addiction is a family issue

NATIONAL COMMITTEE FOR ADDICTION TREATMENT – POSITION PAPER JULY 2011

One person's gambling or use of drugs or alcohol can affect many people especially those closest to them: their parents, children, grandparents and siblings. Family relationships, finances, health and wellbeing can become unbearably strained.

For every person with a drug use problem an average of three others are directly affected – financially, socially, and with impacts on physical and psychological health.

Twenty nine percent of New Zealanders have at least one heavy drinker in their lives, and a quarter of New Zealanders live in the same house as a heavy drinker.

Between 10,000 and 60,000 adults are problem gamblers in New Zealand and 3 percent of New Zealand adults have experienced problems due to someone else's gambling in the previous 12 months.

Gambling, alcohol and other drug problems can negatively impact family members' ability to work and to care for their dependents. Children often get caught in a vicious cycle and develop these problems themselves.

Families also bear the brunt of alcohol-related violence. Evidence shows thirty percent of family violence cases involve alcohol or other drug use.

Problem gambling harms families in many ways causing, amongst other things, poverty, abuse, and family discord. Children of problem gamblers are at higher risk of withdrawal, depression, anger and suicide. One in six New Zealanders say a family member has gone without something they needed or a bill has gone unpaid because of gambling.

The impact is far reaching – from immediate victims and other family members to the doctors, police and judges who deal with the aftermath of alcohol and drug related violence.

There are more than 62,000 physical assaults and 10,000 sexual assaults in New Zealand every year where the perpetrator has been drinking.

Of course children are especially vulnerable. While some parents struggling with gambling, alcohol and other drug problems still manage to parent well, many children will experience neglect, uncertainty, stress or abuse resulting from addiction. International research has shown that children experience stigma and shame when their parents have an alcohol or other drug problem, which often leads to learning and social problems at school.

All of these things come at a huge cost to communities and society as a whole.

CARE FOR THE CARERS

Some parents with gambling, alcohol and other drug problems come to rely on their own parents when they find they can no longer manage caring for their children.

A New Zealand study found **drug or alcohol problems to be the most common reason why grandchildren come into the care of their grandparents.**

But the Grandparents Raising Grandchildren Trust study reported grandparents felt there was very little support for them in taking care of their grandchildren. They struggle to understand how best to care for themselves, their grandchildren, and the person affected by alcohol or drug use. Many are unaware of local treatment services which provide family inclusive treatment.

WHAT NEEDS TO BE DONE?

Getting support to families

Families have repeatedly called for education. They want to know more about the nature of their loved one's problem, the process of recovery, and how they can help their affected family member.

Treatment service providers have a significant part to play in supporting families and whānau and in so doing can help heal entire communities. One of the most sensible ways to make such treatment more widely available is through the courts. The justice system needs to work closely with the Alcohol and Other Drug (AOD) and problem gambling treatment sectors (and other agencies) so families and whānau are offered support when their loved one comes before the courts, even if that person does not yet want to engage with treatment services.

Building family resilience

Increasing knowledge and understanding helps build family resilience. When families have a good understanding of how best to look after themselves they can better support the person with the problem and the outcomes will be better for everyone.

> Programmes that help family members to build support networks and get information around coping and accessing other services have been shown to reduce the levels of problems and symptoms experienced by family members.

Whānau Ora treatment services are a good example. They provide inclusive, culturally-appropriate treatment programmes that empower entire whānau and families to become healthy, rather than just focusing on the individual with the problem. We need to shift our thinking so such holistic approaches to whānau wellbeing become the norm.

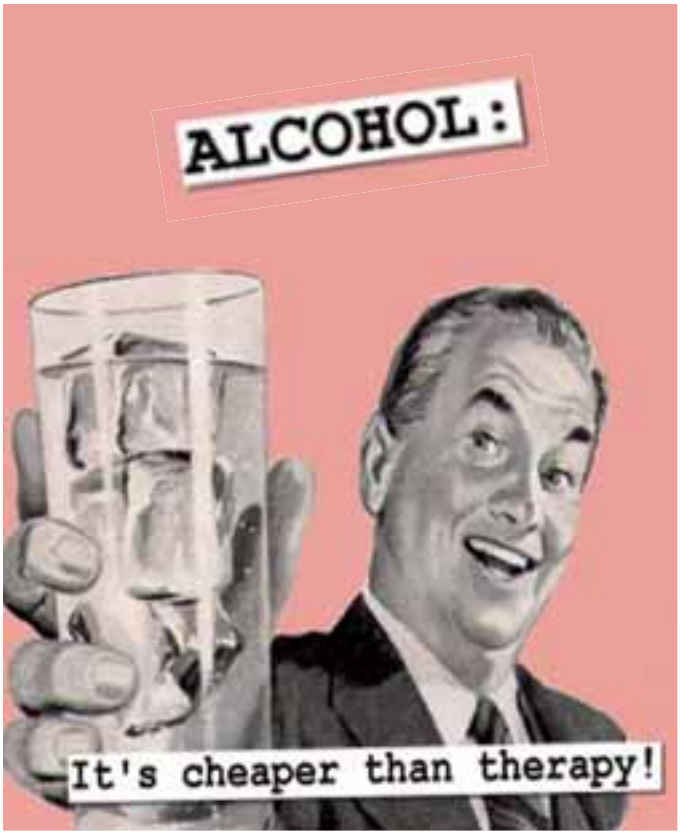
Changing the way we view alcohol and other drug problems

Alcohol and other drug problems need to be understood as a health issue, not just criminal justice or welfare dependency issues. New Zealand's laws need to focus on reducing drug- and alcohol-related harm and providing treatment rather than punishment. Low level offenders can be diverted away from the criminal justice system and provided with health information and treatment programmes. This will significantly reduce costs to the tax-payer, and is more likely to result in people motivated to seek help.

WHAT IS THE SOLUTION AND HOW MUCH MONEY WILL IT COST?

The broadening of the AOD and problem gambling sectors' roles into New Zealand's health, justice, welfare and education policies has put significant pressure on funding mechanisms for the sector. Traditional health and gambling funding frameworks find these new targets inconsistent with their own objectives, while the other sectors expect "health" to pick up the funding responsibilities. The result has been under investment and conflicting financial signals.

Reducing the fragmented funding and delivery of AOD and problem gambling interventions between health, justice, welfare and education services is a high priority. A "whole of government" systems perspective on the client journey becomes essential if more New Zealanders are going to receive treatment and effectiveness is to be improved.



1,900 professionals work in the AOD and Problem Gambling sectors. The annual treatment budget for AOD services through Vote Health is around $120M. In addition, AOD sector funding is managed through other governmental departments, with the Corrections Department being a major contributor through 500 alcohol and drug rehabilitation beds in prisons. The annual budget for problem gambling services is $9M. Both sectors are reliant on charitable contributions as well.

Increasing treatment sector capacity is dependent on two factors. Firstly services have the opportunity to improve capacity within current funding levels through better coordinated contracting processes. Secondly, additional investment is required. Future funding sources most likely include increased contributions through primary care, Courts, Corrections, ACC, Education, Police or Social Development.

The sector is calling for a review of the funding of alcohol and other drug services. Current funding is spread over too many government departments and DHBs. Improved coordination increases access to treatment.

The Alcohol Drug Helpline receives 20,000 calls per annum. NCAT estimates that annually 34,000 people are treated through the AOD sector and 8,000 in the problem gambling sector. A doubling of both sectors' capacity would suggest that around 84,000 people could be treated annually.

Seventy percent of people treated by the AOD sector have alcohol problems. Additional resources can also be funded from an increased excise tax on alcohol through a special levy. Similar funding mechanisms are in place for the problem gambling sector.

HOW MUCH COULD BE SAVED IF THE SECTOR TREATED MORE FAMILIES?

The sector's top five priorities are:

- **Teenagers and adolescents and their families and whānau**
- **Offenders**
- **High deprivation communities, including Maori and Pacific**
- **Young male adults**
- **Maintaining a Public Health approach**

Providing treatment for young people and their families avoids long-term costs associated with chronic gambling and alcohol and drug use.

Recidivism in criminal offending is highly correlated with AOD abuse and problem gambling and any reduction in criminal activity makes substantial future savings.

AOD and problem gambling use in low socio-economic communities is associated with high levels of crime, educational underachievement, poor economic prospects, and chronic welfare dependency. Lifting the standard of living in these communities includes addressing gambling and alcohol and drug issues.

Young adult males are currently the largest demographic group within the AOD treatment population. Treating young adults has positive long-term effects on their families and improves population health.

Evidence based public health policies reduce the incidence of these disorders over time. Key interventions include reducing the availability of alcohol and pokie machines in our communities, increasing the price of alcohol, reducing the marketing of these activities and increasing the alcohol purchasing age.

New Zealanders and the Government expect the AOD and problem gambling sectors to work effectively and turn around the lives of many individuals and their families. Both sectors have demonstrated their ability to deliver but need an improved and coordinated funding environment to reach the next level of service access.

A FAMILY MEMBER'S STORY

This story is a fitting example of how a family member can be supported to develop resilience in the face of a loved one's drug and alcohol problem – provided by Higher Ground addiction treatment service.

When my partner went to treatment, I did not like being on the outside. I was resentful. It seemed like he was being looked after – again – and I was left to cope – again.

I was kept politely but firmly away. It was a valuable lesson to me in letting go, but at the time, I was furious. I believed I had looked after, rescued, paid for and managed our life together – and I felt entitled to contact when I wanted.

My partner was a long-term narcotics addict and he needed to make profound changes if he were to get well. One of those meant extricating himself from me. If we were to recover we had to learn to live without using each other. Treatment taught us about boundaries.

We'd had a covert deal on an emotional level: he looked after my feelings, made me feel better about myself, provided fun; and I covered and kept secrets, backed him, paid the bills.

We always loved, liked and were interested in each other. But I learned that he was never responsible for my unhappiness, or my happiness. I had to take my hands off, my hooks out and look the other way.

It took me longer to realise that my life too was unmanageable, because I was the one who had a career, looked responsible and even successful: I was in control – he was to blame for the chaos.

When I met my partner, he was exciting, loving, warm and he appreciated me. We had some fun and good times. For a long time I did not know he was an addict. He drank a lot, but then everyone did. He was absent a lot, and often I couldn't work out who he was or where he was inside himself.

Some of my ignorance was denial – not wanting to name what was wrong because then I would have to leave him. But my partner kept his drug use away from me, as his way of trying not to bring me down with him.

Seven years later though, we had a baby, I was exhausted, resentful, and obsessed with my misery. My partner was in trouble with drug-dealing.

I finally – almost – admitted I was powerless over addiction. I said 'don't come home'. I realised I had to hand my partner over to others, and that I needed help too.

While my partner was in the Detox unit, a nurse took me to an Al-Anon Family Groups meeting. I was told there was a name for what had happened; that it drove other people as crazy as me, that this was the family disease of alcoholism. (I mentally substituted the word addiction, although my partner was also an alcoholic.)

I had to learn to put myself first, to turn the focus back on what I was doing with my life, learn to give to myself before I could give to anyone else. I also learned compassion for the addict.

At Al-Anon we shared the same feelings. They understood as my other friends could not. Al-Anon encouraged me to stop complaining, and showed me how to stop the self-pity. We didn't talk about them, we talked about us.

After two years my partner and I decided to try again as a couple, and many years later, we have had struggles as well as all the joys of family life.

I continue within Al-Anon where I find guidance and community. My partner has unconditionally supported me, and sometimes even goes to Al-Anon with me too! For me, thankfully, change was possible.

National Committee
for Addiction Treatment

For an annotated version of this position statement see
www.ncat.org.nz/statement.html

For more information contact info@ncat.org.nz or www.ncat.org.nz.
For media enquiries contact NCAT's co-chairs: Graeme Ramsay 09 368 1520 or Robert Steenhuisen on 021 954213.