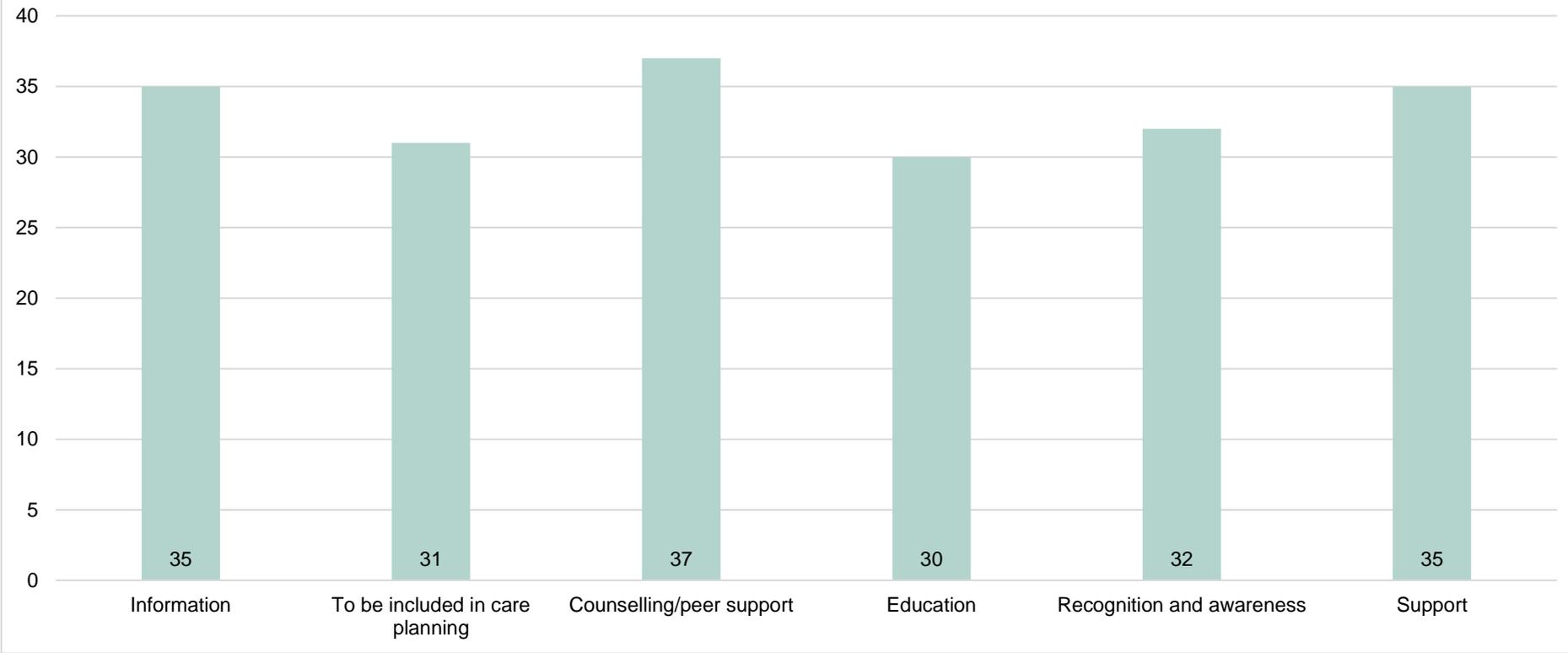
Question 4: How much has the stigma surrounding AOD use impacted you in your support role?



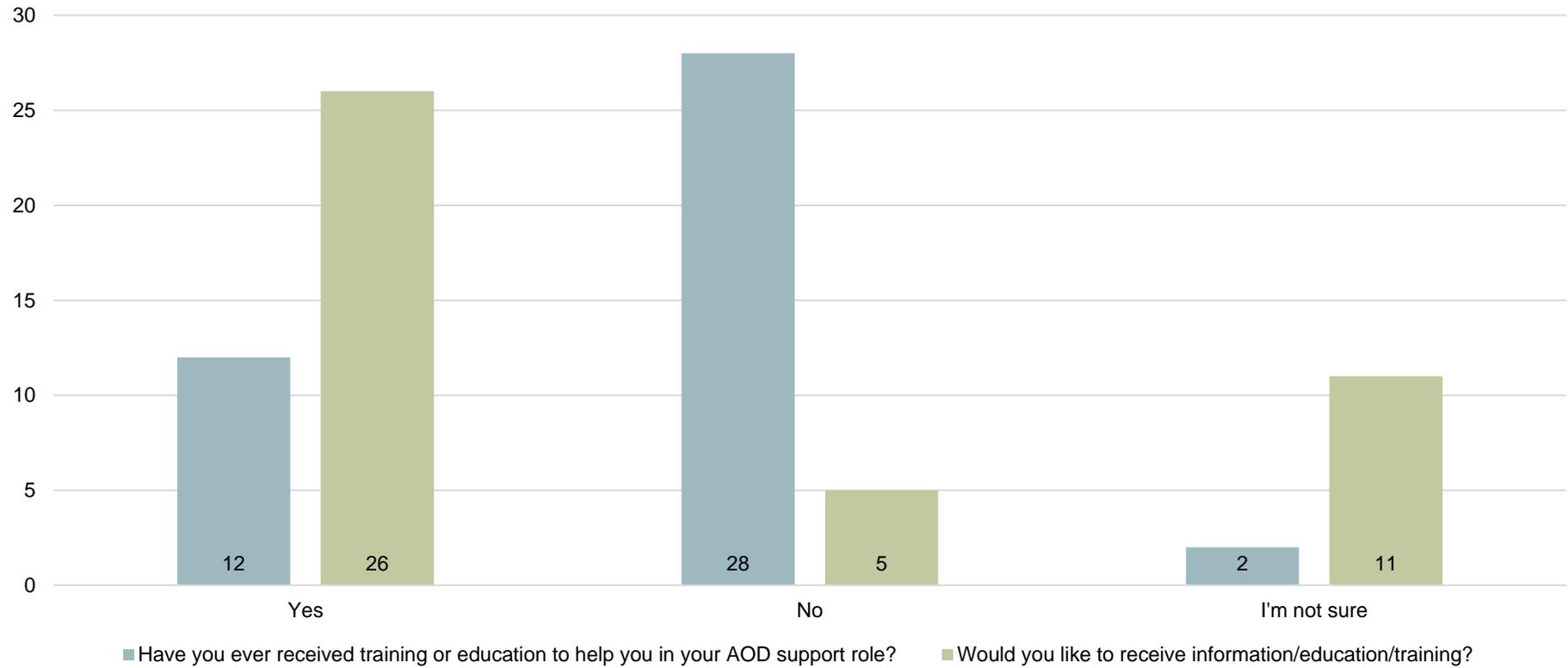
Question 5: Are there any differences in the stigma surrounding AOD use and mental ill health?



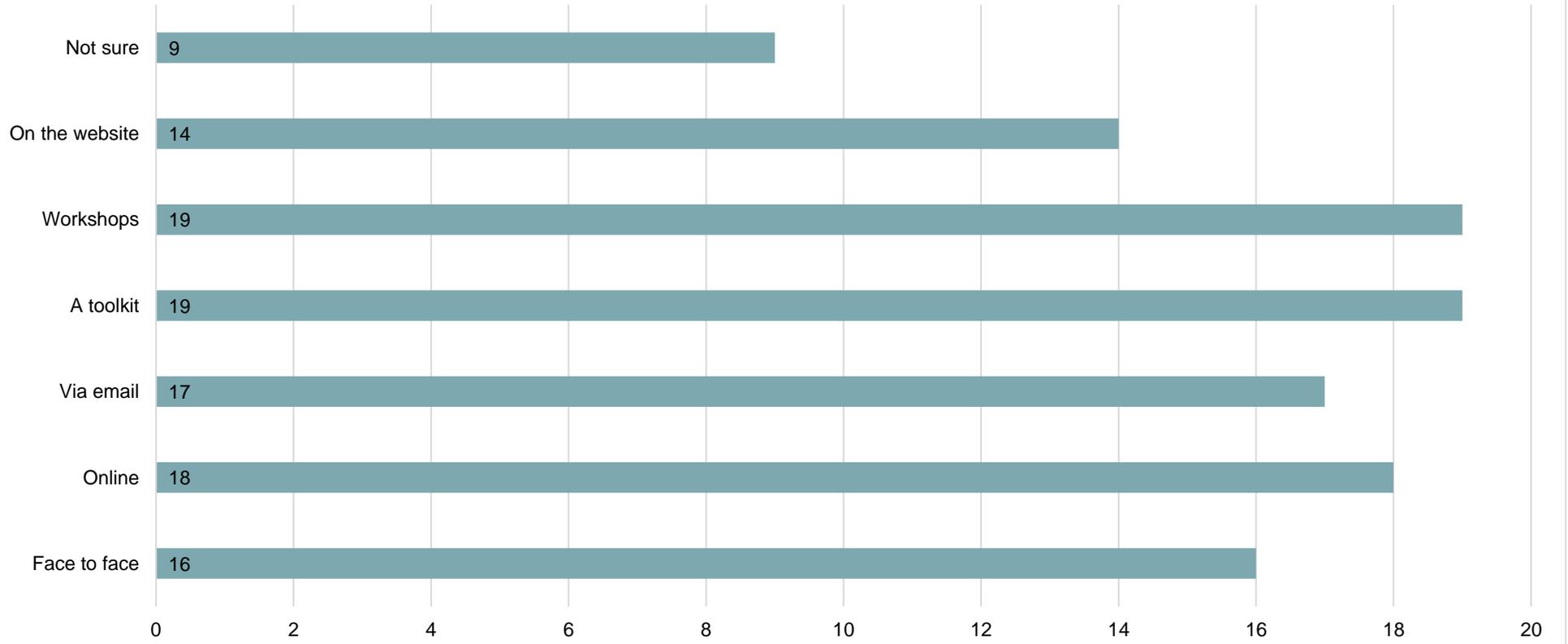
Question 7: What do AOD support people need?



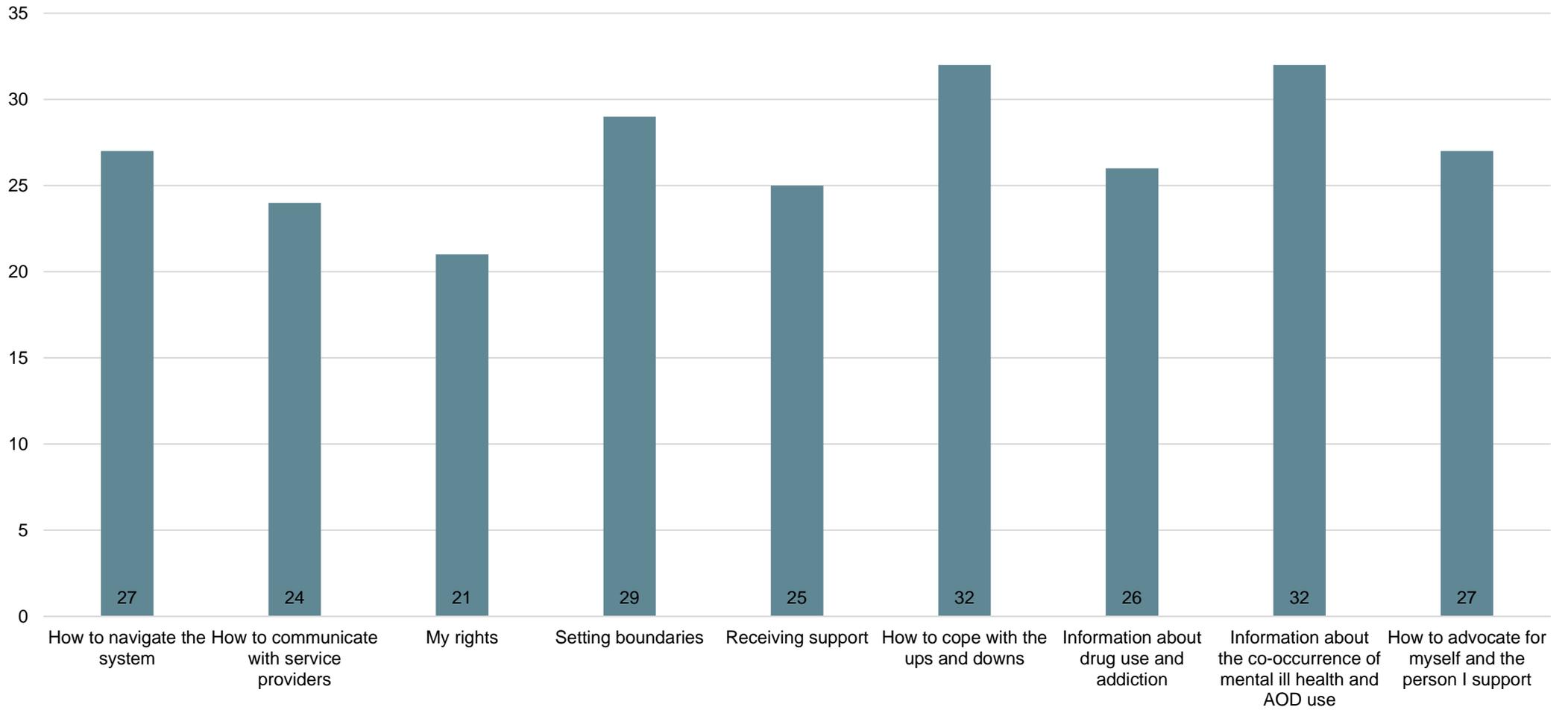
Question 9 & 10: Training/Education/Information



Question 11: How would you like to receive the information/training/education?



Question 12: What information/training/education would you like to see for AOD support people?



Question 13: How similar has your AOD support experience been to your Mental Health support experience?

