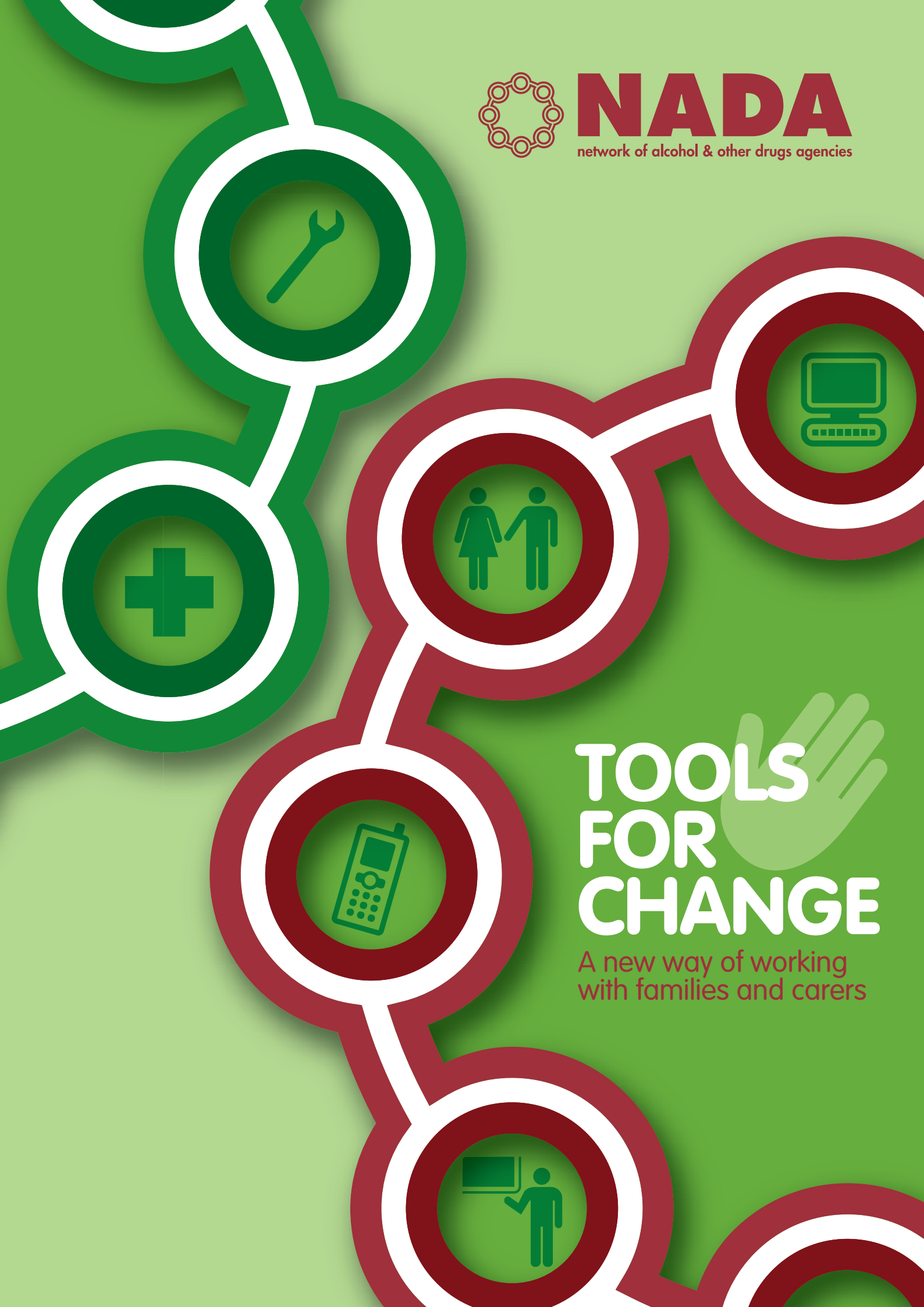
NADA
network of alcohol & other drugs agencies



TOOLS FOR CHANGE

A new way of working with families and carers

The Tools for Change toolkit has been developed by the Network of Alcohol and other Drugs Agencies (NADA) as part of the Mental Health and Drug and Alcohol Family and Carer Project, funded by the Mental Health and Drug & Alcohol Office (MHDAO), NSW Department of Health. The project seeks to improve the support offered to the families and carers of clients with mental illness who access non-government drug and alcohol services in NSW. While the toolkit has been designed for non-government drug and alcohol services, it is transferable for use within any organisation that works with clients who have independent or co-existing mental health and drug and alcohol problems.

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About NADA

The Network of Alcohol and other Drugs Agencies (NADA) is the peak organisation for the drug and alcohol non-government sector in NSW. As a peak body, NADA represents the interests of its members and promotes the diverse and unique role non-government services play in responding to the needs of their community. NADA is also funded to manage projects that build the capacity of members to address specific organisational and service delivery issues, including clients with co-existing mental health issues, responding to the needs of families and carers, information management and continuous quality improvement. These projects are delivered through innovative strategies developed in close consultation with the membership.
For more information go to: www.nada.org.au

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NSW HEALTH

CONTENTS

Families and their needs

Living with someone who's dependent on drugs is often a long and difficult process for those who care about them.

In the early stages of drug use – the pre-contemplation or 'happy user' stage – the family is often in their own stage of denial: they either don't know the drug use is happening or they don't see the warning signs because they don't want to face the impact of the problem. Eventually they're forced out of denial, either gradually by a series of events or by a major incident such as an overdose, arrest or crime. Initial responses are very emotive – fear, guilt, grief and anger being common reactions.

Their families, when they realise they have a major problem, usually want to control things. Most fathers initially want to solve the problem quickly and often they believe ultimatums, control and direction will do the trick. By the time drug taking is entrenched, unfortunately it's beyond simply being a matter of willpower and responsibility.

Mothers, on the other hand, tend to be more sympathetic, supportive and understanding. Unfortunately this can often have a negative side as they become over-involved and responsible, running around trying to help, sometimes hiding problems from the father and at worse becoming 'rescuers'.

Neither form of control works very well, and the family often finds themselves in chaos – feeling powerless and unable to cope effectively. This places stress on the family systems, and some families collapse under the strain; others disconnect from the drug user.

Often the family is keeping things internal. Initial discussions with friends, neighbours, work colleagues and extended family members yield unhelpful, judgemental comments that don't help. Shame and stigma is a powerful force in our community when it comes to drugs, and families start to feel very lonely and isolated. Even trusted people like priests and doctors often reflect community attitudes.

However, all is not lost; family drug and mental health services are now offering support, information and tips on coping. Treatment services offer a way through dependence, and by working together families can negotiate the long, hard journey. No one is more expert on a drug user then their family. The task is to utilise the expertise in productive and constructive ways.

While for most family members the goal is to get their loved one off drugs, they do eventually realise that this is usually a slow, incremental process and many positive steps can be achieved along the road. This can include:

- Better communication among family members, including the drug user
- Building skills that assist families to cope with the various issues
- Putting more effective boundaries in place
- Family members getting on with their own lives – hobbies, interests and relationships
- Putting harm minimisation strategies in place
- Providing information on drugs, mental health, treatment and other relevant matters.

Tony Trimingham
Family Drug Support

WORKING TOWARDS FAMILY INCLUSIVE PRACTICE

WORKING TOWARDS FAMILY INCLUSIVE PRACTICE

DEFINITIONS

Family

For the purposes of this toolkit the definition of 'family' has been broadly defined to include immediate and extended family, partners, friends, carers, and anyone who plays a significant part in the client's life. Other terms used include 'carer' and 'significant other'.

Comorbidity

The terms 'comorbidity' and 'dual diagnosis' are now used commonly and interchangeably. In its broadest context the concept refers to the co-existence of any mental health disorders and substance use disorders affecting the same individual. In practice the term is often more specifically restricted to include severe mental illness (psychosis, schizophrenia) and substance misuse disorder (Williams 2002). In line with recent research, the term 'co-existing mental health and drug and alcohol problems' will be used throughout this document (Velleman & Baker 2008).

Family inclusive practice

This is an approach that recognises that interventions are more effective when they include family members. It supports the view that individuals influence other members in their environment, especially family, and that family members in turn have an impact on these individuals (Kina Family and Addictions Trust 2005).

INTRODUCTION

Co-existing mental health and drug and alcohol problems are associated with a range of social and health problems affecting not only the individual but the family and social network of the individual as well. Yet despite the well-documented negative impact that these problems have on the family unit, treatments tend to be client focused, with families receiving little attention (Copello, Templeton & Velleman 2006).

Families and carers of those with co-existing mental health and drug and alcohol problems often experience heightened levels of anxiety and depression and a higher care-giving burden, and commonly report feeling helpless and isolated. Loss of family support often destabilises the housing situation of an individual, which in turn may lead to greater vulnerability (Price 2002).

The purpose of this toolkit is to assist services in moving towards a more family inclusive model where all parties are considered engaged, supported and involved. With the diversity of services provided in the NSW health system, it is anticipated that the outcome of this will look different for each organisation, acknowledging the different philosophies and capacities of services to respond to the needs of this client group and their families.

While there's no single model that can be adopted by services to meet the needs of families and carers, this toolkit aims to provide services with a range of service models, interventions and practical tools to assist in working towards more family inclusive service delivery.

The toolkit provides interventions that address the three broad categories that family work falls into:

1. Working with family members to promote the engagement of clients into services.
2. Involving families and others in treatment plans.
3. Providing services directly for family members.

(Copello, Velleman & Templeton 2005)

WHY INCLUDE FAMILIES AND CARERS IN YOUR PRACTICE?

It's important to consider families affected by independent and co-existing mental health and drug and alcohol problems for two important and related reasons: first, family members in these circumstances show symptoms of stress that warrant help in their own right; and second, involvement of family members in the treatment of their significant other with mental health and/or drug and alcohol problems can enhance positive outcomes (Orford 1994).

Copello and Orford (2002) argue that an increased emphasis on the role of families and wider social networks in routine service provision can: (i) assist in getting clients to treatment; (ii) improve both substance-related outcomes and family functioning; and (iii) lead to the reduction of impacts and harm for family members and others affected, including children.

Research shows that family work is important in families either where someone has a severe mental health problem or where there are drug and alcohol problems. Smith and Velleman (2007) demonstrated that family approaches can be just as effective when applied to cases where co-existing problems arise as they are when either problem presents on its own. Many of the ideas and skills used in mental health related approaches are the same as those used in drug and alcohol related approaches. They highlighted that work with families of individuals with co-existing problems focuses on the process of change, attributions, motivation and coping. While there are some differences, services can learn from these differences, and collaboration is encouraged to produce family interventions which draw on the best ideas of both traditions.

While further research is required, Copello et al (2006) suggest that several approaches have potential in working towards 'best practice', recommending that services must more routinely: (a) assess the strengths and needs of the substance misuser's current familial and social networks; and (b) implement one or more of the range of evidence-based approaches which impact either the substance misuse in their familial/social context or the affected family members.

Yet despite the accumulating evidence for the important role of families, on the whole service delivery remains focused on the individual, with families and other members of the user's social network playing a very peripheral role, if any. Service providers (and funders) need to pay more attention to, and recognise that there are a broader set of positive outcomes in addition to, reductions in substance use. In this context, the potential reduction of social costs associated with the impact of addictions on other family members is important (e.g. substance-related family violence), as is the reduction of costs associated with resource use through additional health and welfare service demands made by affected family members (Copello & Orford 2002).

Government and other relevant bodies are increasingly recognising the need to engage with families. The Australian National Council on Drugs has identified drug use within the context of the family as a priority area. An intended outcome of the NADA Mental Health and Drug and Alcohol Family and Carer Project is to provide government with more evidence to support the need for further funding in assisting services to work more extensively with this client group.

> ***Family and carers should be integral to the processes of care. It would be valuable to involve them actively in the stages of treatment and to include them as members of the treatment team. (Rassool 2002)***

ASSUMPTIONS OF FAMILY INCLUSIVE PRACTICE

All members of an organisation should be aware of and have an understanding of the assumptions of family inclusive practice:

- Working with family and carers is an essential part of a comprehensive response to working with people with mental health and drug and alcohol problems and entrenched family difficulties.
- Working in an open, respectful and collaborative fashion with families, carers and clients is likely to promote and enhance traditional clinical goals.
- Being open, respectful and collaborative is highly complex and does not always fit well with traditional clinical practices.
- People experiencing mental health and drug and alcohol problems can have a similar effect to major trauma in the sense that trauma puts extreme pressure on clients, families and carers and on their relationships with each other. The effect on families is often hidden and not acknowledged.
- Blame, guilt, grief, shame and frustration are natural companions of the trauma of mental health and drug and alcohol problems and major family difficulties in our culture.
- Most of the personal, professional and organisational responses to mental health and drug and alcohol problems are shaped by complex emotional responses. Some of these responses are helpful, others are not.
- Families and carers have needs in their own right and have a right to have their needs acknowledged.
- By and large, family, carers, clients and workers have a personal and social intention mainly directed to personal and social survival rather than malevolence. Put simply, people usually do the best they can given their situation, history and personal style.
- Approaching families in a generous way, empathising with their hardship and acknowledging their strengths, will in return tend to generate good responses to clients and to workers.
- The distinction between intention (which is usually good) and effect of action is important in understanding why family, carers, clients and workers, at times, all act in extremely unhelpful ways.
- Establishing a trusting relationship with family and carers puts workers in a better position to assist families and carers to overcome crises and problems. This often means time efficiencies in the long term.
- On the few occasions when family and carers behave in destructive ways, an appreciation of the family situation can help workers address this destructiveness more effectively.
- All workers are capable of generating practical ideas for the way your service operates that will improve the quality of life for family, carers, clients and other workers.
- Organisations, while often valuing and supporting family inclusive initiatives, will always find it difficult to change. Organisational change is complex and needs to be approached thoughtfully and with planning.
- It's important to understand these family inclusive assumptions at a personal level in order to be able to make a professional commitment to them.

(The Bouverie Centre 1998)

Specific skills and specialist training is required to undertake family therapy effectively. In contrast, practice that is family inclusive does not require specialist family therapy training and can result in family members receiving the support they need in their own right and can also be beneficial to treatment outcomes for the drug user. (Marsh et al 2007)

CONFIDENTIALITY

It's not uncommon for family members, partners or friends to contact services regarding the progress of a client. Client confidentiality needs to be respected. Any information should be provided only with the agreement of the client, and be in general terms. If the client wants information given to significant others, it can be useful for this to occur with the client present so they know what's discussed. Should the client not wish to disclose information, families and carers should be provided with basic support and general drug and alcohol and mental health information.

It should also be noted that many adult clients don't want family members involved. There are many reasons for this, including conflict with family members, no contact with family members, anger and hurt at neglect or abuse experienced as children from family members, or not wanting family members to know they have a problem. Even in situations when the client doesn't want family members involved with them, or you as their counsellor, family members should still be assisted to find support from other counsellors or other agencies if they want it (Marsh et al 2007).

SAFETY

The safety of all parties, including clients, families and children, is of upmost importance. The Kina Family and Addictions Trust *Family Inclusive Practice Guide* advises that in some situations the maintenance of safety becomes the primary issue and may preclude the involvement of significant others and family or require careful management to protect people. Examples of careful management could include involving a co-worker of opposite gender, having clearly stated rules, and having close liaison with other agencies, especially those providing care and protection, mental health services and services addressing family violence.

Safety reasons for not working with family may include:

- Entrenched and pervasive domestic violence
- Existing sexual abuse
- Unresolved conflict following separation, particularly regarding child custody issues
- Evidence of stress, mental health problems, controlling behaviour or pending separation that precludes effective communication within the family
- Undue hardship for people to attend sessions, or where the client is emphatic that they don't want others involved
- Where the practitioner decides that this approach would detract from engaging with the client, disempower the client or possibly impede the attainment of indentified goals.

In some of these instances referral to specialist services will be required in conjunction with other treatment options. Listen carefully if the client refuses to give consent. The reasons given will provide additional information that the counsellor and the client can address (Kina Family and Addictions Trust 2005).

COLLABORATION

Collaboration goes beyond referral; it should indicate that services have established an ongoing relationship so that the treatment that takes place at one organisation is communicated to and influences the course of treatment or services at the other. This is important in ensuring there's no duplication in services. Such provider collaborations will ensure high-quality referrals, effective outreach and meaningful partnerships. Collaborations should encourage family participation in both services. Of course, determining what a family needs is a decision to be made by the family and not by the service provider. From this perspective, services should encourage empowerment within families to determine their own direction.

Given the complexities of informed consent and confidentiality that arise from adding family interventions to a program's offerings, developing collaborative relationships with mental health and family related agencies is no easy task. Staff members may be called on to be knowledgeable about the services that mental health and family related agencies provide. Matching the resources of various providers with a family's needs and providing the family with information about different options will require a strong community perspective and resource commitment on the part of the service. It may be useful to hold information sessions for staff on local and state wide services (SAMHSA 2004).

QUALITY IMPROVEMENT

Effective quality management leads not only to satisfied clients and improved treatment outcomes, it also allows the sector to reduce its operational risks. The NSW Department of Health (1999) highlighted in the Framework for Managing the Quality of Health Services in NSW that "As techniques to measure the quality of health care proliferate and improve, health professionals are beginning to understand that health consumers and their families, carers and friends hold unique vantage points as expert witnesses to and commentators about care".

The following are examples of quality improvement standards that relate to working with families and carers within your service. They are by no means definitive of the areas that could benefit from working with families and carers, as there are many related standards that could contribute to improving the quality of a service.

Australian Council on Health Standards EQuIP 4 Standards (2006):

Consumer Focus

Standard 1.6: The governing body is committed to consumer participation

1.6.1 Input is sought from consumers, carers and the community in planning, delivery and evaluation of the health service.

Quality Improvement Council Standards (2004):

Alcohol, Tobacco and Other Drugs Services (ATODS) Standard 2.3: The broad context of problematic alcohol and other drug use is explored in the planning and delivery of services and programs.

- By working to improve personal, family and social functioning of people who are engaged in, or affected by, problematic alcohol or other drug use.

The Workplace Audit on the CD-Rom is a valuable tool for services to review and assess their organisation in relation to family inclusive practice.

PRACTICE TIPS

PRACTICE TIPS

CHANGE MANAGEMENT

Use the five key points contained in the 'ADKAR' model for change management to integrate working with families and carers into your organisation's philosophy:

Awareness – of why the change is needed

Desire – to support and participate in the change

Knowledge – of how to change

Ability – to implement new skills and behaviours

Reinforcement – to sustain the change

(Hiatt 2006)

CONDUCT AN AUDIT OF YOUR SERVICE

An audit is a process of gathering information against key questions to understand what's happening currently in your organisation in relation to family inclusive practice. It's a process of observing, collecting and analysing to facilitate reflection, decision-making and change management. This will help inform future planning.

A Family Inclusive Practice Workplace Audit is available on the CD-Rom.

HAVE A POLICY FOR WORKING WITH FAMILIES AND CARERS

The inclusion of a policy for working with families and carers will ensure that all members of staff are aware of the organisation's commitment to working with families and carers and will contribute to improving the quality of the service.

A template policy is available on the CD-Rom.

BE INFORMED – THE ORGANISATION, STAFF, CLIENTS AND FAMILIES

Understand the assumptions of family inclusive practice

It's important that all members of staff understand the assumptions of family inclusive practice. The inclusion of a clause in a staff member's statement of duties could read: "Staff understand the assumptions of family inclusive practice and apply them to their work."

The assumptions of family inclusive practice are shown on page 5.

Educate staff

The goal of educating staff about working with families and carers is to increase staff (and therefore client) confidence and awareness of the role of family involvement in prevention, treatment, recovery and relapse. Increasing staff knowledge of the family as a unit and the influence of the ecological setting with which the drug and alcohol problem occurs should be one outcome of staff education activities (SAMHSA 2004).

Please refer to the Resources section of the toolkit for training organisations as well as the References and Reading section.

> ***All staff in contact with families who have to cope with psychosis or with co-existing problems require an awareness of family work. Without such awareness of family work on the part of staff there will be few or inappropriate referrals. Appropriate referrals are more likely to lead to high levels of engagement.***
> ***(Smith & Velleman 2007)***

Smith and Velleman (2007) advise that staff need: (i) sufficient knowledge of family interventions to see when a family may benefit from this type of help; (ii) the skill to introduce the idea to families; and (iii) knowledge of how to refer to those who will provide the intervention. This level of competence can be achieved by training, relevant presentations, discussions with trained family workers or careful reading of the available literature.

Families and carers

In families where there are co-existing mental health and drug and alcohol problems, there's frequently a lack of knowledge around ambivalence and readiness for change. The stages of change model can provide a useful framework for everyone to understand their role within problem-solving and goal-setting. Lack of knowledge about drug psychosis, the effects of drugs and possible interactions with the client's mental health are also common. There's often a need to provide basic information about drugs and alcohol and their effects, and about psychosis and other mental health concerns (Smith & Velleman 2007).

Clients

Always talk about confidentiality and consent with your client. Any information should be provided only with the agreement of the client, and should be in general terms. As described earlier, if the client wants information given to significant others, it can be useful for this to occur in a session with the client present so they know what information is being disclosed.

An example Privacy and Confidentiality Policy has been developed by the Department of Health and Ageing and is available on the CD-Rom.

> ***As with the client, the family needs to be gradually engaged, and in the long term an aim may be to enable all family members to reduce stress, improve their lives, and develop their own support networks. (Price 2002)***

Know what services are available locally, statewide and nationally

While there are many local services and programs that can assist you in working with families and carers, many clients don't attend a service in their local area, making support for families more difficult. It's important to know what services are available locally, statewide and nationally.

Please refer to the Resources section of the toolkit for family and carer support services.

Seek help if you don't know the answer

You don't need to be the expert. There's no expectation that you'll completely understand and have total competence in working with families. There are many organisations that specialise in working with families and carers that can assist you.

Please refer to the Resources section of the toolkit for family and carer support services.

EFFECTIVE COLLABORATION

As discussed earlier, collaboration is more than two organisations providing parallel services. Effective collaboration can also provide opportunities that don't only apply to client work but have the potential for development, education and respect for the other staff member the particular client may be engaged with. The inclusion of a collaboration clause in a staff member's statement of duties highlighting the benefits of collaboration would be valuable. A clause could read: "Be responsible for the provision of collaborative care, working collectively with other health professionals involved in the continuum of service delivery with a focus on the best outcomes for the client and their family, minimising duplication of service delivery and increased learning and development opportunities for the staff involved."

ASSESSMENT

A widely used tool that has both assessment and therapeutic value is the genogram. This visual representation of a family can help you identify patterns or themes within families that may be influencing or driving the client's current behaviour. This process is also used to identify key family members who can be included in recovery plans, particularly those who are seen to be supportive.

A Simple Guide to Genograms and Standard Symbols for Genograms are available on the CD-Rom.

Another useful tool designed to detail a client's social networks is the Family Support Scale (Hanley et al 1998), which is also available on the CD-Rom.

CHILDREN AND YOUNG PEOPLE

Aside from identifying children at risk through child protection and mandatory reporting practices, services should also aim to identify young carers. It may be that a child or young person is providing support to the client and may require support themselves. Young carers often feel unsafe, alone and to blame for the parent's mental health and/or drug and alcohol problems. There are services available that can provide respite, information and the opportunity to talk about their situation.

Please refer to the Resources section of the toolkit for support services for children and young people.

WORKING WITH FAMILIES AND CARERS AS A CLIENT IN THEIR OWN RIGHT

It's not uncommon for this client group to seek counselling for themselves in order to help them better cope with their family member's or friend's drug use. It's therefore important that they be provided with, or referred to, appropriate support. Goals and treatment plans for counselling should be negotiated. If the client of the family member is in treatment with one counsellor, it's often appropriate for the support for families and carers to be provided by a different counsellor. This helps clinicians avoid conflicts of interest and breaches of confidentiality (Marsh et al 2007).

> ***Workers should aim to create an atmosphere that is conducive to change by being respectful, supportive and persuasive, not coercive or argumentative, with the assumption being that the family members are the 'experts', not the professionals.***
> ***(Smith & Velleman 2007)***

SERVICE MODELS

SERVICE MODELS

> ***There is no single model that can be adopted uniformly. Treatment providers need to strengthen their capacity to deliver a range of interventions in response to the identified needs of each family. (Australian National Council on Drugs 2008)***

Family inclusive practice is not based on one particular service model. Instead, there are various models that are family inclusive.

The Kina Families and Addictions Trust (2005) has identified the following four theoretical models which underpin family-based drug and alcohol treatments. As described earlier, family approaches in drug and alcohol can be just as effective when applied to cases where there are co-existing problems.

Family Disease Model

The Family Disease Model, or 12-step Model, views addiction as an illness of the family, primarily located with the identified client but also directly affecting the family members, who are seen as co-dependent. Interventions primarily involve the use of the 12-step process of change, often self-help group based, with a view to change occurring in individuals independent of one another. Al Anon is a 12-step group for family members affected by the drug and alcohol use of someone close.

General Systems Theory

General Systems Theory focuses on the relationship between addiction and family functioning, with the view that the addiction is maintained by system interactions. The emphasis is to work on family interactions to effect changes in alcohol and drug use.

Example

The Brief Strategic Family Therapy Model (NIDA 2004) is used to treat adolescent drug use. This model is based on three principles:

- Family members are interdependent.
- Patterns of interaction influence the behaviour of each family member.
- Interventions can be planned that carefully target and provide practical ways to change the interaction patterns.

Behavioural models

Behavioural models focus on the positive and aversive factors existing within a family that influence or maintain alcohol and drug use. The emphasis is on identifying these factors and developing strategies and skills to change behaviour, especially addictive behaviours.

Examples

The McCrady Model (2005) focuses on educating the family about addiction, teaching positive interaction styles (particularly in terms of relapse prevention) and developing skills to improve family relationships.

The Stress-Strain-Coping-Support Model (Copello, Orford, Velleman, Templeton & Krishnan 2000) works with relatives of alcohol and drug users in primary care settings and focuses on identifying stressors, exploring coping skills and developing support systems.

The Community Reinforcement and Family Training (CRAFT) Model focuses on behavioural analysis of the drinking or drug using behaviour and training the family to ensure there's reinforcement for abstinence (Meyers & Smith 1995).

The Stress-Strain-Coping-Support Model (Copello et al 2000) has been effective in reducing stress and improving coping mechanisms. The model contains five steps:

1. Giving the family member the opportunity to talk about the problem
2. Providing relevant information
3. Exploring how the family member responds to their relative's substance misuse
4. Exploring and enhancing social support, and
5. Discussing the possibilities of onward referral for further specialist help.

Results from studies are positive, demonstrating that the intervention can lead to changes in coping, improvements in social support and reduction in physical and psychological symptoms.

Social Behaviour and Network Theory

Social Behaviour and Network Theory (Galanter & Brook 2001) identifies, engages and mobilises a social network to develop a plan that supports an agreed drink or drug use goal. Positive responses to relapse and agreement on alternate, pleasant activities are established. This approach is consistent with resilience, strengths-based and recovery models that recognise the importance of relationships and connections within a person's community.

Other models

It should be noted that there are many approaches that fall within these models when working with families. The following are further examples of family-based approaches:

- The Behavioural Couples Therapy (BCT) approach includes two main components: (a) assessing and enhancing positive behavioural interactions between the substance user and partner; and (b) improving communications skills (Fals-Stewart et al 2004).
- The Behavioural Exchange Systems Training (BEST) program is an eight-week group training program which focuses on changing parental perceptions of the relationship with a young person and providing instruction in assertive parenting responses (Toumbourou et al 2001).

WORKING WITH A DIVERSITY OF FAMILIES

WORKING WITH A DIVERSITY OF FAMILIES

WORKING WITH THE FAMILIES OF YOUNG PEOPLE

Therapeutic interventions with the families of young people are an essential component of any program designed to assist young people deal with any substance abuse issues they may be struggling with. This becomes even more important if the young person has a mental health condition as well as a substance abuse concern.

The family of the young person, which may be either functioning or non-functioning as an effective family unit, is the base from which the young person emerges into the realisation of their real self. The young person who does not have access to the psychological and/or physical resources of their family, even when it's dysfunctional, faces major threats to their emerging developmental needs, mental health needs and substance abuse issues.

The benefits of interventions with families are largely focused around the communication needs, relationship needs and developmental needs of the young person. Added to this are the various needs the family unit itself has in maintaining itself in a healthy or even an unhealthy systemic way. When some of these matters are addressed in family therapeutic sessions, the young person has a greater opportunity to move on from any blocks they may have in these areas.

In addition, when a young person has mental health issues, the family may be the principal resource from which information about the genesis and ongoing nature of the problem can be had. This information is important in the development of an ongoing treatment plan to deal with the complex problems surrounding the co-existence of mental health and substance abuse matters.

The challenges for anyone making any therapeutic intervention with families and young people with mental health and substance abuse are myriad. They are manifested in a whole range of human behaviours, from aggression and violence on one hand, to love and compassion on the other.

Therapeutic interventions with the family and young person which address any behavioural, cognitive or spiritual dysfunction of the young person within the family context are an integral part of the treatment of substance abuse and mental health issues with young people and are the gold standard of treatment.

If you have any questions please contact the Ted Noffs Foundation on 02 9310 0133.

WORKING WITH ABORIGINAL AND TORRES STRAIT ISLANDER FAMILIES

Whether you're Aboriginal or not, looking after someone you love with a drug or alcohol and/or mental health problem is tough. Many families suffer in silence, hoping to 'fix' the problem themselves. Cultural obligations are strong – so we stick to family no matter what.

Unfortunately, a lot of us feel shame that stops us from sharing our troubles and getting help. We also worry about others gossiping about us behind our backs. Working with families who are suffering takes time, and it's important that we earn their trust.

Here are some things to keep in mind when working with Aboriginal and Torres Strait Islander families:

- Give information. Tell it how it is but say it with respect.
- Be open-minded and show a positive response when someone says they're ready to talk.
- Be a good listener. Don't interrupt with your own stories or share personal information.
- Create a space for the person to express their own feelings and tell their own story, rather than focusing wholly on the substance user.
- Show empathy and don't judge. Work on building a trusting and confidential relationship, and don't expect carers to tell you everything when you first meet them.
- Think about the family you're talking to, their personal history and culture, and adapt your talk to suit them.
- Don't offer one answer or pressure them into a single action, like getting their loved one into treatment or chucking them out of home.
- Remind them that other families have also dealt with the problem.
- Know your Australian history. Consider how the history of dispossession and socio-economic disadvantage affects Aboriginal and Torres Strait Islander people psychologically, emotionally and spiritually, and impacts on Aboriginal and Torres Strait Islander families.

Remember, trust is a big issue for Aboriginal and Torres Strait Islander families. If you're referring them to someone else, try to make sure that the trusting relationship you've set up is continued. Always ask if an Aboriginal and/or Torres Strait Islander worker is available.

(Taken from *No Blame, No Shame! A Worker's Guide,* (Streetwize Communications and NSW Department of Health 2007).

The full version of this resource is available on the CD-Rom.

Useful number: Carers NSW Aboriginal and Torres Strait Islander Carer Program – 1800 242 636

WORKING WITH THE FAMILIES OF GAY, LESBIAN, BISEXUAL AND TRANSGENDER CLIENTS

Diversity as strength

In gay, lesbian, bisexual and transgender (GLBT) communities, meanings of 'family' may vary widely and be viewed in very broad terms. People may create families that are made up of individuals who take on the significant role of family to provide love, support and encouragement, and assistance to weather life's challenging situations. These chosen families can include friends, partners, families of partners and ex-lovers as well as some biological family members, and may even include individuals who've died or are no longer an immediate part of the person's life (SAMHSA 2001).

Members of chosen families may have shared experiences of hostility or indifference in the broader community in response to their GLBT identity.

One of the situations that most GLBT people face is that of having to 'come out' to their biological families and risk being rejected. Working with biological families may require assisting them to adjust to the person's sexual identification, being mindful that an attitude of tolerance to others doesn't always indicate acceptance of members of their own family (Crisp & McCave 2007).

Increasing numbers of GLBT people are choosing to have children outside of traditional two-parent heterosexual relationships. This adds further complexity to ideas of GLBT family and the issues these families may face. As individuals and the broader community adjust to these new families, care is needed to ensure that relationships are recognised and appropriate services provided.

Considerations for working with GLBT families (SAMHSA 2001):

- Demonstrate respect, understanding and support for chosen and biological families. These individuals must receive the same services as those offered to spouses and family members of heterosexual clients.
- Be sensitive to the diversity and variety of relationships in the GLBT community. Although many individuals seek out a life partner, others are single or may find themselves in non-traditional arrangements.
- Be sensitive to the individual's self-identification; not all individuals in relationships with people of the same sex, or engaging in same-sex behaviour, consider themselves lesbian or gay.
- When working with same-sex families, care needs to be taken to ensure that parental status is sensitively determined. Many lesbian couples, for instance, view themselves as 'mothers' regardless of whether they are a biological parent or not. Similarly, many men who are biological fathers feel hurt or offended at terms such as 'donor' or 'donor-dad' (Millbank 2003). The best method of determining someone's parental status is to ask them.

If you have any questions please contact ACON's AOD Team on 02 9206 2000.

WORKING WITH CULTURALLY AND LINGUISTICALLY DIVERSE FAMILIES

In 2006 about one-quarter (26%) of those living in NSW were born overseas, and about one in five (21%) spoke a language other than English (LOTE) at home (ABS 2006a). There's a highly diverse spread of countries of birth and languages spoken among the NSW population, with no particular regions or languages dominating. The most common languages other than English spoken at home were Arabic, Cantonese, Mandarin, Italian, Greek and Vietnamese (between 1% and 3% each) (ABS 2006b). The local government areas with the highest levels of diversity were Auburn, Fairfield, Canterbury, Strathfield, Burwood, Rockdale and Bankstown, with more than half the population speaking a LOTE at home in these LGAs. Looking at non-metropolitan areas, 21% of people living in Griffith spoke a LOTE at home (ABS 2006c).

It's impossible to summarise the complexity of issues, feelings and circumstances that individuals and families experience when someone they care about has a drug or alcohol problem. When practitioners deliver programs in the drug and alcohol field it's important that issues of culture and diversity are part of the fabric of all reflection and discussion.

Here are some questions for practitioners to ask themselves:

- Am I working in a client-centred way that allows me to reflect on any assumptions I may have about culture and language?
- How might individuals and families from a CALD background understand concepts like treatment or counselling?
- What might help look like in some families' lives?
- What impact does shame have on families seeking support, and how may people understand confidentiality?
- How does cross-generational conflict and new roles and freedoms affect how families function?
- How has the migration experience affected the resilience of what may have been a very different extended family network?
- How has the trauma of a refugee experience affected families?
- Does my agency know and form relationships with key community members to begin to address access issues for CALD families?
- Is the literature I display and produce in community languages?

These questions can begin a process that allows us to review our services and practices to improve the health of those families who are affected by alcohol and other drug use.

If you have any questions please contact the Drug and Alcohol Multicultural Education Centre (DAMEC) on 02 9699 3552.

Other useful contacts:

DAMEC Counselling Service
DAMEC is a CALD-focused counselling service which provides counselling for individuals, and information, education and support to family members in relation to alcohol and other drug use. Telephone: 02 9699 3552

Co-Exist NSW
Assisting people from culturally and linguistically diverse communities and their families:
1800 648 911

Transcultural Mental Health Centre
www.dhi.gov.au/tmhc

Interpreting services
Community Relations Commission: 1300 651 500
Commonwealth Translating and Interpreting Service: 131 450

Please refer to the CD-Rom for information on Assessing the Need for an Interpreter and Guidelines for Working with Interpreters.

WORKING WITH THE CHILDREN OF CLIENTS

There are many ways in which children and young people who have a parent with co-existing mental health and drug and alcohol problems can be supported. Providing help early and assisting families to access appropriate support can reduce risks. Workers can help families access parenting programs, playgroups, respite, childcare and suitable health services. Even if children are in out-of-home care, families can still access these supports (NSW Department of Community Services 2005).

It's difficult to overestimate the levels of anxiety and general stress these children experience, and they may process this in a complex variety of ways. These methods may appear temporarily suitable but are often ultimately maladaptive; for example, children may internalise blame and take on guilt and a sense of responsibility for the wellbeing of the user and the family as a whole. They may subsequently feel compelled to 'fix' or hide the problem in some way. Others may 'act out' in ways that see them encountering social, educational and legal difficulties.

Here are some key points to note:

- Children can often feel isolated, like they're the only kids in their predicament. Group work can be a good way of creating peer support and validation.
- They will often feel divided in their loyalties to family members, or very protective of their family as a whole. As such, it's important to adopt a non-blaming, non-judgemental approach, with a harm-reduction imperative.
- Clinicians will always need to bear in mind just how much 'change' is possible or safe to generate within the context of the broader opportunities and limitations of the child's family situation.
- Likewise, the longer-term, after-hours involvement of at least one responsible adult (be it a parent, guardian, extended family member or case-worker) is important in assisting the child to seek, initiate and maintain relevant change in appropriate and sustainable ways.
- Clinicians working with children can effectively role-model appropriate adult-to-adult and adult-to-child communication skills.
- It can be important for children to hear from adults that they didn't cause the problem and they don't need to fix it, and to receive permission to focus more on things they can change and be responsible for, such as their behaviour and day-to-day lives.
- Working with children from families impacted by problematic drug and alcohol use can be crucial to breaking often intergenerational patterns of abuse, neglect and drug and alcohol use, with the provision of opportunities to understand the continuum of use, stages of change and how to process emotions being vital.
- Services like Holyoake work with children from as young as five. Children under this age should ideally be assessed and assisted by early childhood/child psychology/paediatric specialists.
- It's important to have a clear service protocol for Department of Community Services involvement to communicate with the children and their families.
- Children will often present with the belief that they'll automatically 'inherit' their parent's or sibling's 'addiction'. This myth is dispelled by explaining current findings about what is and is not inheritable, and by reminding children that they're accessing information and assistance that can further reduce this likelihood.
- Finally, and most importantly, while statistics and reality will indicate that these children are an 'at risk' group, the fact that they've often displayed acute, significant survival and adaptation skills should not be overlooked, for these are the same abilities that see many of them surge ahead with the benefit of targeted and timely intervention.

At Holyoake we're in a unique position to offer specialised groups for 5–17-year-olds affected by a family member's substance use issues.

Our Kaleidoscope program aims to offer a supportive and therapeutic setting over eight weeks for children to share their experiences with other children of similar age and circumstances and gain some skills in handling the issues they face in relation to the substance use issues in their family. We help children to reinforce skills in self-care, and in turn we hope to have some influence on breaking the potential development of inter generational transmission of drug and alcohol problems. As we work within a family systems approach, we believe that the needs of children and young people affected by drug and alcohol issues needs attention and support from all those working with families in the drug and alcohol field.

If you have any questions please contact Holyoake on 02 9904 2700.

Please refer to the Resources section of the toolkit for support services for children and young people.

INTERVENTIONS

INTERVENTIONS

The Turning Point Alcohol and Drug Centre has produced clinical treatment guidelines outlining 12 interventions for engaging with families. While the range of interventions is not exhaustive, it provides an idea of the type of interventions that a service might like to add to their existing services. There's no expectation that a service will take up all, or any, of the following interventions. This section of the toolkit serves as a guide to potential interventions in working towards family inclusive practice.

While the original guidelines focus specifically on drug and alcohol, mental health has been included for the purpose of this toolkit.

INTERVENTION 1:
CONSIDERING FAMILIES WHEN WORKING WITH CLIENTS

At the first point of contact with a client, practitioners will ask clients questions that relate to family and significant others. It's important that this happens at the first point of contact with the service in order to establish a framework for family inclusive work. Sample questions could include:

- Who's important in your life at this moment?
- How do they support you?
- Do they know that you're attending the service?
- Would they support you in this work?
- Would you like them to be involved in treatment, and in what way? (If your agency is not able to provide this service, you will need to refer them to one that does.)

Please see the Genograms on the CD-Rom provided with the toolkit.

INTERVENTION 2:
TELEPHONE SUPPORT FOR FAMILIES

Telephone support for families involves practitioners providing information and support over the phone to family members who have a relative with drug-related issues. It differs from telephone counselling in that it often involves only one contact with the service, and focuses more on information-giving than on therapeutic support.

Please refer to the Resources section of the toolkit for other telephone support and counselling services.

INTERVENTION 3:
EFFECTIVE REFERRAL OF FAMILIES TO OTHER SUPPORT SERVICES

Organisations should develop up-to-date information on other services in their local area that they can refer families to. This may include family-specific services or programs (such as Family Drug Support and others listed in the Resources section of this toolkit), support services, community health centres, family support agencies, doctors, allied health professionals, and private counsellors and psychiatrists.

While organisations may not have the resources to provide direct services to other family members, they need to be aware of and support family members to seek assistance for themselves. If family members feel supported and informed this may, over time, assist the client in their recovery.

Please refer to services listed in the Resources section of the toolkit.

INTERVENTION 4:
PROVIDING WRITTEN ALCOHOL AND DRUG AND MENTAL HEALTH INFORMATION TO FAMILIES

There's a substantial amount of written information on drug use and mental illness that is available in the community. This information can be helpful to families in understanding the facts about and treatment options for drug use and mental illness. Realistic information can assist family members to understand what the client is experiencing, and can reduce anxiety or give them a clear base from which to take action. Material is presented to families relative to their level of comprehension and understanding, and acknowledges that family members differ in the amount of information they might find helpful. Accessibility, accuracy and relevance of material should be considered.

Please refer to the Resources section of the toolkit for more information.

Note: Some telephone support services are run with trained staff and/or volunteers and don't involve counselling, or giving verbal information or advice. However, they do give support to family members of people with drug and alcohol and/or mental health issues. The major benefit of this is that they give time, empathy and a non-judgmental listening ear, exploring options and referral to other services (especially for treatment). For the affected families, having this support is a unique and empowering experience and is often their first experience of being able to speak openly to someone who understands. Many callers ring back for ongoing support.

INTERVENTION 5:
PROVIDING COMMUNITY EDUCATION FORUMS FOR FAMILIES

Organisations may choose to run a series of community education forums for families of clients using their services and for the broader community. These are one-off forums that focus on information about mental illness, drugs, the impact on clients and families, and resources available. Information is available at these forums on specific services that families may choose to refer themselves to.

A more informal way of providing information to families that has proved successful for many services is through activities such as family barbecues and scheduled days for families to visit the service.

Your local Community Drug Action Team (CDAT) may be able to assist you in holding a community education forum or barbecue. For more information, or to find your local CDAT, go to www.communitybuilders.nsw.gov.au/drugs_action/

INTERVENTION 6:
ESTABLISHING SUPPORT GROUPS FOR FAMILIES

Facilitated support groups for families are auspiced by the organisation providing them. They're developed and facilitated by experienced drug and alcohol counsellors within the organisation who have skills at managing complexity in groups. They differ from self-help groups in that they're time limited, the service is responsible for facilitation, and participants are registered as a client of the service.

STRUCTURED GROUPS

Some organisations run structured groups over a number of sessions, e.g. Family Drug Support's 'Stepping Stones', Manly Drug Education and Counselling Centre's 'Paving Ways' and Holyoake programs.

These tend to be closed groups which have a structured agenda to guide participants through the various issues confronting family members with drug and alcohol and/or mental health issues. Groups are run by skilled group leaders and facilitators and involve a mixture of information and interactive group exercises.

INTERVENTION 7:
SELF-HELP GROUPS

Self-help (peer support) groups for families whose relative has problems with drug use are usually developed in partnership with drug and alcohol services. They aim to develop mutual support and information opportunities for friends and families of those using drugs. Establishment of self-help groups involves a commitment by the organisation in the initial stages of the group's development, with this reducing over time. Ongoing support of self-help groups by services involves providing the group with information on how to access guest speakers, topics of interest and new information on services.

Please refer to the Resources section of the toolkit for a list of self-help groups.

Some organisations (e.g. Family Drug Support) run self-help groups with trained facilitators to ensure meetings do not get bogged down or dominated by certain group members and to ensure group rules are observed. Self-help groups are open to all family members and generally do not have fixed agendas but focus on the current issues of attendees.

INTERVENTION 8:
TELEPHONE COUNSELLING

Telephone counselling is usually actively developed within an organisation and provides therapeutic intervention, in addition to information and support. Trained and experienced telephone counsellors should ideally provide this counselling. Skills in single session therapy can be useful in telephone counselling.

While some services may be able to offer this service, there are also alternative options, such as referral to Talk Link, operated by Carers NSW.

For more information go to www.carersnsw.asn.au

Please refer to the Resources section of the toolkit for other telephone support and counselling services.

INTERVENTION 9:
SINGLE-SESSION THERAPY

Single-session therapy is a single consultation aimed at optimising existing resources and capitalising on a readiness to change. It's not a model of therapy in itself but has been developed using the principles and ideas of family therapy and brief/solution-focused therapy. It was developed in response to the high numbers of clients who attend one session of therapy only, and to a growing body of research that indicated that clients on the waiting list for counselling often made significant gains by the time they were offered therapy.

INTERVENTION 10:
PROVIDING COUNSELLING TO FAMILIES – INDIVIDUAL AND JOINT

Organisations that provide counselling to clients may choose to involve family members in their counselling sessions. The purpose of this needs to be agreed by the client and the family members before going ahead. This may include joint counselling or separate sessions for family members.

The issues that clients face are complex and can alienate them from family, social and community support. For the client trying to deal with these issues in isolation, or with only the support from the service, this can be extremely difficult. Complex difficulties, although focused on the individual, can often be better addressed through a team approach. Family members can be recruited to be on the client's team, rather than being seen as a further stress or problem in the client's life.

INTERVENTION 11:
SUPPORT FOR FAMILY MEMBERS WHOSE RELATIVE IS NOT A CLIENT OF THE SERVICE

Family members may contact treatment services seeking support for themselves where the person is not a current client of the service and may never be. Any of the interventions listed in these guidelines may be provided to the family in these situations, depending on the resources available in the organisation.

INTERVENTION 12:
NETWORKING AND LIAISING WITH OTHER FAMILY-FOCUSED ORGANISATIONS (INCLUDING MENTAL HEALTH SERVICES)

When services have developed and are practising family work, they may choose to be involved in wider family support networks and forums in their local community and their organisation. Attendance at these forums can be useful for developing information and knowledge about services and new initiatives. It can lead to joint work with other services, and it can provide broad support for the work being undertaken in the organisations. It can also provide a means of accountability to the broader community through the exposure of the organisation's work.

It should be noted that, when considering using any of the above interventions, services should be mindful that some clients may have been accessing services for some time. It may be that families have been engaged by other services. Effective collaboration with mental health or other relevant services will ensure there's no duplication of services being offered to families.

A copy of the clinical guidelines can be purchased directly from Turning Point – www.turningpoint.org.au

SERVICE PROFILES

SERVICE PROFILES

ODYSSEY HOUSE – BRIEF PROGRAM

Odyssey House McGrath Foundation was established in Australia in 1977 to provide residential services (therapeutic community) for drug-affected individuals who had suffered the adverse consequences of their alcohol and other drug usage.

Odyssey House believes that the families of substance misusers play an important role in the recovery, or lack of recovery, of their loved one. Many studies have highlighted the dual role families can have in the recovery process of their loved ones, either positive or negative. It's important to engage families, where appropriate, in family therapy or counselling to explore and work through the conflicts and issues which prevail in these family environments. Families have tremendous restorative abilities which can enhance and support the recovery of their loved one.

In 2003, Odyssey House commissioned a family therapy initiative, BRIEF – Better Relationships In Every Family. The BRIEF groups are an attempt to deal with the issues of family discord due to the substance misuse of a family member. The groups are of a practical nature to enable families to explore their issues within a supportive environment along with other family peer groups.

The program consists of six sessions:

1. Communication skills
2. Family relationships, roles and responsibilities
3. Self-esteem and trust building
4. Assertiveness and managing conflict
5. Dealing with grief and finding happiness
6. The family as a team – moving forward.

The results from the groups – according to feedback and assessment processes – indicate a high level of satisfaction among participants as to the efficacy of the six group sessions.

Why does the program work?

- No blame, confrontation or guilt
- Opportunity for families to begin the long road of getting together again
- Allows everyone to learn something about themselves and explore histories, actions, grief, strengths and resilience
- Part education, part therapeutic, part support
- Tears, but also plenty of laughter
- The role and personality of the therapist or co-therapist
- Flexible content and program.

For more information on the BRIEF program, please contact Odyssey House on 02 9820 9999.

KEDESH REHABILITATION SERVICES – FAMILY ASSISTANCE PROGRAM

Based on the growing evidence for family work, Kedesh Rehabilitation Services (KRS) developed the Family Assistance Program, which has been funded and supported by the Department of Health and Ageing, National Illicit Drug Strategy.

What the program hopes to achieve

1. To improve client outcomes (particularly for clients with dual diagnosis issues) by integrating direct vocational, health promotion and systemic and family interventions within the existing rehabilitation program
2. To increase client autonomy and management of their own health needs
3. To reduce relapse rates of individuals (particularly clients with dual diagnosis issues) by increasing effective family support.

Clients are asked on intake if they're interested in engaging in family therapy. Past experience has demonstrated that in this initial phase of treatment clients tend to be focused on their own internal experiences (high anxiety, being physically unwell) and are unable to adequately access external needs such as those of the family. Clients also present with little understanding of what family therapy is and how it could benefit them, their families and their recovery. Due to these factors we identified that we may not be effectively capturing clients who would find the Family Assistance Program useful.

To address some of these issues, a family therapy group was developed for clients in Week 1 of the program. This group was designed to allow clients to explore their needs in terms of family therapy, and for KRS to briefly describe what family therapy is and to present the Family Assistance Program. The family therapy group was designed with specific consideration for a client's early vulnerable state and the emotive nature of family issues. The group allows clients to explore their family relationships in a safe, non-confrontational environment and to consider their possible family therapy requirements.

Additionally, clients in the early weeks of recovery tend to be focused on their own internal needs and may not as yet have developed the insight or grounding to tackle external family relationships. To address this, a second family therapy group mid-program (Weeks 4 to 6) was implemented. By this stage clients have settled into the program and have developed insight into their substance use and how it has impacted them and those close to them. Along with post-program family therapy sessions, this allows clients to address current relationship problems in real time and to become solution focused rather than problem focused.

This holistic program has been successful in incorporating strategic interventions to facilitate integrated case management, with a particular emphasis on meeting the needs of clients with substance misuse and co-existing mental health disorders. The project has been characterised by increasing the multidisciplinary structure of the Kedesh clinical team. Specifically this involved providing access to an occupational therapist to address needs in vocational, physical health promotion, medication management and housing domains, and a family therapist to address reintegration and interpersonal relapse prevention needs. Staff are also being trained in family therapy.

Family member involvement, as identified in client focus groups, continues to be actualised through a two-hour external family member psychoeducational group, a one-hour client family education group, and the opportunity for three individual family therapy sessions. Family therapy groups have overwhelmingly been a popular service of interest – with the exclusion of families unable to attend due to distance.

For more information on the Family Assistance Program, please contact Kedesh on 02 4222 1800.

MANLY DRUG EDUCATION & COUNSELLING CENTRE – PAVING WAYS

Background

In 1999, the Manly Drug Education and Counselling Centre (MDECC) counselling and treatment team experienced a heightened awareness of drug-related issues and needs in target priority populations such as young people, parents and families.

In MDECC's 2000–2003 Strategic Plan, it was identified that within the counselling and treatment program MDECC couldn't meet the demands of parents and family members seeking assistance on how to deal with their loved one's drug and alcohol use on a one-to-one basis, thus giving rise to the development of a therapeutic family support program.

The program

Paving Ways is a six-week program which aims to provide support and education and to improve coping skills for families. The model recognises that families are an important resource, one that should be valued and nurtured.

Over the six weeks the topics covered include:

- Stages of Change Model/the family's journey
- Fears and coping strategies
- Responsibility, trust and letting go
- Self-esteem
- Communication
- Bringing it all together.

Each topic is a valuable process, but it is the overall process of the program that's important, and participants are encouraged to attend every session. Once commenced, the program functions as a closed group to enhance the therapeutic safety and maintain focus on process.

Paving Ways is currently run approximately four times per year. Each time it is evaluated, and over time there have been modifications to some components to keep the program in line with the needs of participants and evidence-based best practice. Since its beginning, the program has added a workbook and peer support component, both of which were recommendations from past evaluations.

Challenges

As with many community-based projects, challenges mainly arise in the area of consistent recruitment to the group, and there have been times when Paving Ways would require no advertising and others when it did. While MDECC is aware that there is such a need, it's still important to network effectively within the community so that there's an ongoing awareness that such a program exists. With such little support for families and carers of those with drug and alcohol issues, it's essential that the program be publicised as much as possible.

Difficulties can arise when members from blended families (e.g. biological and step-parents) attend the same group. It has highlighted the need for MDECC to thoroughly assess the relationship between these members and the comfort or discomfort of attending the same group before the commencement of the program.

Outcomes

The program has received an enormous amount of positive feedback from participants who have attended; they have made comments about the difference that the support and new skills have made to their family life.

In many cases the program has seen progressive shifts in a family's system or working so that a loved one who may be refusing treatment can make changes. By working with the family as a whole the outcomes are far more productive and progressive.

MDECC Parent Support Group (Reunions)

Families who have previously completed the Paving Ways Program at MDECC are invited to continue to attend reunions, which are held every three months and are facilitated by counsellors at MDECC. The reunions allow participants to have a sense of belonging, a safe environment in which to discuss issues, and a supportive group of families who can relate to each other's experiences. Due to a number of requests for additional reunions, the first Paving Ways Peer Support Group was held in May 2008. This group is held at MDECC but is hosted by two family members who have previously completed the Paving Ways program. These groups are held in between the reunion meetings and occur approximately three times a year. Participants have provided excellent feedback in regards to satisfaction with the Paving Ways Support Group. In addition, the families are encouraged to network with each other away from MDECC to increase sustainability of the support network.

For more information on the Paving Ways program, please contact MDECC on 02 9977 0711 or www.mdecc.org.au.

HOLYOAKE – HELPING FAMILIES BREAK THE DEPENDENCY CYCLE

Holyoake Family Alcohol and other Drugs (AOD) programs achieve positive changes when working with the families of people with substance use problems, regardless of whether the users themselves seek help. Developed in Western Australia in the 1970s in response to the dire lack of services for family members, Holyoake is now the largest AOD non-government organisation in WA and has affiliates throughout Australia.

Pioneering the idea that drug and alcohol problems can be effectively managed within a family systems group therapeutic framework, Holyoake offers a range of programs for all family members – from children through to parents, partners, siblings and grandparents. The group programs provide families with coping skills and effective strategies that have been found to indirectly accelerate the user's progression through their own change process. By working with both children and adults, Holyoake aims to break the intergenerational transmission of AOD problems.

Research conducted by the University of Wollongong with Holyoake showed that 63% of people with problematic substance use either reduced or stopped their use or sought help within six months of their family member's completing a program. Evaluation has also shown that Holyoake clients experience positive changes regarding anxiety, depression, physical symptoms and relationships.

Group programs tailored for all family members:

Focus Program – a 12-week group education, support and therapy program for partners, spouses and other family members of people with a dependency problem, past or present. Topics include the process of dependency and change, family coping styles and dynamics, boundaries, communication, stress and self-responsibility, grief and anger management and self-esteem.

PAUSE Program – for parents who are concerned about their child's AOD use. The program covers all areas in the Focus Program but with additional information on parenting strategies, drug education, expectations and how to 'let go' of the drug problem and still be a parent.

Pathways Adolescent Program – a safe environment for young people aged 12 to 18 to consider their AOD use and develop strategies to control or stop their use.

Kaleidoscope Program – age-specific group therapy for children from the age of five who have a parent or sibling affected by a substance use problem. The eight-week program conveys three basic principles: "It's not your fault, you don't have to fix it and it's important to take care of your own feelings and needs".

Men's and Women's Programs – these promote an improved lifestyle through increased self-esteem and raise a client's awareness of the issues relating to their substance use so they can make informed decisions about their use (Maitland only).

Holyoake also runs outreach groups in partnership with other organisations.

For more information on Holyoake programs, please contact Holyoake on 02 9904 2700 (Neutral Bay), 02 4934 8537/4961 2686 (Maitland) or holyoake@catholiccare.org.

FAMILY DRUG SUPPORT

The aim of Family Drug Support (FDS) is to help families throughout Australia to deal with drug issues in a way that strengthens relationships and achieves positive outcomes.

Our energies are given primarily in supporting families struggling as a result of drug use. We aim to assist in any way possible to empower families to cope with the realisation of their situation and to survive it intact.

Established in 1998, FDS provides a variety of support services to families affected by alcohol and other drugs.

The services offered include:

- National telephone helpline, 1300 368 186, offering 24-hour, 7-day-a-week support, unlimited time, at the cost of a local call
- Website, www.fds.org.au, which includes a bulletin board, chatroom and extensive information for families affected by alcohol and other drugs and/or mental health issues
- Regular support meetings currently in 16 locations around Australia offering facilitated, non-judgemental support in an open setting
- Bi-monthly magazine, *FDS Insight*, which contains easy-to-read articles, information, current drug and alcohol issues and personal stories
- A comprehensive resource, *A Guide to Coping*, which gives information, coping tips and practical help for families
- Bereavement support for those who've lost loved ones
- Other written resources such as *Drugs and Prison*
- Training for volunteers and group facilitators
- Bridging the Divide – a project funded by the Australian Government which aims to specifically assist families of people accessing treatment and also treatment workers to be able to deal with family issues.

Stepping Stones to Success

Since 2000, FDS has run approximately 125 Stepping Stones to Success courses and is currently running more than 20 per year. The course is structured around the stages that families go through in dealing with drug and alcohol and/or mental health issues.

Stepping Stones to Success is a program that requires participants to commit their time and energy to a two-weekend or nine-week course.

The goals of the program are to:

- Provide a safe and trusting place for families to tell their story and express their emotions
- Improve wellbeing of self
- Improve wellbeing of the entire family
- Increase confidence and competence in managing drug issues
- Improve communication and problem management skills
- Become better educated regarding drugs
- Have a realistic view of where you are on the journey
- Become more self-aware in areas requiring work for positive change
- Acknowledge and strengthen all relationships within the family.

Stepping Stones Workbook

FDS and the Australian Drug Foundation have produced a workbook for use by participants in the course but also for those who live in areas where they are unable to attend a Stepping Stones to Success course. The workbook contains valuable information, exercises and support by FDS.

The Bridging the Divide project offers treatment services:

- In-service training sessions/workshops on how to work more effectively with families
- In-service sessions to discuss and align treatment expectations for families
- Partnerships with treatment services to run new support groups and Stepping Stones courses
- Ways to enable treatment clients to reconnect with family and friends
- Dedicated 1300 884 186 support number for both treatment staff and families with members in treatment
- Comprehensive staff training pathways to achieve any or all of the above.

For more information, please contact Family Drug Support on 02 4782 9222.

BRIDGES

Bridges' network approach and family work

Bridges recognises that no single organisation can address drug issues on their own. Bridges takes a network approach that is systemic and strengths-based and which builds relationships to address drug issues. Bridges targets families and communities in the work we do, recognising that families and communities can be affected by and have an impact on problematic drug use. They need to be engaged, as they need support and also can be part of the solution.

Examples of our network approach and work with families can be seen in two projects we have undertaken targeting children.

One involved running therapeutic groups for children affected by parental substance abuse. We partnered with Holyoake, who have a wealth of experience in working with this target group. Bridges engaged the clients and supported the group, while Holyoake were the main facilitators. Bridges also provided counselling for the substance-using and non-substance-using parents, and follow-up work with the children.

Another is our work with Indigenous children, who we engaged through our partnerships with Mt Druitt Indigenous Church and Wilmott Public School. We ran a 'photovoice' project with the children. The children learnt the skills of digital photography, and had their voices heard through their photos and their photos published in a booklet – *Wilmott is the Best Place to Be*. This booklet can be downloaded from the Bridges website www.bridges.org.au. This project increased resilience and addressed protective factors, and it supported the children to have an increased sense of belonging, greater pride in their community, and increased respect, connections and understanding from their peers and broader community.

Developing relationships with other organisations such as these takes time. However, the benefits include shared skills, resources, energies and ideas, as well as the ability to increase our accessibility to target groups who may be marginalised.

For more information on Bridges' network approach and family work, please contact Bridges on 02 9622 7511 or info@bridges.org.au.

NSW HEALTH FAMILY AND CARER MENTAL HEALTH PROGRAM

The Family and Carer Mental Health Program is based on a service model that addresses the needs of families and carers through a strongly linked service model that recognises the need for:

Family-friendly mental health services

The program supports the development of mental health services so that families and carers are recognised, supported and included in treatment planning and service provision.

Generic family and carer supports

The program supports awareness of, and access to, mainstream support services such as counselling, respite and financial support.

Mental health family and carer support

There are four NGOs supplying the Mental Health Family and Carer Support Service, providing not only education and training to build coping skills and resilience but also support services such as direct provision of individual support, information, advocacy and peer support.

The Mental Health Family and Carer Support Service is available to all family and carers affected by the co-existence of mental health and drug and alcohol problems of someone close, and can provide a valuable source of referral.

Please refer to the CD-Rom for the contact details of the non-government mental health service providing information and education to family and carers in your Area Health Service.

RESOURCES FOR FAMILIES, CARERS AND SERVICES

RESOURCES FOR FAMILIES, CARERS AND SERVICES

FOR FAMILIES AND CARERS

Telephone support lines

Alcohol and Drug Information Service
Information, advice and counselling service for people with problems related to drugs and alcohol.
Telephone: 1800 422 599/02 9361 8000

Family Drug Support
Telephone support for families affected by alcohol and other drugs.
Telephone: 1300 368 186

Co-Exist NSW
Assisting people from culturally and linguistically diverse communities and their families affected by co-existing mental health and drug and alcohol problems.
Telephone: 1800 648 911

Lifeline
Counselling and information service for anyone needing support.
Telephone: 13 11 14

Parent Line
Counselling and support for parents and care-givers.
Telephone: 132 055

Talk Link
Information and referral, emotional support and counselling for carers.
Telephone: 1800 242 636

Support services

Family Drug Support
Support groups and programs for families and carers.
Telephone: 1300 368 186
www.fds.org.au

Holyoake
Programs and referral information for parents, children, young people and partners affected by drug use in the family.
Telephone: 02 9904 2700

Al-Anon Family Groups
A fellowship for family and friends affected by the problematic alcohol use of someone close.
Telephone: 02 9570 3400
www.al-anon.alateen.org/australia

Nar-Anon Family Group
A fellowship for family and friends affected by the problematic drug use of someone close.
Telephone: 02 9418 8728

ARAFMI NSW
Support, education and advocacy for families and friends of people with mental illness or disorders.
Telephone: 1800 655 198
www.arafmi.org

Carers NSW
The peak body for carers, including young carers. It provides a range of support and information services, and lobbies on behalf of carers in NSW.
Telephone: 1800 242 636
www.carersnsw.asn.au

Carers NSW Aboriginal and Torres Strait Islander Carer Program
Telephone: 1800 242 636

Relationships Australia
Provides a range of services aimed at building stronger relationships.
Telephone: 1300 364 277
www.relationships.com.au

Counselling Online
This service is free for anyone seeking help with their own drug use or the drug use of a family member, relative or friend.
www.counsellingonline.org.au

Family Relationships Online
Provides all families (whether together or separated) with access to information about family relationship issues, ranging from building better relationships to dispute resolution.
www.familyrelationships.gov.au

Support services for children and young people

Holyoake
Programs and referral information for parents, children, young people and partners affected by drug use in the family.
Telephone: 02 9904 2700

Kids Helpline
24-hour telephone counselling service and web counselling for children and young people.
Telephone: 1800 551 800
www.kidshelpline.com.au

Children of Parents with a Mental Illness (COPMI)
Provides information for family members across Australia where a parent has a mental illness and for people who care for and work with them.
www.copmi.net.au

Headspace
Australia's National Youth Mental Health Foundation, providing services to young Australians aged 12–25.
www.headspace.org.au

Young Carers
Providing information and support for young people caring for a family member, friend or relative.
Telephone: 1800 242 636
www.youngcarersnsw.asn.au

Youth Drug Support
Providing information to young people with drug and alcohol, mental health and other relevant issues.
www.yds.org.au

Reach Out!
A web-based service that helps young people get through tough times.
www.reachout.com.au

Useful reading for families and carers

A Guide to Coping
Available from Family Drug Support – www.fds.org.au

Carers Support Kit
Available from Carers NSW – www.carersnsw.asn.au

Drugs and Prison: A Handbook for Families and Friends of Prisoners
Available from Family Drug Support – www.fds.org.au

The Families Handbook: A Guide for the Families of Prisoners
Available from Community Restorative Centre – www.crcnsw.org.au

Not My Family, Never My Child: What to Do if Someone You Love is a Drug User
By Tony Trimingham
Available from Family Drug Support – www.fds.org.au

The Sane Guide for Families
Available from Sane – www.sane.org

Stepping Stones Workbook: Guiding Families through the Journey of Coping with Drug and Alcohol Use
Available from Family Drug Support – www.fds.org.au

Unchartered Waters: Support for Carers, Family and Friends
Available from ARAFMI – www.arafmi.org

FOR SERVICES

Training organisations to support staff in working with families

Bouverie Centre Family Institute
Telephone: 03 9385 5100
www.bouverie.org.au

Centre for Community Welfare Training
Telephone: 02 9281 8822
www.acwa.asn.au

Education Centre Against Violence
Telephone: 02 9840 3735
www.ecav.health.nsw.gov.au

Holyoake
Telephone: 9904 2700
Email: holyoake@catholiccare.org

Institute of Family Practice
Telephone: 02 8830 0755
www.ifp.nsw.edu.au

MHCC – Learning and Development Unit
Telephone: 02 9555 8388
www.mhcc.org.au

Relationships Australia
Australian Institute for Relationship Studies
Telephone: 02 8874 8090
www.relationships.com.au

TAFE NSW
Telephone: 131 601
www.tafensw.edu.au

Other information and support services

Network of Alcohol and other Drugs Agencies (NADA)
Peak body for non-government drug and alcohol services in NSW.
Telephone: 02 9698 8669
www.nada.org.au

Mental Health Coordinating Council (MHCC)
Peak body for non-government mental health services in NSW.
Telephone: 02 9555 8388
www.mhcc.org.au

FamS (NSW Family Services Inc)
Peak body for non-government family support services in NSW.
Telephone: 02 9692 9999
www.nswfamilyservices.asn.au

NSW Department of Community Services (DoCS)
Promotes the safety and wellbeing of children and young people and works to build stronger families and communities.
Telephone: 132 111
www.community.nsw.gov.au

NSW Users and AIDS Association Inc (NUAA)
Provides education, practical support, information and advocacy to users of illicit drugs, their friends and allies.
Telephone: 1800 644 413
www.nuaa.org.au

Drug and Alcohol Multicultural Education Centre (DAMEC)
Primary focus is to bridge the service gap by assisting and supporting service providers to make a difference to the way they access and service culturally and linguistically diverse clients.
Telephone: 02 9699 3552
www.damec.org.au

Druginfo (NSW Department of Health)
The official NSW Government website on drug issues.
www.druginfo.nsw.gov.au

Additional resources

Clinical Treatment Guidelines for Alcohol and Drug Clinicians, No 11: Working with Families
Available from Turning Point Alcohol and Drug Centre – www.turningpoint.org.au

Dual Diagnosis Support Kit: Working with Families Affected by Both Mental Illness and Substance Misuse
Available from NSW Department of Community Services – www.community.nsw.gov.au

Families and Carers Affected by the Drug and Alcohol Use of Someone Close
Available from NSW Department of Health – www.health.nsw.gov.au

Family Inclusive Practice in the Addiction Field
Available from Kina Families and Addictions Trust – www.kinatrust.org.nz

No Shame, No Blame: A Workers Guide for Helping Aboriginal and Torres Strait Islanders Affected by Drugs and Alcohol
Available on the CD-Rom in this toolkit

Therapeutic Journeys: Counselling Family Members
Available from Sushi Productions – www.sushiproductions.com.au

Therapeutic Journeys: Counselling Aboriginal Clients and their Families
Available from Sushi Productions – www.sushiproductions.com.au

Please note: There are also many local programs and resources that can assist you in working with families and carers.

USING THE *TOOLS FOR CHANGE* CD-ROM

The following documents are available on the *Tools for change* CD-Rom and NADA website.

Workplace Audit
The Workplace Audit is a process of gathering information against key questions to understand what's happening currently in your organisation in relation to family inclusive practice. It's a process of observing, collecting and analysing to facilitate reflection, decision-making and change management. This process could form part of an internal quality improvement system.

Template Family Policy
This template policy can either be used as a stand-alone policy or incorporated into an existing policy, and should be tailored to meet the needs and philosophy of your service.

Simple Guide to Genograms
This visual representation of a family can help you to identify patterns or themes within the family that may be influencing or driving a client's current behaviour.

Family Support Scale
A useful tool designed to detail a client's social networks.

Family Member Impact Assessment
An assessment designed to examine the impact a client's mental health and drug and alcohol problem has on families and carers.

Consultancy Form
This form is used to collect data on families and carers seeking support and to record the services provided by your organisation, including telephone support, information and effective referral to other services.

Consumer and Carer Involvement in Comorbidity Treatment Planning Tools
This Department of Health and Ageing project included a model, process and the development of information kits for both carers and consumers. While the kits are quite lengthy, they can be tailored to suit the needs of your service. The kits contain useful information for families, ranging from general information to discharge planning. It may be valuable to spend time setting up the kits to incorporate your service's policies and philosophies.

The documents available on the CD-Rom include:

- Model for Consumer and Carer Involvement in Comorbidity Treatment Planning (including policy outlines: Cultural and Literacy Policy, Process for Service Re-entry Policy, Consumer and Carer Participation Policy and Privacy and Confidentiality Policy)
- Process for Consumer and Carer Involvement in Comorbidity Treatment Planning
- Planning Together Information Kit – For Carers
- Planning Together Information Kit – For Consumers.

Comorbidity Information Kits are also available from the Department of Health and Ageing.

No Shame, No Blame! Workers Guide
A guide for helping Aboriginal and Torres Strait Islander families affected by drugs and alcohol.

NSW Family and Carer Mental Health Program
Contact details for non-government mental health services, providing information and education to families and carers by Area Health Service. A useful referral point for families and carers affected by the co-existence of mental health and drug and alcohol problems of someone close.

How to: Assessing the Need for an Interpreter
A tip sheet to help you determine when and how to use an interpreter.

Guidelines for Working with Interpreters for Counselling and Health Care Staff Working with Refugees
A valuable tool for staff working with culturally and linguistically diverse groups and refugees.

List of Support Services for Families
A list of available services for families and carers. This could also be adapted to include service information and be provided to families and carers.

Tools for change
A new way of working with families and carers.

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