WHAT IS THE IMPACT OF THE INNERVISIONS TREATMENT CENTRE'S FAMILY PROGRAM ON CLIENTS AND THEIR FAMILIES?

By

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In

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We accept this proposal as conforming

To the required standard

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Billy Weselowski

Researcher

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Chapter One – Study Background

The Problem/Opportunity

This thesis was about addiction, addiction treatment, family involvement, InnerVisions programs, the InnerVisions Family Program, and the evaluation of that family program. It was well documented that addiction was a prevalent problem in society. There was a multiplicity of strategies that addressed this problem, ranging from attending twelve step groups, private counselling, day and evening programs, and residential treatment programs.

The term "family/aftercare" described the ability to provide services to the families of someone who was affiliated with the disease of addiction, during and after leaving a treatment centre. One major problem was the lack of resources available for family systems to receive assistance when a family member was in residential treatment. The InnerVisions Recovery Society operated residential treatment programs for over twelve years, and it was our experience that we became inundated with requests from clients to assist family units as a whole, as resources in our community were just not available.

InnerVisions dealt primarily in residential treatment for both men and women. There were many casual conversations with staff, clients and other professionals in regards to family involvement in treatment, aftercare, or both. The fact was that almost everyone with whom I discussed this issue agreed that services were needed; yet they were either (a) not in place, (b) not readily accessible, or (c) not affordable. Additionally, there was a lack of local empirical data which certainly needed to be addressed.

The organization began to view the family unit and addiction in a different context, and through a learning lens. As a result, we looked very carefully at the family unit and the barriers that hindered a family's wellness. We developed a family program that was available to family

members of clients attending our treatment centres which made us ask the question: **What is the impact of the InnerVisions Treatment Centre's Family Program on clients and their families?**

I recently encountered two situations that highlighted this issue. An elderly couple came to have a counselling session with me. Their daughter, in addiction for 20 years, was in residence at our women's facility, Hannah House. The mother and father both were completely bewildered as to having any understanding about the disease of addiction and what services were available for their daughter as well as for themselves. The financial devastation that addiction had caused the mother and father had been horrific. What I have described is not uncommon whatsoever in the 14-½ years that I have been involved with helping people. Another situation that came to mind occurred when a woman who brought her son for treatment told me that her son had manipulated and coerced her entire life savings, including her formerly mortgage-free house. Unfortunately, this example was very common.

When I asked them what they had done over the years in order to address this problem, they told me that all they knew about was going to Al-Anon and trying to access government-funded services, which were usually delayed because of the overwhelming need. The other plan of action was private counselling, which was at times very expensive or not affordable. Clearly, my experience showed that there were very limited avenues for families to receive help in my community.

We believed that knowing the rest of the family was receiving some assistance was comforting to the individual who was actually in residence. One of the significant areas we wanted to explore was the relationship between families reinforcing the cycle of addiction as opposed to deterring the same cycle.

We believed that this research needed to be done because our organization currently encompassed men and women who could now access residential treatment. Because of this evolution, we were faced with the simple fact that the women have forced us to face a new reality.

One area of difficulty was that a man or woman could come into our centres and be surrounded with help and attention 24-hours a day, while the rest of the family unit received small attention. If they were unaware of what help was available in the community, this lack of knowledge became very revealing when talking to other family members who were involved with residential treatment.

Family members described that at times they felt like they were being left behind and articulated that they were not growing and progressing at the same rate as the in-house resident. Family members went on to explain that in fact, the gap of attention was quite often stressful on the other family members, noticeably in the area of communication.

A simple set of questions put to the clients on May 2, 2002, showed that the clients wanted family involvement for two main reasons: (a) to educate family on addiction the way they have been educated, and (b) to help bridge the emotional gap created by addiction. Using the above-mentioned measurement tool indicated that our organization was lacking in these areas.

Impact/Significance of the Problem/Opportunity

My experience was that the impact on families with respect to addiction had been utter devastation. The value of a healthy family as a support mechanism was a “given,” however, our records reflected that there was a major breakdown in most cases. What we hoped to discover

through this research was its major causes, to develop a better understanding, and discover what different solutions were available.

What I thought was significant was that many people who came through our doors mourn the fact that they had become disconnected from their families. It was not uncommon to see men and women reduced to tears about the destruction that had taken place in the family because of addiction being present in that system. I wanted to discover possible ways that we could interrupt that process and introduce some alternatives, such as normalizing addiction and family systems. Helping the families to develop strategies that involved healthy choices, around family members through understanding addiction, and resources available.

One benefit of doing this research was that we possibly provided one stop shopping, in terms of helping the entire family as we had treatment centres for both men and women. This became a valuable addition to help the rest of the family and to accelerate the re-connection of the family unit, as well as provide some education to everyone involved. The part that excited me was that we had a complete system in place to help people. We believed that this was an opportunity to discover that families were a part of the solution, and additionally, to identify those who were victims of family disconnection.

Potential Causes of the Problem/Factors Contributing to the Opportunity

It was not uncommon for us to work with about a hundred families over the course of a year. One cause of the breakdown in family systems resulted from the lack of awareness and education within the entire family unit, in terms of understanding addiction and the impact on the family. While the resident was learning at an accelerated rate, the rest of the family was minimally exposed to the same education. This widening gap lead to great difficulty in terms of

inclusion and intimacy. Oftentimes the rest of the family did not get a chance to unload their pain, distress, or were unable to talk about how they had been impacted. Intimacy suffered as well because as the resident learned and changed, the family experienced difficulty in getting re-connected at a level of equality.

A second cause was the lack of resources, financial as well as manpower. Residential client costs were covered through a variety of means, while the family was left with very limited opportunities such as accessing the local government counselling office or seeking very expensive private counselling. There was a long wait list for accessing the government counselling offices due to minimal manpower.

A third cause was that families had stated they did not feel as connected with going outside of our organization because of the contrast between the style of our organization and that of the government. The InnerVisions treatment program was directional and structured in the first 30 days of residence in terms of education that ignited a passion and fire within the client to dream and have hope. Families were expressing their desire to receive the same structure and direction as their loved one was receiving—a style hard to achieve by being on the outside of the organization.

The Organization

Potential Research Sponsor

My main research sponsor was the InnerVisions Recovery Society of which I am the Executive Director. My reasoning for collaboration with this group of people was that it was my experience that we were very committed to helping our communities. The Board of Directors,

was supportive of my involvement in this Masters program, and realized that this work was very beneficial to all people involved.

The contact person for the Board of Directors was Mr. Bob Kirby, who worked in concert with me because he understood the value of research. In the event of any differences with respect to the research, we mutually agreed on a third party that was not involved with the organization or the research to mediate any difficulties that arose. InnerVisions Recovery Society was committed to make this thesis possible as well as meaningful, and developed a good understanding of what its responsibilities were in terms of finances, time, and use of the facilities. I had no doubt that the organizations that currently sponsored InnerVisions such as the Rotary Clubs, Lions Clubs, assorted Foundations, and private-sector companies would continue to support any project in which InnerVisions became involved. They were involved in every level and all had different functions.

Information Review

InnerVisions Family Program

The InnerVisions Family Program was founded on the disciplines of the InnerVisions Residential Treatment Program and provided a structured, safe, and enforced service to the community for over twelve years. Clients completed all assignments and consistently attended, in order to receive a certificate of completion.

This program was available to families of any InnerVisions client and those families were able to access this program for one calendar year.

Starter Kit

Each family was given a starter kit containing:

1. *An Alcoholics Anonymous Big Book* with a schedule for completing the reading of the book. Five to ten questions pertaining to their current readings were assigned to family members each week.
2. A duo-tang of writing paper, writing guide and a pen for daily reflection were briefly checked each week.
3. A written description of the weekly meetings, and what the topics were.

Week One: Understanding Addiction

Participants went through the cycle of addiction, covered the doctor's opinion in the *Big Book*, watched the "InnerVisions Addiction" video, and had open discussion.

Week Two: Understanding the Addict

Participants watched the InnerVisions "Profile of an Addict" video, covered chapters one and two of the *Big Book*, covered the Disease Model, and had open discussion.

Week Three: Understanding the Solution

Participants watched the InnerVisions "Solution" video, covered chapters three and four of the big book. Facilitators shared part of their stories, and had open discussion

Week Four: Communication and Power Imbalances

Participants watched the InnerVisions "Anger" video, covered the conflict resolution four-stage model of communication, and had open discussion.

Week Five: Look at the Family System

Participants developed a "where to from here" plan, watched the InnerVisions "Family" video, covered the Satir Family System Model including exercises and explanations of such

areas as the Iceberg and stances, covered other possible community resources, and had open discussion.

Week Six: Debrief and Celebrate

Participants discussed their "where to from here plan," had discussion about what happened for the learner, and where they were going from here, and what help they needed to reach their goal. Certificates were given out and beverages were available.

Chapter Two – Literature Review

Review of Organizational Documents

The review of organizational documents consisted of:

1. Mission and Value statement
2. Ethical Conduct
3. Annual Report 2002
4. Organizational documents
5. Commission of Accredited Rehabilitation Facilities (CARF)

We included the operating structure size, the scope, and target population we would serve. The Commission of Accredited Rehabilitation Facilities (CARF) recognized InnerVisions and we would explain how InnerVisions' policies and procedures were one of the main management controls that governed the organization.

Our Mission and Value statements were the guiding light in our organization, because the organization was created to help those suffering from the effects of addiction. Our mission was to help in a holistic manner based upon the foundations of honesty, compassion, trust, spirituality, and a 12-step philosophy.

InnerVisions residential treatment program ensured that ethical principles and practices were well documented for staff and volunteers. This was another cornerstone of the organization, and the ethical obligations were continuously scrutinized to ensure their adherence. InnerVisions ethical policies were approved by an external accredited organization.

The 2002 annual report was a document that was created due to our accreditation process and became an extremely valuable tool in both informing ourselves as an organization and the community. The annual report also contained our projected goals, and was a document that could

systemically heighten the awareness of our organization via our web site (www.innervisionsrecovery.com). The report also contained information in areas such as effectiveness, customer satisfaction, demographics, referral sources, efficiency, quality assurance, and clients' drugs of choice.

The Commission of Accreditation Rehabilitative Facilities (CARF) is a private non-profit organization that accredited programs in several fields, one being behavioural health and medical rehabilitation. This particular field developed the standards that needed to be met by an organization applying for the accreditation, which consisted of the person served, professionals, and purchasers of services. The standards were applied through a peer review process to determine how well the organization adhered to the set standards.

Review of Supporting Literature

Introduction

This chapter of the thesis reviewed the literature regarding the various types of treatment processes that are available today with regards to substance abuse. When considering treatment in today's society, we must ponder all of the different forms that are available. We have to understand that there are a number of forms that are administered by agencies involving a number of different people. On many levels the treatment process has several key participants that are measured in various ways.

This review will discuss a number of the sub-topics, the first one being the modalities of treatment. These modalities come in alternate forms and are administered in different ways. The modalities are altered for the individual who may decide on what type of treatment he/she would like to undergo. The main treatment modalities are self-help groups, private counselling, day or

evening programs, and residential treatment. The individual may want his or her family to be involved in the recovery process, but most treatment facilities are geared towards the individual, while the family is on the outside looking in.

Despite the evidence of the familial impact of addictions, many of the current treatment modalities limit therapy to the addict, concurrent care for family members, or both (Earles, 1994, p. 8). Residential treatment is the traditional way of dealing with substance abuse. There are other forms of dealing with addiction that would be considered alternatives. We ought to look at these forms of treatment and wonder how they are implemented and by whom, and if the addict is geared towards using these types of methods. As suggested by Breslin, Reed and Malone (2003) we can offer the addict more unconventional methods of treatment such as holistic modalities. These holistic modalities will include tai chi, art therapy and cultural awareness. Programs like this would give the addict newfound self-esteem and self-identity.

Aftercare programs, which may include safe housing and relapse prevention, are areas of importance that we will discuss. What the addict does after he or she has received treatment is of great importance to the individual. First we ought to ask ourselves, if there is any form of treatment that is available for the addict after he or she has completed the residential program, and if there is, how can it be measured? For example one common modality is to get connected with a 12-step programs such as Alcoholics Anonymous.

We can look to Seraganian, Brown and Tremblay (2003) for some insight to this question. They asked for participants and broke them into two groups, the consent group and the non-consent group. The people in the consent group were subject to the more in-depth aftercare program, which involved a 10 week 90 minute group session with regards to social reintegration, relapse prevention, and health and psychological adjustments. This proved to be valuable

because the people in the non-consent group were subject to less attention and were more likely to relapse.

The second sub-topic in the review is the need for family involvement. Bowen and Kerr (1988) states that family group therapy conducted by a skilled therapist can be extremely useful for reducing anxiety and relieving symptoms. Addiction is a major cause for family anxiety and has to be dealt with on a family level. As mentioned before, when the addict goes to treatment, the family is left behind and does not have the same access to counselling regarding addiction. We ought to get the family involved on a deeper level in the recovery process so that the members of the family can relate to the addict and try to understand what he or she is going through. We need to decipher what role the family members can play and how effective it will be towards the addict's recovery.

The programs that are available to families are minimal. This is the third sub-topic for the review: What programs are available for families? There seems to be several different ways for the families to be involved. The data indicates that several forms seem to have different effects. We will look at this data to further understand what we can do in order to promote change and reduce anxiety in that family system. In order to measure these programs we must first implement them, then we must gather measurable data that can be used to decide whether or not the program is having any effect.

InnerVisions implemented a Family Program that involves families in the treatment process—independent of the client in residence. InnerVisions conducted this process by having questionnaires filled out by willing participants (client and family members), implementing an educational starter kit for all involved, by having focus groups cover the nature of the problem and where the anxiety is coming from.

Modalities of Treatment

The first topic for the review is the modalities of treatment. The first modality that we will discuss is the residential treatment process. Residential Treatment is available to anyone who wishes to come in, if they feel they have a substance abuse problem. Usually clients are referred by their family doctor or by an addiction specialist.

Weisner, Matzger and Kaskutas (2003) ask the question does treatment "work"? They suggest that a large body of research suggests that treatment does work. They discovered that many people who do enter treatment stay sober or otherwise change their habits and have fewer problems. On the other hand, they have also found that the majority of the population do not feel that treatment centres are a viable way of treating substance abuse considering that a small number of people actually stay sober. If this is the case then we must look at what programs we can have in place to ensure a higher success rate.

One form commonly used is Coerced Treatment. Such treatment occurs when the courts mandate an offender to attend if alcohol and drugs are the person's main problem. There are many benefits for the offender to have drug and alcohol treatment. As set out by Mottern (2002) the benefits are as follows: no physical violence, no drugs, chemicals or contraband, no implicit or explicit sexual behaviour, no destruction of property, and no absconding. These are all issues that individuals would face if they were in an unstructured environment. The residential treatment process for these people would allow the individual freedoms that they would not have if they were unsupervised. Although they are mandated to treatment by outside forces, they are free to leave at any time. If they did decide to leave then they would be subject to the appropriate punishment.

An article written by The Brown University Digest of Addiction Theory and Application (2000) states that coerced treatment can yield equal, or better outcomes than voluntary treatment. The authors conclude that providing alternative consequences appeared to motivate patients/clients to comply with addiction treatment. The coerced patients were found to have "more to lose" in terms of leaving the treatment centre than someone who had entered voluntarily.

Farabee, Predergrast and Anglin (1998) conducted a study on the effectiveness of coerced treatment for drug abusing offenders and discovered that the research emphasis on external pressure to enter treatment, and its relative success, has largely eclipsed initially, the potential role of internal motivation. There is strong support for the role of internal motivation as a predictor of program retention and positive treatment outcomes.

Substance abuse in the work place is a major issue. Employees of companies are often times caught using drugs and alcohol at work. In order to keep their job, they are coerced into treatment. Lawental, McLellan, Grissom, Brill and O'Brien (1996) found that when employees are coerced into treatment through their employer they went into treatment with significant substance abuse and other life area problems, but when their treatment was complete these problems were generally less severe and the employees had fewer problems.

Berg, Anderson and Alveberg (1997) suggest that former addicts as support workers enhance a client's length of stay and outcomes because they model success. My personal experience as a recovering addict, working in addiction for 14 years, reflects that to be true. As mentioned in the introduction, residential treatment is the most common form of treatment for substance abuse.

The methods of treatment a given centre implements will have an outstanding effect on the person's recovery process. In the article *Female and Male Alcoholics in Treatment; Characteristics at Intake and Recovery Rates* done by Smart (1979), he compared the characteristics of males and females at intake and their recovery rates in treatment centres. The treatment centres' that Smart chose covered a variety of therapies and approaches including in-patient and out-patient care, individual and group psychotherapy, protective drugs, tranquillizers and anti-depressants, family therapy, day care and occupational therapy. The methods used in outpatient care are available at most residential treatment centres; however, day care and family therapy are not.

The question that we could to ask is: What do we do with the people that need the two above services? It traditionally has not been cost-effective for a treatment centre to have family therapy and day care. It is not only a financial cost, but it will also cost the staff time that they do not have. These are areas that the literature needs to address in terms of viability for the client as well as the facility. InnerVisions is committed to finding out through samplings and various researches if all of these parameters can be accomplished and if they will be able to benefit all of the parties involved.

A modality of treatment that is vital to a person's recovery is the aftercare portion. Safe housing is a method of treatment that would have the recovery process less intense, but still plays a vital role in the person's sobriety by keeping them in touch and around the program if they choose to do so. As mentioned in the introduction, the work done by Seraganian, Brown and Tremblay (2003) would suggest that patients involved in an aftercare program, which includes safe housing would help the addicts in their recovery. A solid aftercare program would allow the

addicts to get the help that they need and to help them with the reintegration process of living life on life's terms.

Breslin, Reed and Malone (2003) discovered that a holistic approach to the outpatient and aftercare process may provide much insight to the treatment process. This program is designed to provide patients with not only traditional modalities of treatment such as individual or group therapy, but also provide an opportunity for patients to express thoughts and feelings through holistic modalities. These modalities would include, as mentioned in the introduction, tai chi, art therapy, leisure and recreational skills, spiritual growth and development, cultural awareness and appreciation, and vocational services.

In an article written by Bacci (2002) in *The Toronto Sun*, she describes a charitable organization called Caritas. Caritas focuses on a non-medical program that offers a 25-month program for overcoming addiction. The main focus of this holistic point of view is to reinforce the importance of education and active participation in the work force.

Hagemaster (2000) did a study on therapeutic touch in the treatment of drug addictions. Her preliminary findings would indicate that the use of therapeutic touch could be effective in prolonging periods of abstinence for alcohol and other drug abusers in two ways. First, it is possible that the mood elevation effects of the intervention could enhance attaining and maintaining abstinence. Second, the enhanced test scores could only be found in the therapeutic touch group that would indicate indicators for enhanced sobriety through reduction of social stressors in general.

A study conducted by McDonough and Russell (1994) looks at alcoholism in women and from that they developed a holistic, comprehensive model. Their research suggests that it seems like an objective, non-judgemental outreach effort is critical in discouraging the stigma that is

projected with women and alcohol. Women see alcoholism as a "manly" disease to have, therefore when treated for alcoholism they must have a more holistic, spiritual approach. When addicts are in the thrust of their addiction, they take many things for granted. All of the above ideas would give the addict or alcoholic a new found way to live and provide a method to express their feelings without resorting to using drugs. The holistic method is not proven to work and does not guarantee that the person in recovery will not relapse, but it is a modality of treatment that must get some consideration.

Family Involvement

Family involvement plays a major role in addiction. Addiction is a family disease because it affects everyone and everyone affects it. Earles (1994) states that therapy with a family systems approach may be particularly helpful in treating substance abuse because of the reciprocal nature of abuse and familial relationships. The role that the family plays will be a big part of the recovery process.

We can look to Freeman (1976) for some insight into family treatment. Freeman states that there are three stages of family treatment, which can be used as a mechanism for therapy.

The first stage is "redefining the problem": we must re-orientate the family on what exactly the problem is. The family must realize that they are in fact a system and that they must work on the problem collectively. This would allow for the whole family to be involved from a much deeper level, compared to one-on-one counselling. The second stage is the "working through stage." This allows the family members to recognize that as a unit they can better meet their needs at a group and individual level The third stage is the "letting go" stage which has the family members already recognizing the problem and developing a solution and putting that solution into practice.

The three-stage model is a valuable way for the family members to get involved on a profound level. Karno, Beutler and Harwood (2002) developed a study that demonstrated that alcoholism treatment—family or individual—effectiveness can be predicted by the interaction between baseline patient characteristics and the in-session process of psychotherapy assessed early in treatment. Furthermore, these interactions between patient attributes and the therapy process were better predictors of alcohol use than were the interactions between patient attributes and treatment modality. On one level we have Freeman (1976) suggesting that family treatment comes in three stages and is incumbent upon the realization that they are a system, but we have Karno et al. (2002) suggesting that the relationship between the patients and therapist is at the forefront. Once that is in place then the family can get involved in the process.

In accessing the family involvement of treatment, Morgenstern and McCrady (1992) use the behavioural model and the disease model to assess treatment. They suggest that experts seem to favour the integration of the models, because we cannot really tell if addiction has more to do with environment or a biological factor. This would involve the family on both levels. If it is an environmental issue then the family and the surroundings must be gauged. If it is a biological issue then there must be some education to make the family members aware that addiction does run in the family.

The family relationships between different members are what bring a family together. The husband–wife relationship, the father–son relationship, the daughter–mother relationships comprise the immediate family. The husband and wife relationship is one of importance. According to Janzen (1978) when the wife always forgives the alcoholic husband, then he has it in his mind that it is all right to keep doing what he is doing, so he always does. This is where interventions need to be introduced, as the husband must know that the alcoholism itself is a

disease, but the reciprocal behaviours that follow must be dealt with in order to have a viable marriage.

Family Programs

To date, there are not many programs that directly involve the families, except for government programs and expensive counselling. We want to develop a way where we can have family intervention that is cost effective. Our objective is to have an educational component that is accessible to the family members of any client in the InnerVisions residence.

Ritson (1979) has proposed an idea that could become quite feasible. We could develop a community-based alcohol team which would help the front line agencies, not fully understanding addictions and families, develop competence and confidence in dealing with alcohol programs which they met daily amongst their clients and patients. This study suggested that it is quite possible to provide consultation and support to social workers, general practitioners, and other front line agencies in this way. This community-based alcohol team could be made up of a various number of people. These people could include family members of recovering alcoholics as well as practicing alcoholics to identify the problem and work on a common solution.

This common solution could come in many different forms. Family therapy seems to be the solution that is referred to most often. If we can get the families involved on an even playing field, so they will be enriched with the same knowledge as the addict/alcoholic, then we will be on our and their way to understanding addiction and its affect on the family. The problems that families face as described by Orford (1992) is how to cope or respond to the addicted family member. Community agents and legislators face the same dilemma. These revolve around questions of control, confrontation, collusion and support. These things are universal features of social systems, large or small, particularly under conditions of conflict. This development of

thinking might open up badly needed new developments in the prevention of substance abuse problems. If the families can learn to cope, then we might be on the road to discovering new methods for family programs.

Conclusion

This thesis is a review of the literature that is available to articulate the points of view on the modalities of treatment, family involvement of treatment, family programs and the evaluation of family programs. The modalities of treatment come in various ways; this review focused on three modalities.

The coerced theory is one that is used quite frequently in today's society. As Mottern (2002) points out, coerced treatment is what the courts use to mandate an offender to treatment. This method would allow them a safe environment to have for their recovery. The Brown University Digest of Addiction Theory and Application (2000) stated that coerced treatment could yield better outcomes than voluntary treatment. Farabee, Predergrast and Anglin (1998) would have us believe that the role of internal motivation for coerced patients is strong enough to otherwise produce good results. Lawental et al. (1996) found that employees that were coerced into treatment had major life problems going into treatment, but found them to be less severe when they got out.

The second modality of treatment is the aftercare portion of the recovery. Although there is not much literature on this modality, we can look to Seraganian et al. (2003) who dictates that the aftercare portion is a big part of the recovery and patients that are involved have a greater chance for sobriety than those who do not.

The third modality of treatment discussed in the review is the holistic approach. Breslin et al. (2003) tell us that the holistic approach to the outpatient would provide much insight to the

recovery process. This modality would encourage patients to express themselves in a non-conventional way.

In reviewing the research we find that the holistic modality is becoming more available and more common. Bacci (2002) describes a charity in Toronto that offers a non-medical program, which consists of a 25-months for overcoming addiction. This charity is helping people reintegrate back into society. Holistic modalities branch out into other forms.

Hagemaster (2000) found that therapeutic touch could be effective for prolonging long periods of abstinence. The review on the literature pertaining to family involvement has a few different insights. Earles (1994) suggests that therapy with a family system component would be helpful in treating substance abuse. Having said that, Freeman (1976) gives the model of the three stages of family treatment; the three-stage model can be useful, for it provides a redefining the problem stage, a working through stage, and a letting go stage. This would be beneficial to the family as a whole. Karno et al. (2002) says that the relationship between the patient and the therapist would give a better indication of the therapy that is required, and the characteristics of both would be crucial to the family involvement. Family programs and family involvement are congruent subjects. Ritson (1979) suggested that we could have community-based alcohol teams that we could use to help the practitioners and the social workers with alcoholism. These teams could be made up of family members of recovering alcoholics and practicing alcoholics that would give the community much needed awareness. Awareness is what's needed; Orford (1992) says that the problems families face is how to cope or respond to the addict/alcoholic. Family programs can help heighten abilities to cope and respond to the addict or alcoholic whether it is through family therapy, group therapy, or even individually amongst them.

Potential Solutions to the Problem

Evaluation of Family Programs

In evaluating these programs, InnerVisions is developing a way to produce measurable data. Upon entry to the treatment centre, the client will be assessed through a questionnaire which will ask a number of questions with regards to client's well being. The client will also be given an assessment half way through the stay and will be given a final assessment upon leaving the treatment centre. All of these ways will produce information that is measurable as to the well being of the client and get them involved in an after-care program.

InnerVisions has a residential treatment program for men and women. InnerVisions over the years has developed a stringent recovery program that tackles addiction and takes it on with a "no bullshit" attitude. This allows the addicted individual to be able to work on himself or herself with the guidance of skilled recovered addicts.

Chapter Three-Conduct of Research study

Research Methods

In August of 2003, InnerVisions conducted research that had the families of residents in our treatment centres involved in a family program. InnerVisions developed a program of measurable activity that allowed us to track the progress of the addict/alcoholic as well as the family members.

Upon entry to the residential treatment program, the client was asked to participate in the study. We then had them fill out both a pre- and post-questionnaire (see Appendix 1). We also asked the family to participate, and if consent was given, they filled out a pre- and post-questionnaire as well (see Appendix 1). This allowed us to have measurable data so that we could begin to monitor the progress of the client and family.

The researcher conducted two learning circles with each client group, including some advisory personnel. These groups were implemented following the administration of the surveys. The advisory group also had two focus groups, following the learning circles to de-brief and discuss the learnings. This was another opportunity to determine the various themes that manifested because of the learning circles.

The learning circles were recorded by using flipchart paper, and as points are raised and discussed; they were written for the entire group to view and speak to. The researcher continually checked with the group throughout this process to ensure that these points were accurate and valid. In closing the group the researcher referred to the points on the flipchart and got consensus with respect to what was on the paper. As suggested by Smart (1979) we sought to measure the following:

1. Social stability
2. Physical health
3. Resources the addict/alcoholic has to help him in terms of people to help him
4. Resources the addict/alcoholic has in terms of interests not connected with drinking
5. Client satisfaction with various life conditions
6. Attitudes towards abstinence
7. Motivation for treatment

All of the above ideas gave us a good understanding of where the client was when they come into treatment, and gave us areas to monitor while in their stay. These items will also gave their family a barometer of what to work on with the family in terms of aftercare. The aftercare is important; it will play a major role in the sobriety of the client. The above measurable attributes were dealt with on a family level, and helped the family get a better understanding of where the client was and what needed to be worked on.

Project Milestones/Schedule

The project was carried out with the following schedule:

Agreement Letter Submission	August 2003
Ethical Review Submission	August 2003
Correspondence with Participants	September 2003
Learning Circle	October 2003, January 2004
Advisory Focus Group	October 2003, January 2004

Data Collection	September pre-post 2003 December post 2003
Data Analysis	February 2004
Completion of First Project Draft	March 2004
Submission of Final Project to RRU	April 2004

Project Participants

The key participants involved in implementing the study were the employees of InnerVisions, the clients and their families. Below is a list of actual individuals who were involved in scoping out the problem, producing solutions to the problem, and implementing the study recommendations.

Scoping Out the Problem

1. Executive Committee of InnerVisions
2. Employees of InnerVisions
3. EAP Workers

Producing Solutions

Executive Committee of InnerVisions consisting of the following:

1. Jerry Topley, senior staff
2. Cory Wint, senior staff
3. Brad Clancy, senior staff

4. Kim Weselowski, senior staff
5. Teresa McLellan, senior staff
6. Employees of InnerVisions
7. Clients and Families

Implementing the Study Recommendations:

1. William Weselowski and Associates Ltd
2. Executive Committee of InnerVisions
3. Employees of InnerVisions

Study Participants

In the initial plan to do the study, we had hoped to involve family members associated to about 25 clients. However, we found it extremely difficult to contact and schedule this number for an initial program. In the final analysis we had 18 family members start the program, and of these just 13 stayed through to the end. Accordingly, the research itself is based on a sample of 13 family members - each of whom completed a pre- and post program questionnaire.

The background characteristics of these family members, as per their responses to the pre-program questionnaires are as follows:

- 46% are parents of clients
- 38% are spouses or girl friends of clients
- 77% are female
- Their average age is 41years old
- On average these are people whose families have been affected by addiction for 23 years.

Project Budget

The Sponsoring Organization covered all costs connected to this project. The photocopying and questionnaires were done in-house. Administering the questionnaires was done by the researcher and with the advisory board. There were some costs for stamps, pencils, pens, envelopes, and paper. It was originally estimated that this project would not exceed $1,500.00, and it turned out the final outcome was just below that.

Chapter Four-Research Study Results

Study Findings

As discussed, the questionnaire used in this study was administered to family members of clients in our residential treatment centres. Family members completed a questionnaire at the beginning and also at the end of the program. This chapter reports on the results of the questionnaire specifically pertaining to the comparison between the questionnaires completed at the beginning of the program and those completed at the end of the program. Tables in this chapter present the participant responses to the pre- and post-questionnaires. Each table addresses the response data to a specific question as it sequentially appeared in the questionnaire.

Section One

The results relating to section one were presented first, followed by the results associated with the remaining five sections of the questionnaire. Following this presentation of quantitative evidence from the individual sections, a qualitative analysis on comments offered by respondents to each section was provided. The chapter concluded with a section drawing attention to common themes that indicated the apparent limitations of the survey.

As can be seen by Table 1, the first thing we can say is that most families saw themselves as being adequately connected to the family unit at the beginning of the program. However, they did not see themselves any more connected at the end of the program (see Table 1). Similarly, the extent to which respondents saw addiction affecting their family's finances did not change further over the course of the program (see Table 2). The degree to which family members felt respected within their family was unaffected over the course of their participation in the program (see Tables 3, 4, and 5). Finally, the extent to which families felt there was a drinking problem in

their family, and the extent to which they saw that problem as serious, did not change over the course of their participation in the program (see Tables 6 and 7).

The first section also provided participants with an opportunity to comment on what the participants felt was the most serious contributing factor to their family's difficulties. People entering the program responded by writing that the leading problems were the actual addiction or using of drugs by a family member, as well as mistrust, communication problems, and heredity of addiction within the family itself. When the surveys were redistributed towards the end of the program the results changed somewhat, with participants only seeing problems with communication as an issue.

Table 1.

How close would your rate your family in terms of being connected?*

Questionnaire Group	Not connected	Somewhat connected	Adequately connected	Very connected	Extremely Connected	Total
% Pre-test responses	8%	17%	25%	42%	8%	100%
% Post-test responses	8%	17%	50%	8%	17%	100%

* Results not significant

Table 2.

To what degree has addiction negatively affected your family's finances? *

Questionnaire Group	Somewhat affected	Adequately Affected	Very affected	Extremely affected	Total
% Pre-test responses	17%	25%	33%	25%	100%
% Post-test responses	9%	18%	54%	18%	100%

* Results not significant

Table 3.

To what degree do you feel respected in your family? *

Questionnaire Group	Not respected	Somewhat respected	Adequately respected	Very respected	Extremely Respected	Total
% Pre-test responses	8%	0%	67%	17%	8%	100%
% Post-test responses	8%	17%	50%	8%	17%	100%

* Results not significant

Table 4.

Generally, to what degree do you respect other family members? *

Questionnaire Group	Some respect	Average respect	Good respect	Excellent respect	Total
% Pre-test responses	.0%	33%	58%	8%	100%
% Post-test responses	17%	17%	50%	17%	100%

* Results not significant

Table 5.

How often do family members show disrespect to each other? *

Questionnaire Group	Daily	Weekly	Monthly	Never	Total
% Pre-test responses	10%	40%	30%	20%	100%
% Post-test responses	20%	30%	40%	10%	100%

* Results not significant

Table 6.

Do you think there is a problem with drinking and/or using in your family? *

Questionnaire Group	No problem	Alcohol	Both	Total
% Pre-test responses	8%	33%	58%	100%
% Post-test responses	25%	0%	75%	100%

* Results not significant

Table 7.

How serious do you consider this problem to be, not including the person in treatment? *

Questionnaire Group	Very serious problem	Somewhat of a problem	Minor problem	Manageable	Not a problem	Total
% Pre-test responses	27%	18%	18%	18%	18%	100%
% Post-test responses	17%	25%	8%	25%	25%	100%

* Results not significant

Section Two

The second section of the questionnaire dealt with what the participants felt were the most important goals that they and their families wished to achieve over the next calendar year. Many people responded to this question with feelings in the beginning that they would like to see stability and interaction with the family to be important goals. As well, they wanted to regain trust, learn to communicate better, and help the family to stay clean and sober. These goals did not change as the program progressed; participants still felt that they wanted their families to be close, healthy, and happy with each other.

Looking at the Table 8, "how has addiction affected the family's ability to participate in family activities?" the analysis indicated no significant difference, from the beginning or the end of the program. Table 9 also shows no significant difference as far as addiction affecting the family's medical health, and Table 10 showed no difference between pre-and post affects on the family's physical activities. Family members reported at the beginning relatively healthy mental wellness within the family (see Table 11). As well, Table 12 reported no significant difference in terms of how addiction had affected the family's emotional wellness. The family members reported that addiction had not affected trust in the family or themselves at the start of the program, and reported no significant difference after the program (see Tables 13 and 14). There was also no significant difference in regards to addiction affecting the family's ability to keep promises or commitments to their families, (see Table 15) as well as to themselves (see Table 16).

Table 8.

How has addiction affected your ability to participate in family activities? *

Questionnaire Group	Minimal participation	Some participation	Normal participation	Good participation	Excellent participation	Total
% Pre-test responses	50%	25%	25%	0%	0%	100%
% Post-test responses	25%	25%	25%	17%	8%	100%

* Results not significant

Table 9.

How has addiction affected your family's medical health? *

Questionnaire Group	Not healthy	Somewhat healthy	Average health	Very healthy	Extremely healthy	Total
% Pre-test responses	17%	0%	50%	17%	17%	100%
% Post-test responses	25%	8%	33%	33%	0%	100%

* Results not significant

Table 10.

To what degree has addition affected your family's physical activities? *

Questionnaire Group	Not affected	Somewhat affected	Normal wellness	Very affected	Extremely affected	Total
% Pre-test responses	8%	0%	58%	17%	17%	100%
% Post-test responses	8%	25%	25%	25%	17%	100%

* Results not significant

Table 11.

To what degree has addiction affected your family's mental wellness? *

Questionnaire Group	Not affected	Somewhat affected	Normal Wellness	Very affected	Extremely affected	Total
% Pre-test responses	8%	0%	17%	17%	58%	100%
% Post-test responses	8%	8%	17%	17%	50%	100%

* Results not significant

Table 12.

To what degree has addiction affected your family's emotional wellness? *

Questionnaire Group	Not affected	Somewhat affected	Normal Wellness	Very affected	Extremely affected	Total
% Pre-test responses	8%	0%	17%	17%	58%	100%
% Post-test responses	8%	8%	17%	17%	50%	100%

* Results not significant

Table 13.

To what degree has addiction affected trust in your family? *

Questionnaire Group	No trust	Some trust	Average trust	Good trust	Total
% Pre-test responses	42%	58%	0%	0%	100%
% Post-test responses	33%	42%	17%	8%	100%

* Results not significant

Table 14.

To what degree has addiction affected trust in your self? *

Questionnaire Group	No trust	Some trust	Average trust	Good trust	Excellent trust	Total
% Pre-test responses	8%	42%	33%	8%	8%	100%
% Post-test responses	8%	25%	42%	17%	8%	100%

* Results not significant

Table 15.

To what degree has addiction affected your ability to keep your promises and commitments to your family? *

Questionnaire Group	Sometimes keep them	Normally keep them	Keep them frequently	Always keep them	Total
% Pre-test responses	25%	17%	25%	33%	100%
% Post-test responses	42%	17%	17%	25%	100%

* Results not significant

Table 16.

To what degree has addiction affected your ability to keep your promises and commitments to yourself? *

Questionnaire Group	Sometimes keep them	Normally keep them	Keep them frequently	Always keep them	Total
% Pre-test responses	25%	17%	42%	17%	100%
% Post-test responses	25%	50%	17%	8%	100%

* Results not significant

Section Three

The third section of the survey queried people about what they felt were the two most important areas that would help their family in the recovery process. The two overwhelmingly given answers were communication skills and conflict resolution skills, with the ability to understand a close third. Many participants did not change their minds after programming, but fewer answered the question possibly meaning they had already obtained these new skills.

As you can see by Tables 17 any 18, most families rated their communication and problem solving skills as average to good with no significant difference after the intervention. How the families rated their ability to express their feelings in an open and honest way showed in Table 19 that the results were not significant. The evidence in Table 20 revealed no significant difference in how the families rated their listening skills in as far as feeling misunderstood by

other family members Table 21 shows no significant difference before or after the intervention. The data in Table 22, "how often the individual shut down mentally when faced with family conflict" was not affected by the intervention.

The degree to which family members were able to receive positive and negative feedback about themselves (Table 23 and 24) showed no significant difference, after the program was completed.

Finally this section rated the level and quality of communication in the families (Table 25), and relatively good communication was reported both before and after the program. How often the family argued, and to what level they usually got to (Tables 26 and 27) report no significant difference, both before and after the intervention.

Table 17.

How would you rate your communication skills? *

Questionnaire Group	Very poor	Poor	Average	Good	Very good	Total
% Pre-test responses	8%	17%	42%	33%	0%	100%
% Post-test responses	0%	17%	58%	17%	8%	100%

* Results not significant

Table 18.

How would you rate your conflict resolution/problem solving skills? *

Questionnaire Group	Very poor	Poor	Average	Good	Very good	Total
% Pre-test responses	17%	8%	42%	33%	0%	100%
% Post-test responses	0%	33%	50%	8%	8%	100%

* Results not significant

Table 19.

How would you rate your ability to express your feelings in an honest and open way? *

Questionnaire Group	Poor	Average	Good	Very good	Total
% Pre-test responses	33%	25%	25%	17%	100%
% Post-test responses	17%	42%	33%	8%	100%

* Results not significant

Table 20.

How would you rate your listening skills? *

Questionnaire Group	Poor	Average	Good	Very good	Total
% Pre-test responses	8%	8%	67%	17%	100%
% Post-test responses	0%	33%	58%	8%	100%

* Results not significant

Table 21.

How often do you feel misunderstood by family members? *

Questionnaire Group	Often misunderstood	Sometimes misunderstood	Not a difficulty	Rarely misunderstood	Total
% Pre-test responses	25%	42%	8%	25%	100%
% Post-test responses	25%	42%	17%	17%	100%

* Results not significant

Table 22.

How often do you shut down mentally when faced with a family conflict? *

Questionnaire Group	Often shut down	Sometimes shutdown	Not a difficulty	Rarely shut down	Total
Pre-test responses	33%	50%	8%	8%	100%
% Post-test responses	25%	50%	0%	25%	100%

* Results not significant

Table 23.

To what degree are you able to hear positive feedback about yourself? *

Questionnaire Group	Very unable to hear feedback	Somewhat able to hear feedback	Able to hear feedback	Somewhat open to hearing feedback	Very open to hearing feedback	Total
% Pre-test responses	0%	25%	42%	33%	0%	100%
% Post-test responses	8%	25%	25%	17%	25%	100%

* Results not significant

Table 24.

To what degree are you able to hear negative feedback about yourself? *

Questionnaire Group	Somewhat able to hear feedback	Able to hear feedback	Somewhat open to hearing feedback	Very open to hearing feedback	Total
% Pre-test responses	50%	33%	17%	0%	100%
% Post-test responses	33%	33%	25%	8%	100%

* Results not significant

Table 25.

How would you rate the level and quality of communication in your family? *

Questionnaire Group	Very poor	Poor	Average	Good	Very good	Total
% Pre-test responses	0%	42%	42%	17%	0%	100%
% Post-test responses	8%	33%	25%	25%	8%	100%

* Results not significant

Table 26.

How often do you argue in your family? *

Questionnaire Group	Daily	Weekly	Monthly	Almost never	Total
% Pre-test responses	17%	17%	42%	25%	100%
% Post-test responses	17%	25%	17%	42%	100%

* Results not significant

Table 27.

To what level do these arguments usually get to? *

Questionnaire Group	Healthy discussions	Loud conversation	Heated conversation	Yelling, screaming	Total
Pre-test responses	8%	50%	17%	25%	100%
% Post-test responses	18%	46%	18%	18%	100%

- Results not significant

Section Four

The fourth section of the questionnaire also dealt with picking the two most important areas that would help the family in the recovery process. In this section, participants generally felt that learning to be honest and educating friends and family about the disease of addiction were the two most important areas to be considered. Additionally cohesion of the family unit, as

well as interaction among members rated quite high. For those who had completed the program, honesty and cohesion were the only two responses that stood ahead of the rest.

Looking at whether the family members had any previous alcohol and drug education or awareness (Table 28) demonstrated no significant results. As well, family members reported no significant difference with respect to having been educated with the disease model of addiction (see Table 29). Family members reported that they thought a family education on addiction was important. However, Table 30, show no significant difference after completion of the program. There was also no significant difference about the families' beliefs about the importance of doing things together like eating and spending quality time to help the recovery process (see Table 31).

In the area of twelve step meetings and reading recovery information together (Tables 32 and 33) the families reported no significant difference yet emphasized the importance of participating in those activities together. How often the family spent one on one time together also showed no significant difference (see Table 34).

Table 28.

Have you had any previous alcohol and drug education/awareness? *

Questionnaire Group	No education	Some education	Average education	Good education	Excellent education	Total
% Pre-test responses	17%	8%	17%	33%	25%	100%
% Post-test responses	17%	42%	0%	33%	8%	100%

* Results not significant

Table 29.

Have you been educated with the disease model of addiction? *

Questionnaire Group	Yes	No	Somewhat	Almost never	Total
% Pre-test responses	42%	25%	33%	0%	100%
% Post-test responses	55%	9%	27%	9%	100%

* Results not significant

Table 30.

How important do you think a family education on addiction is to the family recovery process? *

Questionnaire Group	Important	Very important	Extremely important	Total
% Pre-test responses	8%	25%	67%	100%
% Post-test responses	8%	17%	75%	100%

* Results not significant

Table 31.

How important do you believe things like eating together and quality time are to the recovery process? *

Questionnaire Group	Somewhat important	Important	Very important	Extremely Important	Total
% Pre-test responses	8%	8%	25%	58%	100%
% Post-test responses	0%	8%	25%	67%	100%

* Results not significant

Table 32.

How often do you attend 12 Step Meetings together? *

Questionnaire Group	Daily	Monthly	Never	Total
% Pre-test responses	8%	0%	92%	100%
% Post-test responses	8%	8%	83%	100%

* Results not significant

Table 33.

How often do you read recovery information together? *

Questionnaire Group	Daily	Weekly	Monthly	Never	Total
% Pre-test responses	8%	8%	17%	67%	100%
% Post-test responses	8%	25%	17%	50%	100%

* Results not significant

Table 34.

How often do you spend individual one on one time together? *

Questionnaire Group	Daily	Weekly	Monthly	Never	Total
% Pre-test responses	8%	33%	33%	25%	100%
% Post-test responses	8%	58%	8%	25%	100%

* Results not significant

Section Five

The fifth section of the questionnaire asked the participant to list what would be the most beneficial service in their community that could provide assistance to families dealing with addiction. Before participating in the program many people felt that N.A., A.A., private counselling, family programs and treatment were the most important. After participating in the

program there was a slight shift as more people felt they wanted more affordable counselling, treatment and family programs in their communities. As well both before and after participation, participants felt that more education was needed on the subject of addiction and prevention.

Tables 35 and 36, reported the importance of the belief in a higher power both individually and in the family unit. However, the tables also revealed no significant difference in pre-and post-test questionnaires. The families rated honesty to the family recovery process extremely high (see Tables 37and 38), and reported no significant difference after the program was completed. Looking at how often family members ignore the facts to protect their family (Table 39) reported no significant difference.

As can be seen by looking at Tables 40 – 45, there was no significant differences reported in the areas of awareness of community resources, understanding the resources available in our community, the importance of accessing these community resources to help the family process, or the awareness of family support groups in our community. There was also no significant difference in the accessing of resources in a timely manner or the importance of supporting the family in assessing these community resources in the community, before and after the intervention.

Table 35.

Do you believe in a higher power of some sort? *

Questionnaire Group	Somewhat	Yes	Absolute faith	Total
% Pre-test responses	17%	58%	25%	100%
% Post-test responses	17%	58%	25%	100%

* Results not significant

Table 36.

Do you believe in spirituality is important to the family recovery process? *

Questionnaire Group	Not important	Somewhat important	Important	Very important	Extremely important	Total
% Pre-test responses	17%	17%	0%	42%	25%	100%
% Post-test responses	0%	0%	17%	33%	50%	100%

* Results not significant

Table 37.

How vital is honesty to the family recovery process? *

Questionnaire Group	Very vital	Extremely vital	Total
% Pre-test responses	8%	92%	100%
% Post-test responses	8%	92%	100%

* Results not significant

Table 38.

How important is self-honesty to the family recovery process? *

Questionnaire Group	Somewhat important	Very important	Extremely important	Total
% Pre-test responses	0%	8%	92%	100%
% Post-test responses	8%	17%	75%	100%

* Results not significant

Table 39.

How often do you ignore the facts to protect your family? *

Questionnaire Group	Often ignore	Sometimes ignore	Rarely ignore	Never ignore	Total
% Pre-test responses	8%	42%	42%	8%	100%
% Post-test responses	8%	50%	25%	17%	100%

* Results not significant

Table 40.

How do you rate your awareness of community resources in your local area? *

Questionnaire Group	Not aware	Some awareness	Average awareness	Good awareness	Excellent awareness	Total
% Pre-test responses	17%	25%	17%	42%	0%	100%
% Post-test responses	0%	25%	25%	42%	8%	100%

* Results not significant

Table 41.

In helping the family recovery process, how important is an understanding of resources available in your community? *

Questionnaire Group	Important	Very important	Extremely important	Total
% Pre-test responses	33%	50%	17%	100%
% Post-test responses	8%	42%	50%	100%

* Results not significant

Table 42.

How important is accessing these community resources helpful to the family recovery process? *

Questionnaire Group	Somewhat important	Important	Very important	Extremely important	Total
% Pre-test responses	8%	17%	58%	17%	100%
% Post-test responses	0%	8%	50%	42%	100%

* Results not significant

Table 43.

Are you aware of family support groups in your community? *

Questionnaire Group	Yes	Somewhat	Total
% Pre-test responses	67%	33%	100%
% Post-test responses	67%	33%	100%

* Results not significant

Table 44.

How important is timely access to the resources in your community? *

Questionnaire Group	Somewhat important	Important	Very important	Extremely important	Total
% Pre-test responses	8%	33%	25%	33%	100%
% Post-test responses	8%	8%	33%	50%	100%

* Results not significant

Table 45.

How important is supporting your family in accessing these community resources? *

Questionnaire Group	Somewhat important	Important	Very important	Extremely important	Total
% Pre-test responses	8%	25%	33%	33%	100%
% Post-test responses	8%	8%	33%	50%	100%

* Results not significant

Section Six

The last section of the survey was a summary that allowed for participants to add any additional suggestions that they thought were not covered in the survey. Prior to their participation in the program, participants felt more education that included more family members was needed. As well, they were questioning the availability of other programs and other information. Upon completion they generally just wanted to say how wonderful the program was and to inquire as to what sort of after or family programming was being offered as a continuation of this program.

Tables 46 and 47 showed no significant difference in the family's awareness of private family counselling services in the local vicinity, as well as having had previous counselling.

Table 46.

Are you aware of any private family counselling services in your area? *

Questionnaire Group	Yes	No	Somewhat	Total
% Pre-test responses	58%	8%	33%	100%
% Post-test responses	75%	8%	17%	100%

* Results not significant

Table 47.

Have you had previous counselling? *

Questionnaire Group	Yes	No	Total
% Pre-test responses	50%	50%	100%
% Post-test responses	67%	33%	100%

* Results not significant

Study Conclusions

Part One of the questionnaire asked participants to answer questions that best described their current family situation in terms of finances, respect, connection with each other, drinking and using patterns (both individually and for the family overall). The data revealed no significant difference pre and post intervention.

Part Two of the questionnaire asked participants to rate how addiction had affected their family. Areas covered by this part of the questionnaire included social leisure activities, health and wellness, physical, mental, and emotional health, as well as various questions in regards to trust, both personally and in association with the family. The data revealed no significant difference pre-and post intervention.

Part Three of the questionnaire asked participants to rate the state of communication within the family. Participants answered questions such as the level of their personal communication and problem-solving skills, their ability to express feelings, how often they felt misunderstood by other family members, their understanding of their negative coping skills, and their ability to receive feedback (positive and negative). The participants were also asked to rate the level and quality of communication within the family, as well as how often they argued, and to what extent the arguments escalated. The data revealed no significant difference pre-and post intervention.

In Part Four of the questionnaire, we asked participants to tell us about some of the things they felt were important to their family's recovery process, including whether they had had any previous alcohol and drug education or awareness, their understanding of the disease model of addiction, the importance of the family having education about addiction, and several questions designed to rate family cohesion. This section of the questionnaire also asked the participants to rate the concept of spirituality, and the concept of honesty, both within themselves and the family. The data reported no significant difference pre-and post intervention.

In Part Five of the questionnaire, we asked participants about their awareness of local community resources that supported families and addiction, including questions about: the awareness of community resources, the importance of understanding the availability of resources

in the community, accessing these community resources, and an awareness of family support groups in the community. We also asked how important timely access to the resources in the community impacted participants, how important supporting the family was, as well as the awareness of private family counselling in the area. The data reported no significant difference pre-and post intervention.

Part Six of the questionnaire asked some general background questions such as had the participant had any previous counselling, how many years had addiction affected the family, as well as the age, gender, employment status, family size, and the relationship to the person in treatment.

The survey also provided an opportunity for qualitative data collection, by asking the participants to address some issues such as describing the most serious contributing factors to the families difficulties, what they think are the most important goals that they and their family would to want accomplish over the next year, what they consider to be the two most important areas that would help their family in the recovery process, and what they consider to be the two most important areas that would help their family in the recovery process. They were also asked in their opinion, what they thought would be the most beneficial services their community could provide to assist families and to add any suggestions that could help InnerVisions be as helpful as possible to them and their family.

In conclusion, the quantitative data presented in this chapter clearly demonstrates that there was no significant difference in the participant's response to the pre and post-test questionnaires. However, the qualitative data brings forth a different portrait of what the intervention did for the participants. The qualitative data revealed that the participants had an enriching experience; they received specific direction in terms of how to cope with family

members from two levels: the family overall, and the family member in active addiction. Additionally, the qualitative data revealed that the intervention "normalized" the disease of addiction by seeing and hearing other families share their stories. As a result friendships and cohesion were developed amongst the participants. Furthermore, the qualitative data demonstrated that participants began to develop strategies of how to cope with a family member in the throes of addiction. Based on this data I am led to believe that extreme caution should be exercised when interpreting these results, due to the extremely small sample size, and the qualitative feedback, which disputed the quantitative data received from the family program participants.

Study Recommendations

Based on the quantitative data, the conclusion drawn is that the intervention had no impact on the participants; however, the fact that the sample size was so small, only 13 family members completed the pre and post questionnaires, brings into question the validity of this data. The qualitative information, which describes an enriching experience for participants, reflects a conflict with the quantitative data. Because of the significant differences between the quantitative and qualitative data collected, more research needs to be done on this Family Program and I believe that this study should be replicated.

Chapter Five-Research Implications

Organization Implementation

Due to the fact that the research was inconclusive, we have not implemented any organizational changes other than to continue to offer this program for a period of one year. In addition to the continuation of the program, we are adhering to the recommended revisions contained further on in this document under the section titled Research Project Lessons Learned and the data reveals significant differences.

Future Research

If one looks back to through the literature review in Chapter Two, one can conclude quite quickly that the implications of the findings of this research study, in relation to the body of knowledge being studied, is insignificant. Again, other than the learning contained in the section Research Project Lessons Learned, the results of this study do not affect the body of knowledge on family programs being studied today.

Research Project Lessons Learned

In this section I will discuss the research project lessons learned, specifically what worked, what didn't, and what I would do different should I replicate this project. I will also discuss some themes that became apparent and possible solutions to address those themes.

The questionnaire proved to be a very challenging in terms of what questions we asked the participants, and what the intention and syllabus of the program design. The questions in the questionnaire were broad in nature, dealing with topics such as finances, respect, trust, health and wellness, as well as communication skills, while the intervention focused more on addiction, solutions, available resources, and how to access those resources. Because of the discrepancy between the questionnaire and the intervention, data evaluated pre and post showed no

significant difference, however, tables 8,13, 22, 23, 29, 36, 41, and 42 did show some change. The results demonstrated that the participants were extremely constricted in answering questions effectively. For example, “do you think honesty is an ingredient necessary for recovery?” was asked in the questionnaire, yet we never did any in-depth work on honesty in the actual family program. Consequently, participants rated honesty highly both before and after program participation. What this means is that pre-and post intervention scores showed no statistical significant difference; however, if one does not take into account the problematic questionnaire one would assume the intervention, from a quantitative standpoint, was ineffective. Lessons learned from the questionnaire were that more focus was required in regards to the specific syllabus and intention we demonstrated in the implementation of the family program. Simply put, some of the questions asked had no relevance with respect to the syllabus of the program.

Additionally, we found the participants had a difficult time understanding the questionnaires. This is largely due to the fact that we tried to create a questionnaire that was tailored for both the clients in the residential treatment program as well as the family members. This produced some difficulties, for example, the question “ to what degree has addiction affected your ability to keep your promises and commitments to your family” was intended for the addicts for self-evaluation. Yet, the non-addicted family members were quite confused with this question. It became apparent that we needed to ask questions more specific to non-addicted family members, in the context of their communications with the person in active addiction. Due to this type of confusion, time constraints played a part for the participants; a conflict was created over the time given to complete the questionnaire. These difficulties resulted in not enough time being spent in completing the questionnaires, which we believe resulted in the production of skewed data.

Having closely scrutinized the quantitative data of the survey, I have come to believe that some of the questions that were asked in the survey were not worded as well as they might have been and were not appropriate for the survey.

The actual implementation of the family program by all accounts was extremely successful for the participants in terms of family cohesion within their own families and other family members, by having access to an arena where the families of addicted people could get a voice and ask questions in a safe environment. Families felt a sense of connection with other families because they all had basically the same issues to deal with, which created a therapeutic environment. Every person who completed the program stated emphatically that the program was an enriching experience, and beneficial to their families.

Two of the strategies that worked well for this program were the providing of day care and offering to pick people up at certain locations. The issue of day care became evident because when we started to phone participants, we realized that not being able to provide day care would impede some families from attending. Offering day care was instrumental in having a single Mom being able to attend. This woman had two small children and was grateful for the assistance so she could attend. Day care was provided on site where the family program was located.

Again, from phoning the participants we discovered at the outset that some families might have difficulty with transportation, and after some staff discussions we decided to provide rides from certain locations as needed. It turned out that we never needed to provide any rides; however, it was discussed every week, and the families worked with each other to arrange rides as needed.

The participants being able to access a series of the addiction videos that we had developed (taking them into their homes to review with other family members) was a key outcome that was remarkably successful. These videos, a community project created by TriCity Education and the Rogers Video chain, are given free of charge to anyone who requests them. The videos speak to addiction, anger, solutions and specifically families and addiction. All participants reported that these videos were exceptional in helping other family members understand the issue of addiction. Increasing the awareness of the availability of these videos was definitely a positive aspect of the family program.

The information delivered from the syllabus was valuable and beneficial for the participants. Participants reported having developed a solid grasp of understanding addiction through interaction with the group members, discussion among themselves, interaction with the facilitator, and through educational information handed out to all the participants. Participants also reported an increased comprehension of the disease model of addiction, the 12 steps, and the effects of alcohol and drugs. There was a great emphasis on homework assignments being completed on a weekly basis that strengthened and anchored the learnings that took place in the Program. All participants reported that the information provided through the handouts and discussions was valuable.

The participants stated that it was important for them to come to understand that they were not alone and unique, and hearing the stories of other families helped them to come to terms and better understand their own plight. Another common theme the participants expressed throughout the program was how they would be able to continue to create this sort of an environment once the course was finished. There was much discussion between the various family members about creating a drop-in evening where the family members could get together

and invite friends who might have similar problems in their families. The participants learned that not only were they not alone and unique, but that this was a very widespread problem with very few resources or solutions. I found the qualitative information to be very enriching and clear.

Having thought this through, I would be interested in doing this program again, and here's what I would do differently. I would re-tool the survey, making it clearer to understand. I'm convinced I created some confusion by trying to design the survey for both in-house clients and their families. Family members had assumed that the questions were directed at the family overall, but the intention was with the specific loved ones involved in our treatment programs. I believe that would have had a large impact on the results.

The sample size, being significantly small also had a large impact on the results. I would replicate the program with a minimum of 30-35 participants.

As well, another difficulty that emerged from this research is that people stated that they needed help with communication, and conflict resolution, and that there needed to be more family involvement in the recovery process. These were observations from family members who were not addicts themselves, which sets a tone for future cohesion within these families. The intervention did not contain a component on communication and conflict resolution skills, and thus, the interaction between the family and the member in treatment did not noticeably improve. Providing the participants with better communication skills would create possibilities of real transformation in the family unit. Communication was based around the family members interacting casually amongst themselves in terms of helping an addicted family member. Additionally, communication strategies were designed to help family members begin to interact with an addicted family member, who of course can be very problematic, especially when the

addicted family member is in the throes of their active addiction. More time could have been devoted to communication and conflict resolution.

The program needed to be replicated with a better explanation of what the survey was trying to accomplish (the survey was geared to the quality of life in respect to the client in our treatment centres, not the family overall). Additionally, more time needed to be given to participants to fill out the questionnaires, for the richness and texture of the program were found during the analysis of the qualitative data, not the quantitative.

The sample size, being significantly small (18 started, 13 completed) had a large impact on the results, and the lesson learned is that we needed to start with the larger group size to take into consideration people dropping out and not completing the program. This program was intended for family members of clients who were involved in our residential treatment centres, for example, one client in the residential treatment centre referred three different family members to the family program, and when the residential client was asked to leave the treatment centre for inappropriate behaviours, the three family members in the family program dropped out, dramatically impacting our completion rate. This created some barriers to filling the seats as we had a limited target based population. If I would replicate this program, I would make it available to the general public, heightening the public awareness of the program, through the extensive network that the InnerVisions Recovery Society has developed. The ideal number of participants would be in the range of 30 to 35 assorted family members.

Another difficulty we encountered occurred when we started phoning the different families that residential clients had referred to the family program. There was reluctance in many cases to obtain a commitment to participate in a six-week program. While everyone stated that they needed to have an understanding of what was going on with their loved one in terms of

addiction, when offered an opportunity to participate in this program, a large number of families declined citing reasons such as taking holidays, previous commitments, that it was too long, and some stated while it was important, they were not willing to commit that much time to addressing this issue in their family. The lesson learned from this theme; is that family systems are indeed complex, and fortified. The people who attended the program were highly motivated and extremely curious, while a similar number of people contacted, equally agreed that a problem existed, demonstrated reluctance or low motivation to attempt to improve their family situation.

Another challenge that emerged from the data was the need to focus more on family communication and connection. The six-session intervention was designed and developed for family members of addicted people, and as a result none of the family members in the residential treatment centres were in attendance. What became apparent was that while all people were being educated to a degree, the absence of family connection was very evident. It became noticeable towards the end of the six sessions that all parties would need some sort of facilitation to begin the reconnection process.

While all participants agreed that the information was very valuable, there was much discussion around how to actually begin implementing a process of reconnection with the family member suffering from the addiction. If I were to replicate this program, I would create a minimum of two counselling sessions after completion of the family program. Here, family members and the client in treatment could be provided with guidance, support and structure so that the family could be reunited, and strategies for the future developed to produce a healthy and cohesive family unit.

The family participants described feelings of anger, shame, love, and most importantly, a genuine awkwardness in terms of forgiving their loved ones in treatment for some of the devastating manifestations of their addiction. Addiction breaks up families, destroys trust, and damages communication. While education for family members is important, it does nothing to heal the damage that addiction has caused to the family unit. This can only be accomplished by creating a therapeutic alliance between the family member and the client in treatment. Furthermore, I contend that clients who successfully complete treatment and family members, who successfully complete the family program, being brought together in a safe environment could only accelerate the process of forgiveness, and more importantly begin the process of building authentic trust; ultimately this process would develop a better quality of life for all. The importance of self-communication and reconnection between the family member and the client in treatment is a critical component of a comprehensive program.

The final theme that emerged from this research was the importance of continuing to offer high quality programs for family members and clients in treatment in a very cost-effective manner. A significant amount of qualitative data indicated that this program was a very much-needed resource in our local community based on the participants' feedback in the questionnaires. While the research project was problematic in some areas, the benefits associated with this program far outweigh any of the challenges that we encountered. We have since replicated this program and are committed to continue to do so for a period of one year. Having implemented some of the lessons learned in the second and third programs that we have subsequently offered, the data has varied significantly from the first attempt at running this program. In terms of overall cost, because the organization has locations, access to printed material, and internal transportation should it be needed; the cost per participant is relatively

inexpensive. We will continue to evaluate our family program and make adjustments to the curriculum and syllabus as the data indicates, so we may continue to serve our community with this valuable resource.

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Appendix 1

Questionnaire

What is the impact of

The InnerVisions Treatment Centre's

Family Program?

"Often the longest journey one takes is from the head to the heart."

A Questionnaire

Advisory Team

Jerry Topley	Senior Staff, InnerVisions Treatment Centres
Cory Wint	Senior Staff, InnerVisions Treatment Centres
Brad Clancy	Senior Staff, InnerVisions Treatment Centres
Kim Weselowski	Senior Staff, InnerVisions Treatment Centres
Leslie Colley	Senior Staff, InnerVisions Treatment Centres

Project Researcher

Billy Weselowski Executive Director, InnerVisions Treatment Centres

Project Sponsor

InnerVisions Recovery Society

Project Advisor

Darryl Plecas, ed. D.

Team Facilitator

Survey #

INNER VISIONS
RECOVERY SOCIETY

Residential Treatment Program

August/2003

Dear Potential Research Participant,

You are invited on a voluntary basis, to participate in a research study, which will investigate the impact of The InnerVisions Treatment Centre's, Family Program, on clients and their Families.

I am conducting this study in partial fulfillment of the requirements for a MALT degree from Royal Roads University. The information gathered from these questionnaires now and in three months will be used to determine what impact this program has, how we might improve this service, and what further research we might want to do.

Your opinions are important for this study. The time it will take to complete this questionnaire is approximately 30-45 minutes. Your participation is completely voluntary, and you need only to answer the questions you feel comfortable with. All responses will be kept completely anonymous and confidential. Only the researcher will have access to the individual responses to analyze and prepare the final report.

The knowledge from this study will be available to all who participate. Should you like to receive brief summary of the results of this study, please fill out the small card at the end of the questionnaire.

By completing this survey, it is understood that you agree to having read the above information, and are freely consenting to participate in the study. If you have any questions please contact xxx-xxx-xxxx, or at e-mail to xxxxxxxxx.xxx Your support in this research project is greatly appreciated and I thank you for your time, input, and effort.

Sincerely,

Billy Weselowski

Participant Signature	Date
Researcher Signature	Date

Yes, I would like a brief summary of this completed study,
Please send the results to this address:

Participant Signature	Date

INNER VISIONS RECOVERY SOCIETY

Residential Treatment Program

Part I:

What do you believe contributes to addiction, Please Indicate which phrases are the most important to you?

1) Family Connectedness

Closeness of the family unit

- ❑ Not connected
- ❑ Somewhat connected
- ❑ Adequately connected
- ❑ Very connected
- ❑ Extremely connected

b) Where is your family now in terms of connectedness?

❑ Poor ❑ Fair ❑ Good ❑ Excellent

2) Finances

Ability to live comfortably

- ❑ Financially poor
- ❑ Financially weak
- ❑ Financially stable
- ❑ Financially good
- ❑ Financially excellent

b) Where is your family now in terms of finances?

❑ Poor ❑ Fair ❑ Good ❑ Excellent

3) Communication

Expression of feelings, etc.

- ❑ Poor communication
- ❑ Weak communication
- ❑ Adequate communication
- ❑ Good communication
- ❑ Excellent communication

b) Where is your family now in terms of communication?

❑ Poor ❑ Fair ❑ Good ❑ Excellent

4) Respect

Valuing other Family members

- ❑ No respect
- ❑ Some respect
- ❑ Adequate respect
- ❑ Good respect
- ❑ Excellent respect

b) Where is your family now in terms of respect?

❑ Poor ❑ Fair ❑ Good ❑ Excellent

INNER VISIONS RECOVERY SOCIETY

Residential Treatment Program

6) Stability

Family stableness and constancy

- ❑ No respect
- ❑ Some respect
- ❑ Adequate respect
- ❑ Good respect
- ❑ Excellent respect

b) Where is your family now in terms of stability?

❑ Poor ❑ Fair ❑ Good ❑ Excellent

7) Drinking / Using Patterns

Valuing other Family members

- ❑ No respect
- ❑ Some respect
- ❑ Adequate respect
- ❑ Good respect
- ❑ Excellent respect

b) Where is your family now in terms of drinking/using patterns?

❑ Poor ❑ Fair ❑ Good ❑ Excellent

8) What is the most important contributing factor to your family's difficulties with addiction?

Part II:

To what extent are family activities affected by addiction. Please indicate which phrases best represent what you think.

1) Social/Leisure Activities

Recreational time, hobbies etc.

- ❑ No activity
- ❑ Somewhat active
- ❑ Active
- ❑ Very active
- ❑ Extremely active

b) Where is your family now in terms of social/leisure activities?

❑ Poor ❑ Fair ❑ Good ❑ Excellent

2) Physical Health

Healthy body

- ❑ Financially poor
- ❑ Financially weak
- ❑ Financially stable
- ❑ Financially good
- ❑ Financially excellent

b) Where is your family now in terms of physical health?

❑ Poor ❑ Fair ❑ Good ❑ Excellent

3) Mental Health

Healthy mind

- ❑ Financially poor
- ❑ Financially weak
- ❑ Financially stable
- ❑ Financially good
- ❑ Financially excellent

b) Where is your family now in terms of mental health?

❑ Poor ❑ Fair ❑ Good ❑ Excellent

4) Emotional Health

Healthy feelings

- ❑ Financially poor
- ❑ Financially weak
- ❑ Financially stable
- ❑ Financially good
- ❑ Financially excellent

b) Where is your family now in terms of emotional health?

❑ Poor ❑ Fair ❑ Good ❑ Excellent

2) Health (Physical, Emotional, Mental) Split it up!

❑ Not sure/don't know ❑ Not important at all ❑ Slightly important
❑ Important ❑ Very important ❑ Extremely important

B) Where is the family now in terms of health?

❑ Poor ❑ Fair ❑ Good ❑ Excellent

3) Trust

❑ Not sure/don't know ❑ Not important at all ❑ Slightly important
❑ Important ❑ Very important ❑ Extremely important

B) Where is the family now in terms of trust?

❑ Poor ❑ Fair ❑ Good ❑ Excellent

5) Mostly important goals for you and your fam.

❑ Not sure/don't know ❑ Not important at all ❑ Slightly important
❑ Important ❑ Very important ❑ Extremely important

B) Where is the family now in terms of future goals / dreams?

❑ Poor ❑ Fair ❑ Good ❑ Excellent

INNER VISIONS RECOVERY SOCIETY

Residential Treatment Program

Part III:

I am interested in is what you think is beneficial to you and your families recovery process. Please circle which phrases are the most important to you

1) Cohesion (dope fiend terms eat together closeness, quality time etc.)

❑ Not sure/don't know ❑ Not important at all ❑ Slightly important
❑ Important ❑ Very important ❑ Extremely important

B) Where is the family now in terms of family cohesion?

❑ Poor ❑ Fair ❑ Good ❑ Excellent

2) Addiction Awareness / Education

❑ have had no ❑ have had some ❑ aququet
❑ Much education ❑ Very important ❑ Extremely important

B) Where is the family now in terms of addiction awareness / education?

❑ Poor ❑ Fair ❑ Good ❑ Excellent

3) Spirituality (a beliefe in a higher power of some sort.)

❑ none ❑ Not important at all ❑ Slightly important
❑ Important ❑ Very important ❑ Extremely important

B) Where is the family now in terms of spirituality?

❑ Poor ❑ Fair ❑ Good ❑ Excellent

4) Honesty

❑ Not sure/don't know ❑ Not important at all ❑ Slightly important
❑ Important ❑ Very important ❑ Extremely important

B) Where is the family now in terms of honesty?

❑ Poor ❑ Fair ❑ Good ❑ Excellent

5) Communication

❑ poor ❑ somewhat poor ❑ adequate
❑ Important ❑ Very important ❑ Extremely important

B) Where is the family now in terms of communication?

❑ Poor ❑ Fair ❑ Good ❑ Excellent

6) Use of Community Resources

❑ No understanding ❑ Some ❑ Adequate
❑ Important ❑ Very important ❑ Extremely important

B) Where is the family now in terms of accessing community resources?

❑ Poor ❑ Fair ❑ Good ❑ Excellent

What are the three most important things that would help your fam in recovery

Background Information:

In this section I need you to provide some general information about yourself.

1) Have you had any previous counseling? ❑ Yes ❑ No

2) Have you had any education about addiction? ❑ Yes ❑ No

3) What is your age? Age _____

4) What is your gender? ❑ Male ❑ Female

5) Who are you in the family situation? Relation _____

6) What is your highest level of education? Education _____

7) Are you employed? ❑ Yes ❑ No If so, how long? _____

Comments:

Please offer any additional comments:

Thank You, Again.